Family Medicine

The Turkish Model

The Ministry Of Health Of Turkey

FAMILY MEDICINE: THE TURKISH MODEL

ANKARA 2006

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THE TURKISH MODEL

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EDITOR
PROF. DR. SABAHATTİN AYDIN

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PREPARED BY
DR. SİNAN KORUKLUOĞLU
DR. YUSUF ÜSTÜ
DR. İSMAİL KASIM
DR. A. REŞAT DOĞUSAN
DR. ALİ HACIİMAMAĞAOĞLU

•

ENGLISH TRANSLATOR
ERSİN BALCI

•

ENGLISH EDITOR
DR. SİNAN KORUKLUOĞULU

•

ART DIRECTOR
MEHMET EMİN

•

MAKE-UP
BÜLENT AVNAMAK
SABİT ERTAŞ

•

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FAMILY MEDICINE

PREFACE

Maintenance of the right of health requires a very complex process, ranging from individual health concerns to public health. In many countries general medicine has been successfully implemented, especially in Europe, and the importance of primary health care has shown a marked improvement through reforms, and its positive impact on the cost has been more and more realized.

According to new the approach pervading across the world, the diagnostic, therapeutic and rehabilitative services in the primary health care are included in the definition of basic health care. In the new conception of basic health care, the family physicians assume the primary duty.

Through the Health Transformation Programme, the family medicine, one of the most important strides made in solving the problems that has not been solved so far, is finally being launched with a new approach. We set up our project on family medicine, recognizing the invaluable contributions that had been made by our fellow citi-

zens. This booklet has been prepared bringing together all the works done in the past; and, to depict the whole picture of the issue in question, the countries which have made important strides in promoting health had also been examined in place.

Without rejecting the former achievements, we are attempting to build a new model of practice. To achieve this goal, leaving aside the discussions whether it should be practiced or not, we are calling on everyone to contribute in every phase of introducing family medicine to our country, which has gained a worldwide acceptance.

All the work we have done on introducing family medicine to our country has been accomplished through the wide-range participation of the relevant units of the Ministry of Health, specialist physicians, academicians, physician associations, and primary health care physicians.

I would like to thank everyone who contributed to this work. I would also like to thank all previous governments, all volunteer organizations, all international organizations that give support to our country, and all relevant private and corporate persons for their contribution to improving health and health systems in our country. I express my best regards to all who are behind this effort, believing and hoping that with the advantages of the practice of family medicine our health system will improve, the consequence of which will be providing of our citizens with a healthier life.

PROF. DR. RECEP AKDAĞ
THE MINISTER OF HEALTH OF THE REPUBLIC OF TURKEY

1. INTRODUCTION

Today, health is regarded as a fundamental element of social development. While classic theories of development explain development in terms of many socio-economic and cultural indicators such as GNP per capita, level of industrialization and employment, and consumption level of primary goods and services, today, it is explained primarily in terms of education and health indicators. For it has been realized that high level of income and consumption is not sufficient as a measure of the development of a country. So, today, countries are regarded as developed in terms of their having solved the education and health problems.

The World Health Organization (WHO) resolved that in order to achieve "the goals of health-for-all in the 21st Century", the countries themselves must establish their priorities and prepare urgent action plans, considering the following major principles:

- Health is a fundamental element of social development.
- Equality and integrity of persons must be respected.
- The promotion of health must be based upon a person-centered approach.
- The developments should be evaluated and monitored with scientific methods.
- The continuity of health care must be maintained throughout the whole life span.

Turkey has similar health care problems with those found in both developed and developing countries. Our country entered into the 21st century with complexity in the organization of health care services. This complexity causes difficulties in the coordination of the services delivered and hinders people from benefiting sufficiently from them. One of the problems of the Ministry of Health is its being organized in a centralist structure. The distri-

bution of health care professionals in the country has become unbalanced in years, due to workers' preference of working in developed regions and insufficient encouragement by governments for workers to work in undeveloped regions. The complexity of regulations to regulate the duties and responsibilities of health care professionals, and the insufficiency of those regulations in certain issues has brought about complications and sometimes arbitrary practices in the delivery of the service.

One of the most important steps to be taken in our country to deliver the health care services in an equal and effective manner is to provide them in the appropriate level. If primary health care services are mostly provided in the secondary-level, as it is the case in our country, we cannot talk about the diffusion, equality and productivity of health care.

Everyone has the right to live a healthy life and it is guaranteed under Article 56 of our Constitution. From a citizen-centered perspective, reconstruction of health care is an undelayable necessity.

In our Constitution, health related issues are summarized as thus:

"Everyone has the right to live in a healthy, balanced environment.

It is the duty of the state and citizens to improve the natural environment, and to prevent environmental pollution.

To ensure that everyone leads their lives in conditions of physical and mental health and to secure cooperation in terms of human and material resources through economy and increased productivity, the state shall regulate central planning and functioning of the health services.

The state shall fulfil this task by utilizing and supervising the health and social institutions, both in the public and private sectors.

In order to establish widespread health services general health insurance may be introduced by law."

The most important main act on health care, the Socialization of Health Services Act numbered 224, was adopted in 1961 and its implementation started in 1963. In this act, the medical services are listed in an hierarchical order from the lowest to the highest as follows: health post, health station, secondary level hospital and tertiary level hospital. However, the implementations after the act came into force were not in accordance with what had been planned and health care problems were not able to be solved in a reasonable extent.

Another important act regulating medical services is the Main Act on Health Care Services numbered 3359. It states that in the planning of medical institutions across the country to offer an equal, qualitative and efficient service, a balanced geographical distribution of health care professionals is fundamental.

Since 1978 Alma-Ata Declaration, the idea of "health-for-all" has played an important role in the development of health care policies and the establishment of the priorities of health care systems; thus, giving priority to basic health care has been accepted. The declaration demands urgent and effective works to be done through technical cooperation to improve basic health in accordance with the economic level of the countries.

According to the WHO, the health care system must provide good quality health care services for all. The services provided must be effective, affordable and socially acceptable. In planning a health care system, a country must develop its own one, considering these factors.

2. WHERE ARE WE IN HEALTH CARE?

A health care system must be qualified to perform certain major functions such as basic health care services, improving physical conditions and human resources, financing the services and investments, collecting data for planning and policy development. The coordination of these independent functions ensures the success of the system.

It is known that there are significant differences among the health indicators of countries with a similar level of expenditure, income and education. Extra expenditures are not always reflected on indicators and the quality of health care services. Some health care services are very cheap considering the amount of benefit gained. And, on the other hand, some health care services can be very expensive although they are provided only to a small population in a limited way. The issue of equality is as striking as that. Poor patients who cannot afford to pay either cannot get treatment, or cannot access the services at the same quality level, or they have to wait for more time to get treatment.

Equal provision of health care services is reflected positively on public health. Health care systems must assure the effective use of existing sources, giving particular attention to prior needs. To achieve this, a functional infrastructure to maintain the effective and equal delivery of healthcare services, the participation of costs, and a balanced distribution of professionals and resources must be built. Important steps to be taken are the prevention of citizens from illnesses and relieving the complaint of a patient during his/her first contact with the health care system as much as possible. Another important point is the establishment of a well-defined and good-working referral system from the physician, the first one to be consulted by a patient, to regional hospitals, and to training hospitals.

2.1. A look on the practice of primary medical services and family medicine

The European Union has introduced a Public Health Programme for 2001-2006 with the aim of contributing to improving public health, preventing human illness and disease, and removing sources of danger to health. According to this programme, as general practitioners / family physicians work in the front line of health care, and meet the patients in different situations in life, they have an important role in health prevention. The need to inform the patients must be made obvious to the health policy makers in the different countries so that they organize and finance primary health care in such a way that doctors can take responsibility for effective preventive services and health promotion.

In the 1978 Alma-Ata Primary Health Care Conference, as an approach to basic health care services, the countries were recommended to develop throughout an accessible, that is, a cheaper, more rational, and more efficient system, rather than to focus on complex servic-

es requiring specialty skills. However, the Alma-Ata Conference, having evaluated basic and primary health care services for the individuals as a whole, brought about a conceptual confusion. In the 2000 WHO Report, we see that the difference between them was put forward more clearly. In the new approach, which is becoming increasingly popular worldwide, the concept of “basic health care services” is used to mean the services involving preventive health care, and including primary therapeutic and rehabilitative services, in which family physicians and family health nurses assume the key role.

What is meant basicly by family medicine is the medical practice to which individuals and their dependants can easily access and which is the point of first medical contact with the health care system. These doctors undertake most of the outpatient diagnostic and therapeutic procedures, besides the preventive health care prac-

tices. In different countries, these services are provided by graduate physicians or general internists or specialist physicians. While a medical doctor who completed his/her training in the faculty of medicine is called a physician, the physician who specialized in the field of family medicine is called in some countries a “general practitioner” or in others a “family physician/doctor”. As such persons also serve as the personal doctors of fam-

ily members, we commend using the terms “family physician” or “family doctor” for those who perform the defined services, without making a distinction between a specialist or a practitioner. With the aim of the services be given by the specialists, the existing physicians can be given the opportunity to be specialists through continuing training; however, it is not part of this booklet to explore this issue.

In a successful health care system, education and counseling of the patients, and coordination among various service providers is as important as the provision of the service itself. A family physician, regardless of the socio-

economic level of his/her patients, will serve as a counselor, a service provider and a coordinator. It is obvious that the countries seeking to improve the level of health of their peoples must establish a viable and efficient preventive health care system and give a particular emphasis to basic health care services. And, family medicine plays a crucial role in achieving this goal. It can be seen that this goal is approached, although at differing levels, in the countries where it is implemented. However, day by day family medicine is undergoing change and improving in various regions. Therefore, in spite of seeing the practice of family medicine as a static model, we have to take it as a model that may undergo modifications according to changing regional conditions.

In improving and strenghtening family medicine, distinctive regional, cultural and national characteristics must be taken into account to increase the performance of the health care system. The distinctive economic, political, social and cultural characteristics of a country, its burden of disease and distinctive epidemiology are important dynamics to develop appropriate health care strategies and to establish the resources. For this reason, family medicine practices vary from country to country.

In many countries with low income, family medicine is understood as similar to community medicine and as almost the synonym of basic health care services. In those countries, basic health care services are delivered to the public not only through doctors but also through nurses, midwives, other medical professionals and even through trained local people. These medical professionals, who assume the role of bringing basic health care especially to rural areas remote from population centers, are named as “basic health care professionals”. As the rapid development of medicine requires a steady increase of the level of knowledge and skills, it is obvious how limited can be the practice of basic health care services in that way. In such countries with limited resources, another effective and

important duty of the family physicians is to maintain the training of those basic health care professionals and to give guidance on referring patients. In some countries like Bulgaria, which undergo political turmoils and regime changes, the health care systems are subject to change through revolutionary ideas. In health care reforms of those countries, family medicine practice is mostly included. Those reforms for decentralization, organizing financing resources, and giving priority to private sector have been bringing about new problems due to hasty implementations. The variety of practices and the lack of coordination have been causing uncertainity and distrust so that the main goal of the reform to offer equal and accessible health care service for all is not being able to be achieved. Nevertheless, the most important feature of family medicine is that it assumes the task of coordination in the complex, multidiciplinary, and multi-sectoral health care system. If the practice of family medicine is planned on the basis of that feature, it will assume an important role in overcoming the problems.

In some countries, goals such as individual satisfaction and savings on medical expenditures are being brought into prominence. Although these are the major advantages of family medicine, focusing on them may lead to an impasse where, while the rich benefitting from health care services, the poor are ignored. Therefore, control mechanisms must be established and the system must be taken as a whole. The freedom of choosing one's own physician and a universal access to a good-quality but cost-effective health care service must be aimed. This will ease the acceptance of the system into the society. Raising the public awareness on health issues on the one hand, and supporting family doctors both professionally and financially on the other, will play an important role in establishing an integrated health care system.

It is not so easy to exemplify the forementioned variety of priorities and practices separately on the basis of coun-

tries. In many countries, more than one example can be found together at different levels. Therefore, health care system planners must form the family medicine system, according to the basic needs of their own countries. It is natural that there are differences in practice in accordance with the social, cultural, economic, political and geographical conditions of our country.

2.1.1. Examples of various practices of family care

Below are given different models of family medicine services in different countries where the forementioned major principles are successfully practiced.

2.1.1.1. The Netherlands

In the Netherlands, the social security system is grounded on insurance. There are two kinds of health insurance, both of which are mandatory: the first one, AWBZ, covers 100% of the population and guarantees long-term and expensive treatments; while the other, ZFW, the health care funding system, covers 60% of the popula-

tion. ZFW is only for those with low income, and also for those over 65 years old. The remaining 40% of the population insure themselves with private insurance companies for basic health care and the treatment of short-term illnesses. The health care expenditures make up 9% of the GNP per capita.

In the Netherlands, the conception of basic heath care covers more service areas than it covers in other European countries, since it also includes outpatient treatments, and mental health and home care services, which are performed at different facilities. Besides general medical services, those facilities also provide curative services, maternity nursing), care nursing and pharmaceutical treatments.

47% of general practitioners (family physicians) work self-employed and single practice Gradually more physicians prefer working as teams in health centers. Briefly 625 of 7.000 general practitioners dispenses pharmaceuticals to patients like pharmacists.

In Dutch health care insurance system, almost all insurance companies stipulate that a patient must consult a general practitioner before seeing a specialist except specific situations like that of emergency. Therefore, general practitioner stands in the entrance of the health care system and manages the referral system and the access to other service providers. According to the national statistics, one person consults a general practitioner 4 or 5 times a year. On the average, there are 2.300 patients to a general practitioner. The patients are free to choose any family doctor who will provide the services listed in the health insurance plan. The family doctors, preferred by those who are subject to medical funding system, must have contracted with the fund.

Together with a limited number of fee-for-service, a general practitioner is paid per enrolled patient. In addition to this, he/she is also paid on a fee-per-unit of service basis by the private patients who consults him/her. The income is set on the basis of the assumption that a family physician can theoretically deal with 2.350 patients. The insurance premium may vary depending on being over 65 years old, living in risky areas, and some procedures performed.

2.1.1.2. Denmark

In Denmark, there is a universal health insurance system, within which there are two different groups of health insurance. In the first group of insurance, which covers 97% of population, persons have to choose one particular family physician. They pay neither the family doctor, nor the specialist, nor the hospital on referral from the family doctor. They have the right to change the family doctor after 6 months. In the second group of health insurance, persons pay a portion of the health care service fee. They are free in choosing or changing their family doctors without restriction. They can directly consult any family doctor or specialist. In case of consulting a specialist, there is no need to be referred by a family doc-

tor. But they have to pay an extra charge, charged by the specialist and the doctor receives the fee-per-unit of service from the insurance company.

In Denmark, every family doctor is responsible for the continuing health care and follow-up of an average of 1600 patients. Services such as follow-up of mothers and children, routine examinations, vaccination of children and prescription filling when needed are performed in both office and home visits. In Denmark, there are currently 3.300 family doctors.

An average family doctor sees each of his/her patients 6 times per year. It is preferred that patients choose a doctor in their own neighborhood. However, in case of discord with the doctor, the patient may choose a more distant doctor. Although it is generally stipulated that doctors would not register more than 2.066 patients, this limit is exceeded in locations with shortage of doctors. If the number of persons under the coverage of the first group of health insurance is more than 1.306 per family doctor, another family doctor is allowed to work in that area. In Denmark, there are also doctors who work outside the health insurance system. However, the patients who consult them have to pay the whole fee.

A family doctor is also responsible for providing emergency health care services out of the office hours. To maintain this, there is an out-of-hours duty system in which family doctors in the same area equally shares that responsibility.

2.1.1.3. The United Kingdom

In the United Kingdom, basic health care has been an important area of practice for years. The family doctor (general practitioner) who provides basic health care is the first point of consultation for a patient. Besides direct medical services, the basic health care includes public health services, hospital emergency services, and dental and eye health services. The expenses made for such

comprehensively defined basic health care constitutes 33% of the expenses of the Ministry of Health (National Health System).

Until 1996, different authorities in England, Wales, Scotland and Northern Ireland had been organizing family health services. By that time, these four countries were united under one system.

Family medicine services are provided mainly by self-employed contractual doctors. While dental and eye health services are salaried on a per unit of service basis, a complex system is used to set the salaries of general practitioners.

The health care services provided by general practitioners are called general medical services. And the price of them is paid not by the patients, but by the health authority. 30% of the fund allocated to basic health is spent for general medical services, that is, for the practice of family medicine.

As all the health care expenses are met through the tax income of the general budget, the patients do not pay any

price for those services. Thus, there are no financial obstacles for patients in accessing the primary health care services. Annually, about 300.000.000 patients consult their doctors, 95% of which are general practitioners and 90% of their whole treatment is performed by them. In the United Kingdom, the average person consult their family doctors 5 times per year. 12% of those consultations are home visits, others being office visits and phone calls. Each general practitioner makes 9.000 contacts with 1.800 enrolled patients.

General practitioners work either individually or in groups. In the United Kingdom, the rate of group practice is 80%, most of which are partnerships. Meanwhile, employment of non-physician health care professionals in the field of general medicine is on the rise. Everyone has the right to choose his/her family physician. In the same manner, a general practitioner is free to accept or refuse to register an applicant. To register with a general practitioner some conditions must be met. However, the patients of a general practitioners are not only those determined by the health authority; foreigners with a temporary residence permit can also register with them. They are provided with certain services free of charge such as family planning, mother and child health services, minor out-patient services, and trauma and emergency services.

In the United Kingdom, general practitioners are salaried in different ways. More than half of their income comes from payments per enrolled beneficiary, and the remaing part depends on their performance (fee for per unit of service). And some services such as a certain number of vaccination shots for children and cervical cytology are added into the salary. Moreover, The expenses for staff members, office materials like computers, and other direct expenses are met. When doctors practice under medical groups, the income is shared among general practitioners not on the basis of registered patients or service but on the basis of the partnership contract.

Since 1991, National Health System (NHS) has opened itself to local economy with a new approach and has taken the service providers into the system as fund holders. So, general practitioners who have more than 5.000 enrolled patients can be fund holders in place of the health authority. Those physicians are given a fixed budget to meet by themselves certain hospital services for their patients, including out-patient diagnostic services, and elective surgical services. In this system, which has been implemented in various pilot areas, physicians have to manage the budget prudently to maintain the continuity of their contracts. Thus the system is expected to save in expenses. In the United Kingdom, there are such pursuits aiming at building new factors of stability into the health economy.

A new contract for primary-level physicians suggesting a payment system on the basis of performance has been accepted in a vote in which 70% of the physicians voted, and 80% of them voted “yes”. This has been interpreted

as the indication of the willingness of primary-level physicans to accept a payment system on the basis of the quality of the service they provide.

2.1.1.4. Germany

In Germany, more than 90% of the population is under the coverage of health insurance. For out-patient treatment, it allows choosing the doctor, without making a distinction between general practitioners and specialists; and with some exceptions health care services are provided free of charge. A portion of the prescribed medicine, physiotherapy services, the services for the first 14 days of hospitalization, and the cost of visiting a hospital without referral are met by the patient.

In Germany, family medicine services are provided by general practitioners, pediatricians, internal medicine specialists and other specialists choosen according with the prior needs of the patients. As it is observed that the balance between general practitioners and other specialists has been changing against the latter, the encouragement of new doctors to become general practitioners is being discussed.

In basic health care, the priority is given to defined preventive medical programs, including follow-up of children to 4 years of age and annual cancer screenings. Moreover this, general practitioners are striving to taking place in the fields of social medicine, emergency medicine, health counseling, and occupational health care..

The offices of some general practitioners are as well-equipped as the offices of internal medicine specialists. However, the health care service provided by a primary care physician is limited.

In Germany, the traditional payment system on the basis of per unit of service has been changed since 1996 and it is still in change. In order to limit the services, a gradual payment system has been introduced. For instance, fees for services are reduced after that a certain number is exceeded. On the other hand, in order to prevent doctors from making unnecessary procedures, individual budgets are made. Fixed budgets are made for the patients referred to the non-medical treatments such as outpatient treatments, medicines, physiotherapy, ergotheraphy, and speech theraphy. However, service fees may fluctuate according with the number of the services provided.

2.1.1.5. Poland

In Poland, family physicians are paid per enrolled person. This payment includes the fee for the specialist consultation, minor surgical interventions, and simple laboratory tests. The contract includes the list of the patients for whom the doctor is responsible. New-born babies of the families are automatically added into the doctor's list. However, family doctors demand confirmation, sending letters to the families registered with him/her. While in some regions positive answer is taken as a basis, in other regions negative answer is taken as a basis. In the procedure of registry in which positive answer is taken as a basis, registry with the physician is upon the demand of a person. And in the procedure of registry in which negative answer is taken as a basis, a certain number of persons are registered with a physicians, but in case of a person does not want to be related to that physician, he/she can transfer his/her registry to another physician. All the services mentioned in the contract, including basic health care services, specialty services, and labo-

ratorial and rehabilitative services are provided free of charge. In case of family doctor refers the patient to other specialty services, hospital services and rehabilitation services which are provided within that city are also free of charge.

Family doctors have to serve 5 days a week within office hours. Some family doctors serve 24-hours a day or provide on-duty physicians. Every physician is obliged to employ at least 2 nurses till the number of his/her registered patients reaches 2.500. Basicly, payment is made per enrolled person. However, persons are divided into 3 categories of age (under 6, 6 to 59 and over 60) and their capitation premium is determined on that basis. The premium for infants and children is fixed as 130%, while the premium for the elderly is fixed as 150%. Every month the relevant authority is informed on the amount of realization by sending the bills for charges and the repayment is made within 14 days.

2.1.1.6. The Czech Republic

In the Czech Republic, mandatory health insurance was applied on January 1, 1993. Transition from tax-based

health care services to insurance-financed health care services has been speeded up as health care professionals supported the introduction of the health insurance system. Today those services are met from nine health funds. The system, grounded on equality and solidarity, is financed by the contribution of the individuals, employees and the state. Payments of the unemployed, the retired, students, women left from work after giving birth, males working in the army, prisoners, and those who take social benefits are made by the state. In the transition period in 1990s the financial support has been provided by the state budget, the budgets of municipalities, personal payments, donations and health insurance fund.

The provision of health care services are on a local basis. Local health office is responsible for establishing the necessary conditions for the local people in receiving health care through accessing the primary care physician they choose. Persons can change their physicians after 6 months of the contract with them.

In the Czech Republic, four types of physicians contact with patients in the primary-level: practitioner physicians for adults, practitioner physicians for children and the youth, practitioner physicians who provide with mobile gynecology service, and oral/dental health physicians.

The licence of providing primary health care is controlled by Czech Medical Chamber and approved by local health offices. Then, doctors sign an agreement with insurance funds. Doctors generally work individually or, coming together, they establish health centers or outpatient clinics in which they provide basic health care services besides specialty services. The ownership of the centers are held by municipalities. If those centers are used by private physicians rental payment is required from the center.

Basic health care involves general health, mother and child health, gynecology, oral/dental health, home-care services by nurses, 24-hours emergency health services, preventive medicine services (vaccination, screening, etc.) and laboratorial services. Those centers are well-equipped (with electrocardiograpy, ultrasonograpy, x-ray equipments) and they employ nurses and physiotherapists. Work conditions of the physicians who provide basic health care services vary. Although the rate of consulting to specialists is quite high, this rate is being tried to be reduced. Some primary care physicians also provide specialty services which are beyond the scope of insurance coverage.

2.1.1.7. Bulgaria

The Bulgarian Parliament passed the Health Insurance Act in 1998, with which mandatory and voluntary health insurance was introduced. Mandatory health insurance is a system for protecting the health of the population. Mandatory health insurance, which guarantees a package of medical services, is implemented by the National Health Insurance Fund (NHIF) and by its regional subdivisions, that is, by the Regional Health Insurance Funds (RHIF). On the other hand, the voluntary health insurance is implemented by joint stock companies registered under the Commercial Law.

The aim of the new system is to establish clear and distinct rules in doctor/patient relationship. In this framework, here are some of the major goals: to guarantee an accessible health service at every level of the health system, to provide the patients with medical care of good-quality, to establish competition between doctors and health institutions for patient satisfaction, to set up a sufficient and satisfactory salaries structure for the workers in the health insurance system.

In Bulgaria, mandatory health insurance is implemented in accordance with the major principles of Article 5 of the

Health Insurance Act. NHIF is a public organization. The structure of NHIF has been set up in accordance with the idea of “Funds should be managed by their providers”. NHIF management is grounded on the triplet of “employees, the state and insurants”. The principle of shared responsibility for health is guaranteed by the premiums or by the payments of the state, municipalities, employees and workers. According to the Health Insurance Act, every insurant assumes the responsibility by regular visits for mandatory preventive check-ups.

To be able to raise the responsibility for their own health, the insured citizens pay a certain user fee when using medical services. The amount paid per visit to a general practitioner is 1% of the minimum salary fixed for the country. 2% of the minimum salary for the country is paid for a day's stay in a hospital care establishment, but not more than 10 days a year. A patient who needs a long treatment does not pay a user fee after the 10th day. Certain groups of citizens have been exempted from the user fee: individuals suffering from some specific diseases, unemployed, the military, war veterans, disabled soldiers, socially underprivileged and individuals in social institutions.

Accessibility to medical care is a major requirement of the European social health insurance systems. All citizens have equal rights of access to medical care within the frames of the package of medical services guaranteed by the NHIF.

NHIF is a public institution and separated from the structure of the social healthcare system. NHIF was founded through an act and economically it is independent from the state budget. Representatives of the insured individuals who stand up for their rights participate in the NHIF management.

According to the Health Insurance Act, the financial relations between NHIF and the medical care providers are negotiated at two levels: National (National Framework Contract) and individual. If a provider of medical or dental care does not want to sign a contract with the health insurance fund, his/her work will not be paid for by the fund. The NHIF may withhold contracts of medical and dental care providers, if they do not meet the requirements for providing treatment of good quality. With the introduction of the health insurance system, the freedom of choosing one's own medical care provider is guaranteed and the insured citizens have the right to use the services of medical professionals that have concluded a contract with the health insurance fund, regardless of their location within the territory of the country and the form of ownership.

Bulgarian Physicians' Union has been recognized as the single party to negotiate the fees for health care services provided by family physicians with the insurance companies. But its uncompromising attitude put the process of health care provision into jeopardy. However, the disagreement between the parties has been mostly resolved.

2.1.1.8. Cuba

All Cuban population is under the coverage of health care services which are provided free of charge. As pre-

ventive services are given importance in Cuba, the health indicators of the country have been rised. Health care services are provided by more than 68.000 doctors, 32.000 of which serves as family doctors all around the country, including the whole rural areas. Approximately there are 1.000 patients to 6 doctors. And an average family doctor provides health care services to about 500 members of population per year. Family doctors work both in health centers and offices scattered across the neighborhoods. Every family doctor is assisted by a nurse. Family doctors have four major tasks: providing rehabilitative services and preventive health care services, vaccination, and encouraging a healthy life style. On the other hand, other specialist physicians visit the offices of family doctors on a regular basis where they meet the demand of consultation requests and provide continual training for them.

Patients can directly visit family doctors, polyclinics and hospitals for using health care services. Each health area hosts a polyclinic in which family physicians work amongst local people. Although patients have the right to consult a hospital, most patients consult family doctors. Besides attending their patients in their offices, they often make home visits and follow-up pregnants and children.

In Cuba, to start clinic specialty training, physicians must have receive 2 years of family medicine training, after graduating from the faculty of medicine.

2.1.1.9. Finland

In Finland, one has to register with KELA, the mandatory health insurance, to benefit from health care coverage. Those who are not registered with it are also restricted from benefitting other services provided by the state. Health expenses are met by the taxes collected by central or local administrations. However, health premium, which amounts to 35% of the salaries, is collected by the income tax system. Employees also contribute to this amount.

In Finland, health care services are provided by local administrations. There are health centers in every neighborhood and the local people enter into the health system through general practitioners who work in those centers. Physicians, after graduating from faculty of medicine, obtains the title of general practitioner after specialty training, lasting 6 years. General practitioners work as a team staffed with two physicians, one nurse and one medical secretary.

Patients can also recieve care from physicians who work in their private offices. As they had to wait long for an appointment from the local physicians, patients were increasingly preferring going to private medical offices for a consultation. To prevent it, an act was inacted in March 2004, stiputating that an appointment for an examination in the primary-level must be given within 3 days after the request. This deadline has been set as 3 weeks for an examination in hospital; and, it has been stipulated that patients cannot be waited more than six months for surgeries.

Primary health care services are provided as preventive services, programs for the promotion of healthy life, and therapeutic and rehabilitative services. In the primary health centers which are called health stations, 11 Euro is charged per examination for the first three examinations in a year. In those stations there are also monitoring beds, investigation and scanning facilities. When a referral to a hospital is necessary, the general practitioner takes an appointment from the specialist or the clinic.

2.2. A look on the primary medical care in Turkey

A significant feature of health care services in our country is that they are performed through a central planning and administration. Health institutions across the country are being tried to be administered from Ankara, the capital, through the central bodies of them. About 650 hospitals, 6.000 health station, 6.000 active health posts and other institutions are being administered by the central body of the Ministry of Health. In those institutions, tasks such as construction, renovation, management, staff administration, planning and auditing of the services are administered either directly from the central body or through its local bodies.. Although certain authorities transferred to province bodies, they are yet limited.

Administration and improvement of services through that bulky structure are becoming difficult.

The same health care services are delivered to same persons by a variety of institutions. For instance, vaccination services are provided to the same persons by health stations, mother and child health centers, public hospitals, institution physicians, private physicians, private outpatient clinics and hospitals. And this situation results in duplicated or disowned works, difficulties in logistic plannings, and problems in statistical evaluations.

Health care services are in a fragmented structure regarding both provision of services and financing. The existence of various budget and non-budget revenues has brought about a multi-layered system of health care provision. In our country, there is almost no public institution which does not provide health care service. Some of the ministries, public economic enterprises like PTT, General Directorate of Security, Military, universities, some of the municipalites, and institutions such as SSK (Social Insurance Institution) provide health care in their own hospitals and dispensaries. In such a mentality and complexity of service, primary health care services are, as it were, ignored and excluded from the system. This complex structure prevents the provision of services from being efficient as there are difficulties in administration and supervision. Since the delivery of primary health care services falls short of efficiency, this resulted in the assumption of those services rather by secondary and tertiary health care facilities. On the other hand, the current situation brought about unhealthy management of referral system. This situation leads to a unmanageable patient intensity in secondary health care facilities, therefore to occlusion in the health care provision.

Being one of the important areas of problem, especially in urban areas, health stations are not used as the first point of consultation.. Due to the patient congestion in

hospitals, unwanted and unethical situations like informal payments occur. Informal payments complicates the accession of poor and dispriviledged patients to health care services.

The distribution of physicians and supportive health care professionals varies according to provinces and the rural-urban areas within the same province. In metropols, while population per physician can fall under 500, in subprovinces this number can rise to 15.000-20.000. Health care professionals, clustered especially in metropols, has created an idle capacity. However in Istanbul, ironically, the shortage of medical practitioners is striking.

In the current salary policy, as equal and insufficient salaries are paid for all, unmindful of their performance, service suppliers have not been able to be encouraged. In the delivery of public health care service, the lack of freedom of choosing one's own physician on the one hand, besides an additional work-load and the lack of advantages of being choosen on the other, results in an atmosphere of negative competition. As those who supply a good-quality service are evaluated as the same as those who work poorly, the former lose their motivation in time. Within the frame of “Health Transformation Programme”, a new implementation has been introduced, encouraging hard-working health professionals, rewarding them in payment in accordance with their performance and their success especially in primary-level preventive health care services. Through employment of contractual personnel and performance-based additional payments, first steps has been taken to reward those

who work in deprived areas and those who have a heavy work-load.

With the act, enacted on July 10, 2003, relating to "employing contractual health care personnel in locations where there is difficulty in employing personnel", to ensure the provision of health care services in an effective and efficient manner in those locations and fields of service in which there is difficulty in employing personnel, the way has been opened to employ contractual personnel. Through this act, 15.000 health care personnel was employed in the beginning of 2004 and with their employment it was aimed that the personnel shortage in the unpreferred rural settlements would be overcome, and that no health station would be left without a physician. Stipulating higher salaries, health care personnel will be encouraged to work in those areas.

For the delivery of primary health care, organization models based on population were tried out in our country like many other countries; however, those models were ineffective due to the fact that rewarding on the basis of performance, encouragement for working in deprived areas, and the factors encouraging competition for providing service had not taken into account. The

consequence of having not been able to use the health care personnel and the new institutions effectively was that the health indicators of the country could not achieve the intended level. Demographic data and health indicators of our country show that health preventive and promotive services were not delivered sufficiently in terms of preventable deaths and of diseases.

Indeed, “Primary health care” is a term to be used to mean health care services to prevent health on the basis of individuals, and to provide treatment and rehabilitation on that basis. As its name evokes it has to be the first step of consulting. Those services, together with those of aiming at public health, have been accepted within the frame of basic health care. In our country, all those services are planned to be provided in health stations and that resulted in the intermingling of those two separate tasks, and caused difficulties in providing sufficient service for the treatment of diseases, so that public health services have begun to be regarded as less important.

It is a fact that, owing to insufficient waste management, the level of water, air and solid pollution is rising. In delivery of food surveillance services, there has been a disagreement on who the authority is among the Ministry of Agriculture, the Ministry of Health and municipalities. While special fields of expertise such as food engineering and environmental engineering have been developed and even those areas of services have been organized as separate ministries, that responsibility's still being tried to be performed by health stations has caused us to face with the current situation The transfer of food surveillance services to the Ministry of Agriculture and the cooperation of Institute of Hygiene laboratories with the Ministry of Environment and Forest has allowed those services being delivered by the experts of the field and has lessened the work-load of health organization.

The scarcity of human resource and unbalanced distribution of health care personnel in our primary health care

institutions, the collection of services in one hand, and the inability to adjust with the rapid modern developments and specialization caused the problem of setting priorities in service items. As the social demands focused basicly on the patient's problems with the provision of health care, not only the problems of the individuals have been resolved satisfactorily, but also practices relating to public health have increasingly been neglected.

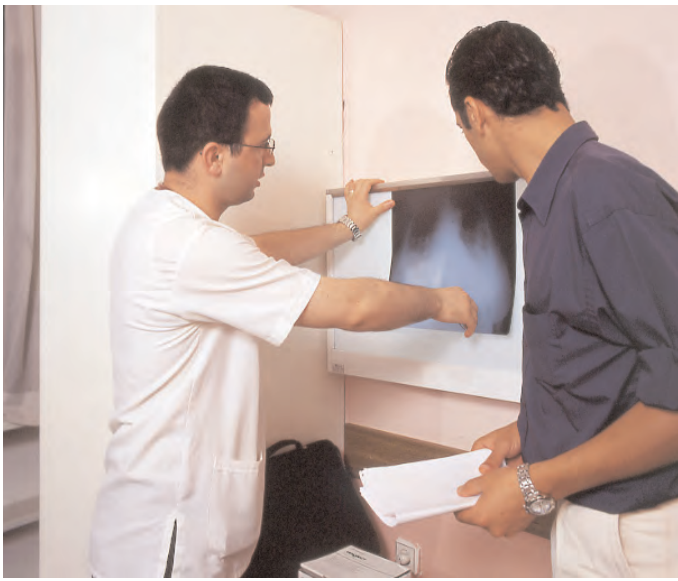
Within the frame of Health Transformation Programme, “a patient examination room for each physician” has been aimed and the number of patient examination rooms has been doubled. Total number of units of service is increasing rapidly through newly opened health stations and rental of additional space for them. With additional payments based on their performance, admission and treatment of patients in health stations is being promoted.

3.HEALTH CARE DEFINITIONS

The world-wide accepted method for the effective and efficient delivery of health care services is to deliver them in the appropriate level. In this approach, the service is presumed to be delivered in two or three levels. However, sometimes these graded services are perceived differently in various countries due to distinctive definitions and organizational structures of the health care; and, even there are confusions caused by differences in translation.

In order to resolve that confusion, the World Organisation of Family Doctors (WONCA) established a working group in its 16th World Congress in 2001 to unify the distinctive interpretations and definitions in a common terminology. The definitions set by the group was published by WONCA in 2002 as a booklet titled “The European Definition of General Practice / Family Medicine”.

As to the current situation in our country, Article 13 of the Act Relating to the Socialization of Health Services, announced in the Official Gazette on January 12, 1961,



defines this three-level graded health care system in the chain of health station, health center and hospital. Specialty services can be defined as those of provided not in the primary-level, but in hospitals or mobile facilities by specialists of a field. However, to define the primary health care is more complicated. In the USA, in an attempt to define it, at least ninety-two definitions has been achieved. Similarly, the definition of the primary health care varies from country to country in Europe. Its definiton must be evaluated on the basis of the content, of the process, and of the team members of the services.

In various documents published by the WHO, it can be seen that there is not a full clarity on the concepts of basic health care and primary health care. These two concepts are often used interchangeably with the other. In this booklet, the following definitions are offered for the concepts of basic health care, primary health care, and for those to be used in the new period.

3.1. Basic health care

Basic health care, in a general sense, involves the preventive health care services in a considerable extent and includes the primary health care and is delivered in the primary-level. In the closure of the Alma-Ata Primary Health Care Conference, as an approach for the delivery of basic health care, all countries were offered to develop an accessible, that is a cheaper, more efficient and more rational system, rather than the delivery of sophisticated care which requires specialty. However, in the Alma-Ata Conference, basic and primary health care had been evaluated as a whole and that resulted in a confusion on the concepts.

3.2. Primary health care

The concept of primary health care corresponds to public health services, to preventive services for individuals, and to diagnostic, therapeutic and rehabilitative health care services. It is the first point of receiving service from the health care system for the patients.

3.3. Primary health care facility

Primary health care facility usually takes place in the social setting of a person. It is the facility where the patient makes his/her first contact with health professional in situations other than those of emergency (traffic accident, trauma, heart attack, etc.) that require a hospital intervention.

3.4. Primary health care physician

A physician from whatever discipline working in a primary care facility.

3.5. General Practice / The discipline of family medicine

General practice / family medicine is an academical and scientific discipline and a field of clinical specialty, directed to primary health care service, having its own education curriculum, researches, clinical practices based on evidence.

3.6. Family health center/ Family health unit

A health facility where family doctors provide service.

3.7. General practitioner/ Family medicine specialist

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing health care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture. They have a occupational responsibility to their community and they work in cooperation with social health centers.

3.8. Family doctor / Family physician

Family medicine specialists practicing family medicine and other physicians undergoing the training required in the transitional period for family medicine.

3.9. Family dentist

A preventive dentist practicing primary diagnostic and therapeutic services.

3.10. Family health staff

A health care professional who will work with the family physician / family dentist. According to the characteristic of working conditions, this person can be a midwife, a nurse, a health technician, an emergency medicine technician, a medical secretary or a laboratory technician. A family health technician must have been trained to do simple laboratory investigations and medical secretarial duties in the Family health center, besides the duties of a midwife and a health technician.

3.11. Specialist physician

A physician from whatever discipline who has undergone a period of higher postgraduate training.

3.12. Community health center

Health centers located in each subprovince, minimum one in number. They perform public health and administrative services, together with training and supervision activities. By those centers the following tasks are performed in coordination with family physicians: health education of the public, struggle with infectious diseases, preventive environmental health care services, school health services, delivery of equipments for vaccination and family planning and extensive immunization programs, laboratorial, radiological and other diagnostic services, in-service training of the health care staff, forensic medicine, public screenings and collecting medical statistics.

3.13. Public health spiecialist/ public health physician

Public health specialists and other physicians undergoing the training required in the transitional period. They provide public and environmental health care services and administrative duties.

3.14. 112 emergency aid station

Stations where emergency interventions, first aid, and ambulance services are provided within their area of responsibility.

3.15. Secondary health care facility

A health care facility aiming to solve the health problems of the patients referred from primary-level in which their illnesses could not have been diagnosed or treated. It is a highly technically equipped in-patient or out-patient facility where specialists of a field practice. Most of those facilities provide service in more than one field of specialty; however, the facilities such as birth hospitals and child hospitals that limit access to their services on the basis of age, sex or diagnosis are also secondary health care facilities.

3.16. Tertiary health care facility

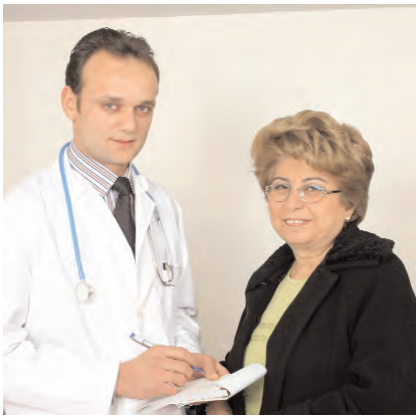
A facility where health care and training in main-specialties and sub-specialties are performed. A tertiary health care facility usually aims to provide service for the group of patients referred from the secondary-level.

3.17. Local health administration

A unit of administration organized in provinces and sub-provinces which performs public and environmental health services and administrative duties. Local health administration also performs the supervision and coordination of the family physicians.

4. PRIMARY HEALTH CARE IN THE HEALTH TRANSFORMATION PROGRAMME

Every human being has the right to live a healthy life. For the protection of this right, providing citizens a good-quality and sufficient health care service as much as possible is the duty of the state and governments. The success of the governments in accomplishing that duty depends on making regulations in compliance with the real health needs of the population and geographical, economic and cultural conditions of the country. We can say that, throughout the history of our Republic, important strides have been made in this direction. However, advocating universal and scientific approaches for the delivery of health care can sometimes become difficult because of political interventions. It is a fact that the decisive steps taken can encounter with obstacles resistant to innovations stemming from political and economic worries.



We have to admit that in our country there not is a well-planned and performance-based health system for the delivery of basic health care services. Performance evaluation of health care delivery must be based on the evaluation of the whole health team, on the measurement of service outputs, and on the improvements in the level of health of the population. Almost everyone agrees that there are breakdowns in our existing health care system. Amending and rehabilitating the existing structure are among the priorities. It is necessary to establish a structure in which the institutional position of the basic health care services has a determinant effect on other levels of care. The starting point of the transformation in health will be the improvement of the living conditions of individuals in general, and of patients and health care professionals in particular.

In rural areas, supporting preventive health services for individuals and public is important. This duty has been assumed by health stations. However, due to shortage of personnel and motivation, the result is not satisfactory enough. Those services will be improved by clarifying the definitions of duties, by introducing encouragement factors, and by supporting them with mobile health care service. A reorganization will be made to ensure the services being provided in a widespread, organized and disciplined way. Organizational structure of health care must be simple, accessible, widespread, and easy to control and coordinate. In the primary-level, existing ver-

tical and horizontal organizations will be harmonized, the duties of workers and their limits of authority and responsibility will be clearly defined. The awareness that family physicians and community health physicians are the head of the team in their unit and area of responsibility will be established. The duty of the team leader is to improve the efficiency of the service through continually controlling the team members and maintaining their occupational and personal development.

In basic health care services, sharing the responsibility, esteeming the value of the individual, and maintaining easy and equal access to the system are important factors for success. Therefore, the preventive services for individuals and primary diagnostic and therapeutic services are aimed to be delivered by the doctors chosen by the individuals themselves. Thus, through establishing close and personal relations with family members, their role will be strengthened in health education and in prevention from diseases and in improving the level of health. The importance of that issue is emphasized in the statement of reasons for the Law on Socialization of Health Services: “Indeed, medicine have developed as a self-employed vocation and the freedom of choosing one’s own physician has constituted the very essence of the relation between a patient and a physician. If a person whose health and life is in danger consults a physician he/she trusts, his/her morale goes up and this positively affects the treatment process. On the contrary with this, if a person has no trust in the physician, his morale may go down and this situation negatively affects his healing.”

4.1. Aim and goals

Among the leading goals of modern health care systems are maintenance of universal accessibility to health care services to meet the needs of everyone, and thus,

improvement of quality of life and health standarts of persons, giving priority to primary health care services. The major goal of the Health Transformation Programme is to organize, finance and deliver the health care services in an effective and efficient way in conformity with equity.

Effectiveness expresses the goal of improving the level of health of the population by the system to be implemented. The major goal in the provision of health care service must be preventing people from being ill. This goal can only be achieved through improvements in epidemiologic data. Especially, the reduction of mother and child mortality will be the concrete indicator of this goal being achieved.

Efficiency means to reduce the cost through using the resources properly so as to produce more service with the same resource. Practices of preventive medicine, appropriate distribution of human resources, rational drug use, and health business management must be evaluated on that basis. Good management of all sectoral resources of the country will improve the efficiency. In this frame, the health expenses of the poor must be assumed by the state.

Equity, is to maintain accession of everyone to health care services according to the extent of the needs and making them contribute to financing the services through health insurance according to the extent of their financial abilities. Among the goal of equity are decreasing the disparities in accessing health care services and in health indicators among distinctive social groups and between rural and urban areas and between East and West regions.

To achieve these goals, reorganization and expansion of primary health care services in a modern approach, and their provision in an acceptable manner by the whole population is aimed. That there are to be family doctors chosen freely, accessed easily, and consulted without

any obstacles is the leading one among the main factors of this approach. In the words of Prof. Dr. Nusret Fişek, who made permanent contributions to health policies implemented in our country: “Preventive medical services for individuals and outpatient and in-home care must be performed in an integrated way. (...) The simplest model of the integrated organization is the modern family medicine. The family physician performs the periodic examinations and the vaccinations of the children in the family; teaches baby care to mothers; makes periodic examinations of the eldery and pregnants and gives necessary consultations; educates family members on health, home and personal hygiene; and, treats them when they are ill or refers them to a specialist or a hospital when necessary.” (Halk Sağlığına Giriş, Hacettepe Yayınları, Ankara, 1985)

By the World Health Organization, better access to family and community based basic health services by 2010 has been figured among the goals of “health for all” in the 21st century. The Health Transformation Programme, aiming at achieving that goal, stipulates to provide family and public based basic health care services in an integrated way through teams well-equipped in knowledge and skills, whose duties have been clearly defined.

In order to be able to access to all population, the need of reconstruction for primary health care services which must be delivered by well-trained and geographically well-distributed health teams cannot be ignored. The goal of family medicine is to provide primary health care services in a professional spirit and in a way to maintain the participation of the public.

In the delivery of health care service, the satisfaction of individuals who benefit from the services is important. Major principles are: improving and strengthening primary health care services through continuing training, encouraging hard-working physicians and other health care personnel, giving weight to preventive health care system, and initiating an acceptable referral system. Putting those principle into practice will hinder the congestion in the secondary-level and enable to allocate enough time for the patients who are really have to be treated in that level. Delivery of the primary health care services in an effective way will not only decrease the burden of disease on the population but also allow secondary and tetriary care facilities to provide a better and good-quality health care service and health care training.

4.2. Why Family medicine?

A family physician is responsible for the health and health problems and diseases of the all members of a family, from the fetus in the womb to the most elderly. For the problems beyond primary health care services, the family physician assumes the role of coordination and directs the patients to other doctors such as specialists, dentists and dieticians. Therefore, at the same time, he/she is in the position of being a health counselor for the persons registered with him; he/she guides them in health issues and advocates their rights.

Thanks to family medicine, individual satisfaction increased and the relation of a patient with his/her physician gained continuity in countries where it is implemented. For instance, in countries like the United Kingdom, Denmark and Australia the lasting of relation between physicians and a patient is about 8-13 years on the average.

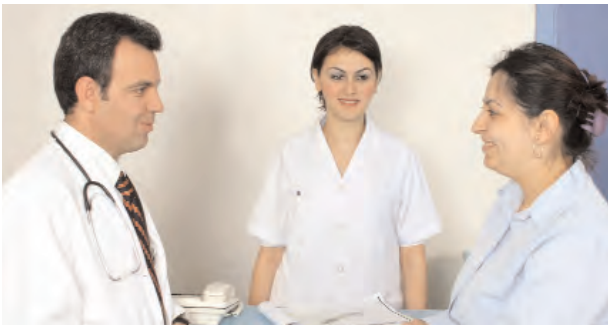
The family physician is usually close to the residence of the family members and can be accessed easily. He well knows about the community he/she provides service and evaluates family, environment and business relations. He/she is the one who knows best the health situations, life conditions of all the family members; therefore, he knows well how to implement preventive health and health education programs for those individuals. Those doctors evaluate the individuals under their responsibility not in the frame of a disease but as a whole within a holistic approach together with risks, health conditions, pyscho-social environment and other existing acute or chronic health problems.

Family medicine records are an invaluable source of data in researches on health. Family medicine ensures a considerable success in the referral chain and enables the illnesses to be treated in the appropriate level. When a referral is needed, the family physician directs the

patient to the appropriate specialist or facility with his/her health information; therefore, enables high-cost secondary health care services to be used more effectively and economically. In this sense, family medicine also prevents many misdirections, disorganizations, unnecessary health expenses, unnecessary congestions in the secondary-level, queues and unjust treatments of patients.

Instead of a prejudicial approach against the organs or the system, family medicine stipulates a holistic approach through health care; it is multi-disciplineary. It establishes communication based on reliance. It handles the problems with their physical, psychological and social aspects. In the provision of services based on family medicine, not a “patient-based” but a “person-based” approach is taken as a basis. As a consequence of this approach, the family physician is responsible for improving the health level of the persons under his/her responsibility together with other members of his/her team. The physicians and other health care personnel will not confine themselves to providing therapeutic services with patients who visit them, but they provide everyone, be it a patient or not, with health service. Besides being individual-centered, with its features of unifying, continuity, being family and public based, family medicine is an important building stone of health care system. The need of primary health care services for a gradually aging population can be met more effectively by those who know them and who they can easily access.

It can be said that this approach facilitates to diagnose far more quickly and correctly and to choose the appropriate method of treatment. As there will be a follower of each individual’s health, and as the patients will easily access to the doctor and receive the service quickly, the informal ways of access to heath care services will be abolished.



4.3. Who is the family physician / family doctor?

The family physician deals with the individuals within their family and community context and provides preventive health care and treatment together and deals with the biological, psychological and social aspects of the indiviudals under his/her responsibility. They are chosen by the individuals themselves. It is essential that there is a continuing relation between the individual and the family physician, and that it continues with the consent of both parties. The family physician is the one to whom the patients entrust their health, from whom they receive consultancy and to whom they contact first as a physician for the preservation of their health and for the removal of their health problem.

Even in countries with middle and high income, there are problems in practice and perception of family medicine as a medical discipline. For this reason, the setting cannot always be provided to encourage the medical graduate physicians to prefer family medicine as a specialty field. As to our country, although there is a specialty field on family medicine, it has not gone beyond to be a field of specialty that takes less students than needed. Therefore, the services which enter into the family physicians' area of duty are provided by practitioner physicians. In such cases, as it is assumed that every medical graduate physician bears that responsibility, medical

training must be oriented in a way to overcome the major health needs of the population. There are two alternatives: first one is that physicians may assume this duty through such a training; and, the second one is that they may be trained under an advanced specialty discipline. These two alternatives can be discussed considering the conditions of the country. In our country, despite medical graduate physicians are burdened with these duties, in our faculties of medicine, a training oriented mostly to Medical Specialty Exam (TUS) is being given. In this point, the preferences must be clarified and undergraduate and specialty medical training must be restructured. In order that the family medicine practice would be preferable for physicians and acceptable for and accessible to the public, the system must be transformed through education, infrastructure regulations, and encouragement.

4.3.1. The duties and responsibilities of the family physician

Family physicians are primarily responsible for individuals registered with him in the prevention of their health and in their treatment when they get ill. They are individuals' entrance to the health care system, except emergency situations. Among the duties of the family physician are recording the health records of the persons registered with him/her, assuming primary diagnostic and therapeutic services together with immunation and other preventive

health care services, and coordinating their secondary and tertiary care. Also among the duties of a family physician are submitting the notifications to higher institutions/bodies in contributing to the planning of national and regional health goals and priorities, and implementing the programs stipulated by the central authority after planning.

These duties and responsibilities can be put briefly in the following titles:

1. Administring the family health unit, supervises the team he works with and providing their in-service training,

2. In regional health planning, working in cooperation with subprovince health administration,

3. Informing community health center and subprovince health administration about the situations relating to public and environmental health he met during his medical practices,

4. Providing person-based counseling and health promotive and preventive services; in this context, providing mother and child health and family planning, periodic examinations (such as breast cancer and womb cancer screenings), and individual preventive health care services,

5. In the first registry, through a home visit, assessing the health situation and going on home visits in the frequency stipulated by the Ministry of Health,

6. Providing primary diagnostic, therapeutic and rehabilitative services in family health unit or in at-home visits,

7. Referring the patients who cannot be diagnosed or treated in the primary-level to relevant field of specialty, evaluating the examination, investigation, diagnosis, treatment and hospitalization information of the patients referred, coordination of secondary and tertiary therapeutic and rehabilitative services and home care,

8. Providing basic laboratorial services or enabling them to be provided,

9. Sending the records and notifications relating to family medicine practices to relevant authorities,

10. Providing first aid and emergency intervertion services or enabling them to be provided,

11. In areas with difficulty in supplying medicines set by local health administration, opening a medicine cabinet according with the relevant regulation, or enabling the supplication of those medicines,

4.4. The important points in transition to the practice of family medicine

In the countries where family medicine is practiced the following three main points are significant:

1. A family physician's performing the function of entrance to health care system is maintained. That is, entrance to health care system is through each individual's own physician. Family physician is primarily responsible for the delivery of health care services.

2. Referral and feedback is maintained in a considerable extent.

3. Surveillance has become effective through localization.

When the world health systems and the reforms made are evaluated as a whole, some important clues about the steps to be taken in our country attracts notice. Under the Health Transformation Programme, legal regulations in the framework of transition to General Health Insurance which aims the universal health coverage, and to the practice of family medicine are the important steps to be taken in a multi-sectoral approach. Expansion of family medicine in the whole country is a long process which will cause a change in behaviour, and require the adaptation to the new situation for both health care professionals and citizens. In order to accomplish this process successfully, ensuring adaptation and trust are as important as legal regulations, maintainance of financial structures, and organization.

In this respect, local practices will be carried out, taking into account cultural characteristics, habits and pre-suppositions; and, when necessary, the system will be ready for revisions in the direction of the results acquired from

the preventive measures, the surveillance system, and the payment systems. When the referral organization and surveillance fully established, the intended goals will be achieved in the forementioned system.

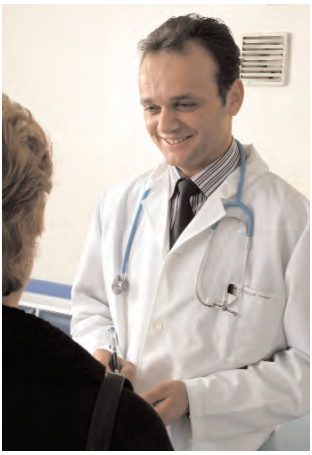
In the family medicine system, planning and surveillance will be organized dynamicly by one hand through the Ministry of Health. As the continuity of surveillance will be maintained by local health administrations, the distribution of the service and the rates of specialty/general medicine and rural/urban physicians will be held in balance. Promotional measures will be taken to maintain the preference of the existing permanent and contractual physicians for being family physicians and to maintain, when necessary, the application of self-employed physicians for practicing family medicine, and then, to maintain family medicine specialty to take place among the prior choices in Medical Specialty Exam (TUS).

It is important to establish a system in which our citizens rely on the family doctors chosen by themselves, and in which family doctors perform their duties in competition for service, and in which a good-quality service will be directly reflected on the physicians' income. Promotions to encourage the practice of preventive medicine and to eliminate the regional disparities will strengten the system.

An effective health care system requires the appropriate exploitation of the resources, and the mobilization of the resources and service providers for basic preventive and clinical services. Such a mobilization can be done through health care professionals who have been equipped sufficiently for correct diagnosis and treatment, and who are well-trained and balancely distributed to meet the needs of the population. Considering these points, a special importance will be given the continuing training and a balanced distribution of family physicians. The principle of social justice requires the universal delivery of health care on the basis of each person's need. This can be achieved through the expansion of equal health care services over the whole country, and especially through the improvement and expansion of basic

health care services. In order to establish such a system, the needs of the population must be known exactly for planning and for the provision of health care services. Therefore, it is necessary that the family medicine must be practiced together with a good recording system, and it must be handled together with social security reforms.

Education of the individuals in taking active role in preventing and improving the health level of the population bears importance. Expansion of family medicine services will be realized in a certain process through taking decisive and continuing steps on all those points. As equality and quality are two major goals affecting each other, finding the right balance between them depends on the success of the system. The provision of a high quality service, regardless of equality, for a very limited population does not improve the life quality of the whole population but makes it become worse. On the other hand, the goal of providing equal service must not sacrifice quality. Despite the organizational structuring to provide equal health care service for every section of the population, inability to provide enough well-motived and trained work force and financial support can bring about a fall in the quality of service.



Our model of “National Family Medicine” has been developed, evaluating the examples of other countries and the experiences of our country. With this model, safe and decisive steps will be taken and our citizens will be provided with an equal and good-quality health care service. Each country has its own unique way of providing health care services; and, with this model, we are reorganizing the health care services in Turkey in a modern approach, taking into account the social, cultural, economic and geographical conditions of our country.

After the 59th Turkish Government came into office, it began to work on the issues which are mentioned in the Government Program in which transition to family medicine has been regarded a priority in health. In this context, opinions of partners have been taken through several meetings and work groups. Some of those meetings are the following:

- Sectoral Consultation Meeting, July, 2003
- Family Medicine Consulting Board Meetings
  - June, 2003 (with the participation of Turkish Medical Association (TTB) and the Institute of General Practice (GPE))
  - July, 2003 (with the participation of Turkish Medical Association (TTB) and the Institute of General Practice (GPE))
  - August, 2003
  - October, 2003
  - November, 2003
  - January, 2004

- February, 2004
- March, 2004
- December, 2004

■ Working Meeting of Turkish Health Systems Policy-makers, December, 2003

■ Health Care Products Manufacturers and Representatives Association (TEBİAT) Abant Meeting on Health Transformation Programme with Respect to the Turkish Health System, January, 2004

■ Health Care Products Manufacturers and Representatives Association (TEBİAT) Afyon Meeting on the Practice of Family Medicine within the Frame of Health Transformation Programme, May, 2004

■ Secretariat General For EU Affairs – the preparatory works on the act relating to the Recognition of Occupational Competencies (performed as weekly working meetings between February – May, 2004)

■ 6th National Congress of Family Medicine, held in Bursa, May 2004

■ Meeting on the Transformation in Health and Promotion in the Primary Health Care (with the participation of Adana Solidarity Foundation and Adana Chamber of Physicians, May, 2004

■ Workshop on Health Care Services, held in Bolu, May, 2004 (with the participation of The Society of Public Health Specialists and the Ministry of Health)

■ The Evaluation Meeting on Health Transformation Programme, held in Ankara, July, 2004 (with the participation of Foundation-2000)

■ The Meeting on the Strengthening the Basic Health Care Services and Family Medicine, held by WHO Regional Office for Europe, İstanbul, December, 2004

The Turkish model for family medicine has been developed through the opinions and discussions in those meetings. To put into practice this model, Turkish Parliament passed an act on November 24, 2004 and a pilot implementation has been started.

FAMILY MEDICINE

5. ORGANIZATION IN THE NEW PERIOD

5.1. Duties and authority of the Ministry of Health

In the new period, the duties and authorities of the Ministry of Health is being restructured. Among these duties the following come into prominence: setting the international and national standarts of health care services, planning, surveillance, and education. In this new organizational structure, the distribution of resources and personnel will be more healthy and the approach of competition in the service will lead to quality in the provision of services.

One of the major principles in this reorganization is to strenghten the local administration. This approach enables the coordination and integration of services and a better surveillance of the health care services, and it facilitates the effective and efficient exploitation of the resources. In this way, the Ministry of Health, transferring most of its authorities to local bodies, can focus on its own essential functions, having been transfomed into a structure in which it makes the policies and surveills. This

enables the Ministry of Health to perform its duties of collecting and analizing information on public health more effectively. In surveillance, the significance of the Ministry as the health authority is evident. Under the direction and leadership of the Ministry, the local health administrations will assume active duties in surveillance. The Ministry will assume leadership in establishing a system in which payments to family doctors will be guaranteed and in maintaining the provision family medicine services to be free of charge for all citizens.

To improve the primary health care services and to maintain equal access to them, the Ministry of Health performs the following:

1. Sets the curriculum for the training of the physicians who will assume duty in the practice of family medicine.

2. Defines the duty of the family dentist

3. Sets the qualifications and working conditions of the family health technician (nurse, midwife, health technician, etc.) who has to be included in the team of the family physician.

4. Sets the qualitative and quantitative standarts of family physicians to work in a particular area; appoints and surveils them.

5. Sets the qualifications, standarts and the distribution of the settings where family medicine will practice.

6. Maintains the delivery of laboratorial service to has the necessary analysis and investigations made in the primary-level.

7. Makes the regulations to protect the job rights of the family physicians; coordinates the repayment institutions.

8. Maintains the equal distribution of family physicians and health care services, reflecting, when necessary, the differences among regional development level and between urban and rural areas into salaries.

9. To ensure the referral chain and feedback to be fulfilled totally, makes the necessary regulations or have them made in certain intervals.

10. Carefully surveils preventive medical practices, especially that of immunization. And encourages them through reflecting them into salaries.

5.2. Duties and authorities of the Local Health Administrations

Local health administrations, currently organized as province health directorates and subprovince health group directorates, are local organizations directly subordinate to the Ministry of Health. Through new regulations, they will be organized subordinating to provincial private administrations. As the duty of setting the standarts, planning and surveillance is on the Ministry of Health, local health administrations will provide service in the direction of the norms and standarts set by the Ministry.

In some metropols, preventive services for the public are performed through the staff established within health group directorates. Regarding the proposal for the Public

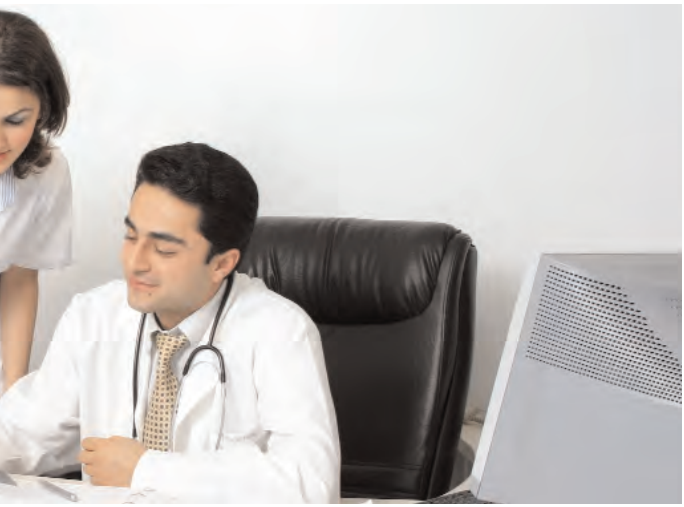
Administration Law, an organization to organize and surveil the health services in the subprovinces is needed. According with population criteria required, subprovince health administrations will be established and the number of their staff members will be fixed according to the population. Under the responsibility of local health administration there will be family physicians and facilities such as hospitals, 112 emergency and first aid stations and public health centers.

It would be appropriate to call local health administrations briefly as province health administration and subprovince health administration.

5.2.1. Province health administrations

Province health administrations are the existing province health directorates. Compared with their current duties, they will assume additional burdens and responsibilities due to localization. Through the introduction of family medicine, their primary duties will be the following:

1. Province health administration regulates and surveils all the health services in the provincial level.



2. According with the demographic and geographical structure of the province, organizes the areas of service of the subprovince health administration and supervises them.

3. Contiunally evaluates statistics and notifications submitted by family physicians which come through subprovince health administrations.

4. Together with its own proposals, informs the Ministry of Health of all the health data and statistical information of the province.

5. Organizes the relation between family physicians and repayment institutions and coordinates the relevant contracts being entered into.

6. Supervises the subprovince health administrations to ensure that registries of persons to family physicians and their transfer to another family physician are being made in a secure manner and that the monthly notifications by family physicians are being recorded.

5.2.2. Subprovince health administrations

The gap caused by the current regulations which is being tried to be overcome through health group directorates

will be filled by subprovince health administrations. The primary duties of subprovince health administrations will be the following:

1. Subprovince health administration regulates and supervises all health services in the subprovincial level.

2. According with the demographic and geographical structure of the subprovince, organizes the distribution of family physicians.

3. Contiunally evaluates the statistics and notifications submitted by family physicians.

4. Together with its own proposals, informs the Province Health Administration of all the health data and statistical information of the subprovince.

5. Ensures that registries of persons to family physicians and their transfer to another family physician are being made in a secure manner and the monthly notifications by family physicians are being recorded.

6. Surveils the family physicians. This surveillance involves the observance of the family physician on working hours, conformity of the office, of the signboard, and of the cachet to standarts, the authenticity of the notification

on registered persons, records of the investigations made, the rate of referrals, the rate of feedbacks, and duties which can be defined in detail by further regulations.

5.2.3. Public health centers

There being a fragmented structure in the organization of our primary health care services, and there being vertical organizations like tuberculosis dispensaries together with horizontal organizations like mother & child health and family planning centers (AÇSAP), bring about confusion, complication and wastage in the provision of health care services. As family health and family planning services have been assumed by mother & child health and family planning centers, those services have been ended up being excluded from the duty area of health stations, resulting in their becoming weakened. Nevertheless, the maintanence of these duties in an integrated way bears great importace for the public health.

Under the administration of subprovince health administration, at least one public health center will be established for each subprovince, including the central subprovince. These centers will make necessary investigations and analysis in the course of family medicine practice; they will also perform other basic health services which are not the duties of family physicians. This will allow a more effective and efficient provision of services as the preventive services for individuals and basic health care services except diagnostic, therapeutic and rehabilitative services will be united under one roof. Community health centers will provide logistic support free of charge to family physicians in the fields of service like vaccination, mother and child health and family planning according with the annual program of the Ministry of Health. In a sense, family medicine practice will be united with community medicine practice. In these centers, public health specialists will be employed.

As the existing health stations have theoretically assumed most of the duties defined for the community health center, and as they maintain the criteria set with respect to distribution, they will keep on performing their

duties relating to public health. Here, what is important is that their duty areas, authorities and responsibilities must be defined clearly. While the appropriate and sufficient health stations will serve as community health centers, the others will be used in the services of family health unit/center which is under the responsibility of family physicians working as permanent civil servants. In the areas where the buildings of health stations and other governmental health facilities are insufficient, new facilities will be built or rented as family health centers.

In Figure 1, the locations where primary health care services are currently delivered and the planned organizational structure in the new period are being depicted.

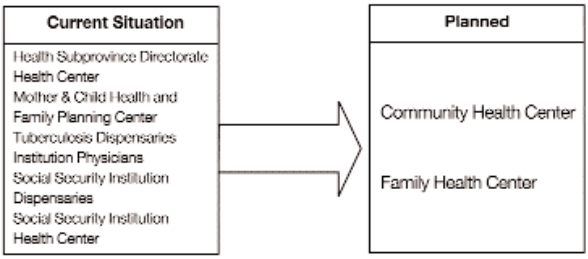


Figure 1. The current and planned delivery model of primary health care services.

Existing health stations, health centers, mother & child health and family planning centers, tuberculosis dispansaries, SSK dispansaries and SSK health stations which actually provide primary health care will be united under two main bodies. The most appropriate existing health facility building in an area will be used as community health center, and others will be used as family health centers where family physicians and family health technician practice. Community health centers will also serve as training and planning centers.

Where appropriate, subprovince health administration, public health center and 112 emergency and first aid stations may serve in the same building.

The duties and authorities of public health centers are primarily preventive services for the public; besides this, they will provide other services set by the Ministry of Health. Major of them are the following:

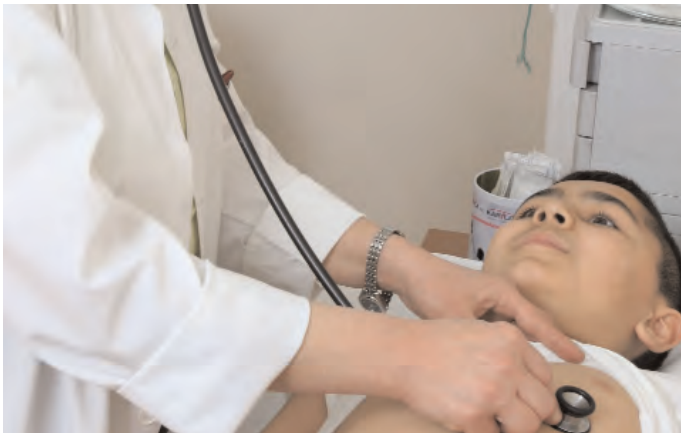
- Community nutrition services,
- Struggle with addictions which lead to eventual health problems,
- Surveillance of drinking water and use water,
- Surveillance of food,
- Surveillance of non-hygienic establishments,
- Surveillance of tradesmen,
- Surveillance of waste disposal,
- Mass health education of the public,
- Social researches, supporting the works on social development, social aid services,
- Measurement of the need for vaccine and contraceptive, their maintanence, preservation, transportation and delivery to the physicians,
- Non-routine vaccination services (campaigns, serums for rabies, gaseous gangrene, snake and scorpion, etc.)
- Surveillance of the schools, children parks, sports facilities,

- School health services,
- Struggle with infectious diseases,
- Forensic medical services,
- Postmortem examination and preparing a burial permission form.

In the transition period forensic medicine will be practiced in community health center. But in the future, certificate training and then the expansion of forensic medicine specialty will be essential.

5.3. Transition to and planning of family medicine

As the beginning, family medicine practice will begin with a certification training and our physicians will be achieved the tranining level stipulated by EU with occupational



training through the implementation of the previously set curriculum. These physicians will continue their theoretical training besides their current practical practices.

Physicians and other health care personnel who work as

civil servants will be given priority if they prefer to practice family medicine. In this way, the job rights of the health care personnel who practice family medicine will be preserved.

If the voluntary family physician is not sufficient in proportion with the population, self-employed contractual family physicians will be allowed to work. When necessary, for the protection of the principle of equal access to health care service, permanent physicians will be commissioned as family physicians. Such physicians will benefit from the additional rights, arising from the duty definition of the family physician, in their period of commission.

During the implementation of the new system, different methods for different areas of service will be used, taking into account the transportation features, socio-cultural structure and the working conditions. A certain number of citizens will be registered to a family physician who practices in their area, and after a certain period of time, they will be allowed to change their physicians (active positive registry). Thus, everyone will be maintained to have one family physician. Then, family physician completes the identity and health records, visiting those families. Persons who prefer to choose another family physician, declare their choice and register with the other family physician. However, for using the option of changing the doctor, there must be other easily accessible family doctors in that area. Although there is the freedom of choosing a family doctor, it is obvious that if there are a few number of doctors in the same area of service, this can be a restrictive factor. It is inevitable that there will be differences between rural and urban areas.

The other method is that, in the beginning, persons register with the family physician they choose (active positive registry). Families can register with a family physician who they can easily access. This method is useful in areas with good transportation conditions and when there are family doctors close to each other.

In setting the need for a family physician, the areas, divided in the light of the population structure, geograph-

ical characteristics, disease pattern and health statistics of the province, are taken into account. In our country, it is seen that the yearly number of consults to physicians is less than western countries. As this number may change in time, the standart and maximum number of persons to be registered will be evaluated and revised by the Ministry of Health. Taking into account the frequency of using health care services, a planning will be done in a way that on average there will be one physician for 3.000 persons.

If family medicine is expanded to the whole country, it can be anticipated on the basis of the current situation that about 24.000 family physicians will be employed. Compared with the European countries, it is possible that this number will reach 35.000-40.000 in time. However, these presuppositions will be evaluated in the process of expanding family medicine across the whole country.

Under the light of these data, it is obvious that, through a specific training, our physicians will assume the main role in family medicine. Physicians who practice family medicine will continue their training in the meantime. Such a training will increase self-confidence of our physicians and improve the quality of primary health care. The conception of family medicine supported with job rights and training and with rewarding the performance will prevent our physicians from neglecting medical practices, focusing on Medical Specialty Exam (TUS). When family medicine is embraced by the public, the prestige of the physicians will rise in the eye of the public and thus they will acquire the status and prestige they merit.

In accordance with modern family medicine practices and with the European Union's relevant directive (93/16/EEC), as the need will only be met by family medicine specialists in the long term, a great number of family medicine specialists will be needed in the future, taking into account the population increase, the retirement of some of the physicians, and the physicians who will shift into another fields other than family medicine. Therefore, it can be said that specialty on family medicine will become an important focus of concern.

6. THE PRACTICE OF FAMILY MEDICINE

6.1. Family medicine training and certification

By 1995, European Union obliged a minimum two years of training after the basic medical training to practice in the primary-level. In 1996, Organisation for General Practitioners and Specialists in Family Medicine in Europe (UEMO), took a recommendatory decision to increase the duration of this training to three years.

General practice / family medicine is regarded to be a discipline dealing with different diseases or illnesses of the same patient, while the other branches of specialty deals with the same diseases or illnesses of different patients. All over the world, the physicians practicing family medicine are increasingly stipulated to receive family medicine specialty training. In those countries which took important steps in this issue, family medicine is practiced as a field of specialty. With the Title IV of

Directive 93/16/EEC, European Parliament has accepted family medicine as a branch of specialty after a three years of training. This directive will be valid starting from 2006. These regulations are important for the free movement of doctors within the European Union. On the condition of meeting those requirements, Turkish physicians will have the right to practice medicine in the European countries.

In our country, as the family medicine specialists are insufficient in number, the existing physicians will practice family medicine in the transition period, as it is the case with many other countries. Therefore, transitional training is acquiring great importance.

The first phase involves a short-term adaptation training which introduces new definitions of duties and practices, and which instructs the authorities and duties. The physicians who received adaptation training will be allowed to practice family medicine. And, this will follow continuing extensive and systematic training, while in the meantime

they continue to practice family medicine. And, by occupational competency examinations their competencies will be evaluated.

The validity of the certificate of the physicians who received adaptation training is subject to the condition of accomplishing second-phase training modules stiputated for continuing the family medicine practice and for the parmanent certificate.

Second-phase training program starts after the first-phase training, and is given within nine months to three years. This program targets the up-dating and improvement of the occupational knowledge. Second-phase training is set in a modular manner and as continuing medical training. Training and research regions, established through the cooperation of the Ministry of Health and universities, will make important contributions to the stability of such a training. The academicians in the fields of public health and family medicine will assume duty in local family medicine and community health facilities and in local administrational units, and this will ensure the training of students and assistant doctors in the field.

In addition to this, with an amendment in the Charter for Medical Specialty, it is planned to allow family medicine practitioners to continue a part-time specialty training. It is planned to set the curriculum of the theoretical and practical traninings and to give the specialty diploma to the de facto family physicians who accomplished the continuing training in six years or more. There are examples of it in some European countries.

In family medicine, maintaining the continuing improvement of a service, based on positive competition, will be beneficial in many aspects. In this way, our existing physicians will provide extensive service while continuing their training in the meanwhile. Giving the opportunity for specialty will enable this training to be taken willingly and wishfully. The eventual goal will be having family medicine specialists who accomplished training curriculum in the norms of the European Union.

6.2. The freedom of choosing one's own doctor

An individual, ideally, chooses the family doctor from among those practicing in his/her own area, and may change the family doctor after a certain time set by the Ministry of Health. It is obvious that in the preference of a family doctor, closeness and easy accessibility play an important role. However, in order to establish a setting of positive competition, patients will not be obliged to register certain physicians.

As forementioned, in rural areas with scattered population and with difficulties of transportation, this freedom has to have limitations. However, this freedom must not be restricted as much as the conditions allow. It is essential that, in case of one's changing his/her family doctor, the records will be transferred.

On the other hand, in case of there is another alternative family doctor a physician may not admit the patient under certain conditions. These conditions are:

- Authenticated misconduct on ethical grounds (attempting to establish a interest relation between patient and physician, etc.),
- Deterioration of the patient-physician relation as such to complicate the diagnosis, treatment and follow-up or to decrease the efficiency of the family doctor,

- A judicial problem between the patient and the physician,
- Situations like abuse or threat.

In case of the physician does not admit a patient in need of intensive health care because of such reasons as chronic illness, the health insurance institution has the right to set ex officio the family doctor of the patient, in cooperation with the Ministry of Health.

Since the demographic structure and disease pattern of the country changes, the works on elderly problems and early diagnosis and treatment of chronic illnesses will be given a special importance in the family medicine practices. For this aim, measures will be taken to enable and encourage the follow-up of people over a certain age and with chronic illnesses.

6.3. Provision of the continuity of service

Maintaining the balanced distribution of family physicians throughout the country as voluntarily as possible is the first step in the provision of the continuity of the health care service. Otherwise, physicians will pursue to work in another area of service or may resign from the duty. Although they may not realize it in the first place, the willingness to realize it will cause their performing their duties unwillingly. The secret of success in family medicine is in the holistic and continual service.

Patients' changing their physician unwillingly is contrary with the fundamental logic of the system and this results in not achieving the intended goals fully. In the countries where this system is implemented successfully, the average duration of registry is 8 to 13 years, being a good indicator of this.

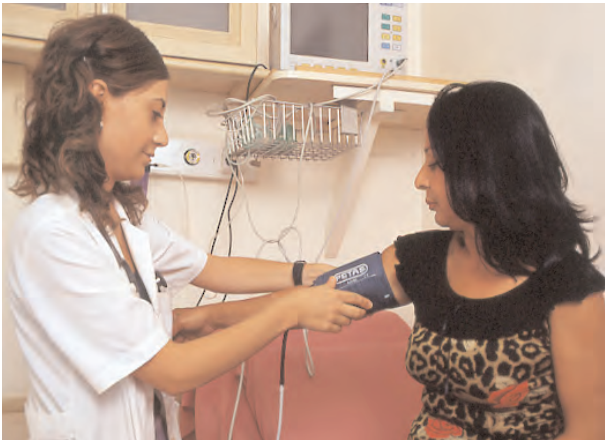
There being more than one doctor practicing in family health centers bears advantages with respect to continuity of training and service. Working as a group facilitates for the physicians to follow the training programs. In addi-

tion to this, in case of illness or taking leave, the patients who know the physicians working together can receive a more convenient service.

A person who will leave his/her permanent residence minimum two months because of business or vacation takes a “temporary care form” from the family physician he/she registered with and gives it to the family doctor he chooses in the location where he temporarily resides. His/her own family physician cannot charge a fee through sending a notification about the person he gave the temporary form. When the person returns, to renew the registry, he/she brings a document showing the procedures performed and that he/she has unregistered from the temporary family doctor.

6.4. Working hours and leaves

Family physicians actively work minimum 40 hours a week. Office hours and days are set, according with the needs of the local population and taking into account the working conditions of the area, by the physician and approved by the local health administration. Office hours and days must be denoted in a visible place of his office. In out-of-office hours and official holidays, the continuity



of the service is maintained on a duty basis with other family physicians.

Family physicians are responsible for the orderly provision of the health care services. He shares his responsibility in the out-of-office hours with other physicians on the basis of on-call or active duty, taking into account the number of the doctors in that area. Physicians work on a full-day basis. As they are expected to be accessed also in out-of-office hours in necessary situations, they are not much approved to have a self-employed job or to work in an other office. Encouraging the establishment of family health centers, where several family physician shares the same space, will facilitate the coordination of the out-of-office hours services among the physicians on the basis of on-call or active duty.

Generally, for family physicians who have to take a long career break because of unpaid leave, military service, maternity leave, illness or any other acceptable and authenticated reasons, their right to return back to family medicine practice is reserved.

6.5. The routine follow-ups and examinations by the family physician

Family physician creates a file for each of the persons registered with him/her and records the routine examinations, follow-ups and their results. These medical records are saved in a written or digital format in a manner set by the Ministry of Health. Thus, every individual is given once a health control. In the beginning, the family physician is supposed to finish the first examinations of the persons registered with him/her in a certain limit of time.

On a regular basis, home visits to the registered families are made by the family physician or the family health technician. Home visits increase the trust of the public and makes contribution to people's embracing family medicine. In addition to this, in home visits, family health team sees the houses and living conditions of the families and obtains the necessary data.

Pregnancy and child follow-up and immunization are among routine follow-ups and are among primary responsibilities of the family physician. In home visits and routine follow-ups and orderly recording of the records, family health technicians can play an active role.

6.6. The effective referral and feedback system

Primary-level doctor is, at the same time, “the doctor who is responsible for the whole delivery of health care”. Family physician not only decides whether his patient needs to consult a specialist of a certain field or not, but also monitors the services provided for the patient and coordinates the service units. By this means, he counsels the patients in directing them to the appropriate specialist physician. And this establishes a communication and balance among primary, secondary and tertiary health care services, preventing wastage, unnecessary use, and duplicate investigation.

Family physician is responsible for recording the personal health records of the registered persons. In case of he refers his patient to an upper level, he has to write the reasons of referral and the basic health information of the patient. After the patient’s investigations and treatment is accomplished in the relevant field of specialty, feedback to the family doctor will be given on the same form or through an epicrisis attached to it. Improvement of the health information system through family medicine will enable at least some of these procedures to be done in a digital format. In some cases, payment of the secondary and tertiary-level service fees by repayment institutions will be on the condition of the feedback to the family physician. Feedback allows knowing all kinds of diseases and interventions and better prevention of level of health of the patient; and it enables the secondary-level services to be under control.

Patients who do not want to enter into the referral chain cannot be forced not to do; and practically such an

enforcement cannot be realized in the intended extent. However, the patient who prefers to consult to a hospital without respecting the referral chain has to pay a certain amount of the fee. The amount of the payment must be dissuasive to the extent to enable the functioning of the referral system. If there would be an obligation for the hospitals to provide feedback to family physicians to be able to charge the health expenses to the repayment institution, this would also enable family physicians to record the recordings of the persons who does not enter into the referral system. On the other hand, this prevents patients from being encouraged by the hospitals to directly consult to the secondary-level.

In order to institute the graded health care among health care facilities and to enable the first consult is made to the primary-level, besides the payment of the contribution share, some promotional implementations such as priority in appointment can be done.

In Figure 2, the movement of the persons in the health system is illustrated.

According to the 1978 Alma-Ata Declaration, up to 85-90 of the health problems can be solved in the primary-level. Principally, the referral rate by family physician must not exceed 20%. This rate can be dynamically set by the Ministry of Health, evaluating the local characteristics, epidemiological data and the feedbacks from the family physicians from all over the country. The family physicians who make excessive referrals are surveilled, warned, and taken into training; and, for those who are found to be neglecting their duty, the payment coefficient can be reduced for the next year.

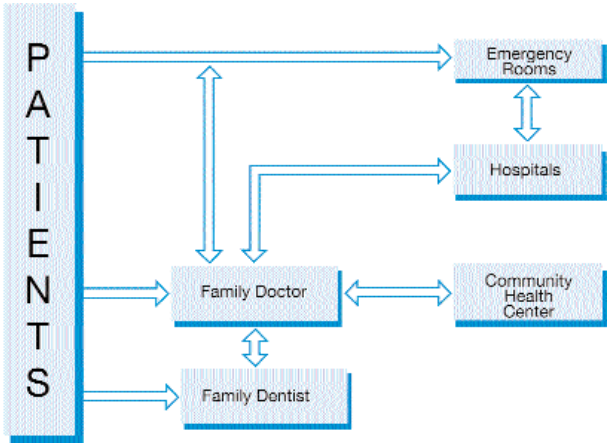


Figure 2. The flow of health care delivery

6.7. Family medicine and mobile service in rural areas

In rural areas, the chance of choosing a physician is limited for the people. This situation may lead to the limited number of registered patients. In setting the salaries of family physicians practicing in those areas, besides the criteria such as the ages of the registered individuals, vaccination rates, pregnancy follow-up, etc., the local level of development will also be effective.

In rural areas, a planning is done to maintain two or more physicians in settlements close to each other as much as possible. So, during the leaves and training services of the family health teams, they can have the opportunity to follow the patients of one another. In areas where patients have difficulty in accessing to medicines, they, especially the basic ones, must be supplied by the doctors so that the patients must not have to go to the province or subprovince center to supply medicine.

In the team of the physicians practicing in rural areas, a midwife can be preferred as the family health technician. In those areas where such an employment is found to be necessary encouraging measures will be taken.

If a family physician has to serve several municipal towns or villages, he resides in the centrally positioned settement found to be appropriate by the subprovince health administration. One of the most important factors of family medicine is the mobile health care service, since under the existing conditions the most disprivileged communities can only be accessed in this way.

One of the principles in health care services is that importance and priority must be given to those under health risk. Those who are really under health risk are those who do not consult to physicians. That section of population is constituted of those who relatively give less importance to their own health. To those people, the health care service can only be given through accessing them in their own locations. For this reason, family physician and his/her team must practice in a way to access those who do not consult to them. Family physician must visit every unit of settlement under his/her responsibility in certain intervals. These visits will also be assured to be done by the family health technician. In order that the mobile health care services can be delivered and home visits can be done on a regular basis, family physicians must be promoted to obtain a vehicle. In setting the salaries of the physicians

who have to provide mobile health care service, the fuel expenses will also be taken into account.

Family medicine can be practiced more easily in the urban areas. Today, the more the population gradually shifts to urban areas, the more the family medicine is needed. In the delivery of health care services, local differences must be taken into account. However, at the same time, the unity of the health care services in all over the country must be preserved. In urban area with the difficulty of transportation, from among the existing health stations and health posts the necessary one will be preserved. And a flexible structure will be established in which the requirements of family medicine practice can take place in the duty definition and setting the salaries of the physicians working in the health stations. Such health stations will also provide support to these duties in cooperation with the public health centers.

6.8. Family health centers and group practice

Family health centers where several physicians practice together with sufficient number of family health technicians can be established in the locations with adequate population and transportation to drop the costs and to allow flexibility in the work time duration of the physi-

cians. Here, only primary health care service will be delivered. Such group workings bear advantages with respect to solidarity and continuity of training and of service. Therefore, group workings must be encouraged as much as possible. Such group workings:

- drops costs.
- increases the accessibility to service through the system of on-duty doctors in the out-of-office hours.
- facilitates the laboratory conditions to quicken the diagnosis.
- facilitates the patient transfer in case of leave and obligatory training.

6.9. Procedures of investigation and analysis

Family physician, in case of necessity, must be able to perform simple investigations such as blood sugar, liver and kidney tests, and cholesterol, urine test, microscopic fecal examination, whole blood measurement, blood typing test, pregnancy test, and EKG. Performing these tests in the Family health unit/Center as much as possible facilitates the service. Together with the forementioned simple investigations, other investigations required for diagnosis and follow-up will be enabled to be done in the community health center. Researches show that the more is the investigation the more is the rate of completing the treatment in the primary-level. Therefore, laboratorial services must be kept at the optimal level.

6.10. Emergency health services

The daily active working hours of the family doctor, in which he/she provides counseling and primary health care, must be in conformity with the durations set by the Law. Individuals may call their family doctor at any time of the day. In order to preserve the daily working order of

the physician, a measure can be taken to prevent the unnecessary demands, charging an extra payment for the out-of-office hours non-emengercy consults. It will be better to decide on the necessity of such a measure after the pilot implementations. However, with regard to emergency situations, family doctor is supposed to be accessible at least on-call. If certain number of doctors work together, the duty system can be performed more easily. Again, family physicians in the same area can perform a duty system among themselves. In emergency situations requiring consult to a hospital, the patient or the emergency service consulted informs the family physician in a short time. If the emergency of the patient is not accepted, normal referral rules are applied.

6.11. Registry system

It is essential that personal health records must be recorded. The security and the confidentiality of the records are under the responsibiliy of the family physician. When the family physician is changed or a referral to a specialist physician or a health facility is needed, the family physician has to give a summary of the record to the patient or the physician who will be responsible for the treatment. In addition to this, during the surveillances by the insurance institutions, the family physician has to open the files to supervisors. During these scrutinies, the diagnosis that the patient wants to be kept confidential must not be revealed. The number of the registered persons, the list of the services provided, the number of the patients examined and referred, diagnosises, and the data relating to vaccination, pregnancy follow-up, infant follow-up, family planning and contagious diseases will regularly be submitted to subprovince health administration.

An electronic system operating on a common database is planned to be established. When this system is in use, the information transmitted in a written format can be transmitted into the database more frequently and securely. In addition to this, additional information such

as the treatments performed and the medicine provisions can be entered into the database. With this system, the referral chain will be more effective, fast and secure. Acceptance of an original reference number such as MERNIS (Central Population Management System) number as an additional element in all health databases will facilitate matching the data regarding the use of health services.

The data must be collected systematically and properly in order to give proper decisions in setting out the problems and the priorities, providing adequate service and efficient use of resources and finance. The way of collecting information efficiently and continually from clinicians with much work-load is to establish a simple and effective data collecting system. Usually, those information systems are planned and administered without there being a reliable data entry from the health unit that provides the actual health care services. However, decentralization of the data entry, that is allowing the health units, providing health care service, to enter data, enables more efficient use of the data to set the health indicators of the individuals and of the population.

In this way, the transmission of data can be provided over a common database and these data can be analysed to play a role in the decision mechanisms. The necessary information on the patients referred to a secondary-level health care facility and the feedback of the epicrisis information can also be provided through this system.

6.12. Family Dentistry

The practice of family dentistry will also be promoted as a complementary of family medicine. In this way, oral/dental health and preventive dental services, widely neglected in our society, will be able to be given extensivly.

Family dentistry can be extended through contractual service provision, as a great deal of dentists work as self-employed in our country. As the persons will register with

the dentists they prefer and as the return of the service fee will be paid in the system as payment per capita, this will facilitate the implementation of the system.

Dental treatments for the elderly are various and expensive. These treatments are met in different rates by the repayment institutions. With the continuity of this implementation, the practice of family dentistry in childhood and early teenage years may come into prominence. Prevention of dental health and taking preventive measures in these periods are inexpensive and they prevent the future problems in a great deal. Providing free dental services for the age group from 5 to 15 years bears great importance in promotion and extension of oral/dental health. The free services provided under the family dentistry will be set by the Ministry of Health and by the relevant institutions.

6.13. The standarts of family health unit / center

6.13.1. Health facility building

The health facility building in which primary health care services are delivered must be appropriate with respect to the kind of the services, satisfaction of the service providers and receivers. It must functionally and structurally maintain the minimum standarts set. And also it must be located in a place where the service receivers can easily access. Health services are a whole within the province; province health administrations will make the plannings according with the criteria such as the population of the area, transportation convenience, and the preference of the public.

Family physicians may practice in local health care facilities subordinate to the Ministry of Health or other institutions. If sufficient conditions cannot be met, physicians may provide service in places they equipped in the standarts required. In that situation, the rental cost will be taken into account in setting the salary.

6.13.2. Physical space

Standarts of the the physical spaces will be set by the Ministry of Health to allow the family physician and family health technicians work together (family health units) to provide the defined services properly, and to allow the easy access of the individuals. If more than one family physician will work in the same space (family health center), considering the additional number of physicians and other health care personnel and the intensity of the service receiver patients, the minimum space standarts will be defined.

The minimum physical standarts of the family health unit can be listed as the following:

1. The building must be safe and must have an adequate ventilation and lightning.

2. It must have a waiting room and a secretary register room.

3. The patient examination room must be minimum 12 squaremeters.

4. Besides the patient examination room, there must be another intervention room. This room must include an examination and intervention table appropriate for vaccination, injection and minor surgical interventions, a gynecological examination table and emergency intervention equipments and disinfection and sterilization devices. This room can also be used as a pre-examination room to collect vital signs and to measure weight and height.

5. If it is planned to have a laboratory, there must be an appropriate room for laboratory devices and for using them.

6. There must be an back-office room for works such as recording the records of the patients, keeping the statistics, and preparing the notifications to official institutions and insurance institutions.

7. There must be a lavatory for the patients.

6.13.3. Minimum medical equipment

In the family health unit there must be, as a minimum, the following medical equipments:

- Stethoscope (for adults and children)
- Blood pressure equipment
- Otoscope
- Ophthalmoscope
- Thermometer
- Tongue depressors (for single-use)
- Light Source
- Snellen chart
- Minor surgical kit
- Wound dressing kit
- Gynecological examination kit
- Examination bed
- Gynecological examination table
- Weighing scales (for adults and infants)
- Stadiometers (for adults, children and infants)

- Tape measure
- Reflex hammer
- Waste disposal container
- Disposable injector
- Airway
- Ambu bag (for adults and children)
- Portable oxygen tank
- Mobile lamp
- Refrigerator
- Paravan
- A medical cabinet for medicines and medical materials
- Basic emergency medicines

6.13.4. Staff

In the units where there are one physician (family health unit) there must be, as a minimum, one family health technician. This person can be a midwife, a health technician, a nurse or an emergency medicine technician. Taking into account the intensity of the service, it can be preferred to employ more than one family health technician. In rural areas, the family health technician is preferred to be a midwife. The family health technician is the assistant to family physician; besides the medical services he performs the procedures such as recording the records of the patients and keeping the statistics.

In units where there are more than one physician (family health center) there will be employed family health technicians as much as needed. With regard to services such as recording procedures, patient follow-up, home visits, laboratorial and radiological services there may be employed personnels with different qualifications. In addition to this, physicians may prefer to employ a caretaker.

6.14. Salary model and its effect on service

The World Health Organization (WHO) and the World Organisation of Family Doctors (WONCA) proposes a mixed payment system: a certain fixed salary and/or payment per capita, plus, payment per unit of service. Regarding the local characteristics, in order to prevent and screen specific diseases, and to provide individual preventive health care services better, it is possible to make promotions through encouragement or payment models. Although payment per unit of service is for proctecting the quality, it is a model which considerable increases the health expenses. On the other hand, in the model of global budgeting and payment per capita, it is essential not to compromise from quality and it secures the controlled expense.

In order to maintain the functioning of the system in a secure manner, we stipulate fixed salary and payment per capita. And to bring to prominence the quality and to be able to be more successful in preventive medicine practices, payments per a unit of service will be included into the system to encourage specific services.

In order to achieve the expected success in family medicine, there must be universal health cover-

age system. In the primary-level, it is essential to have a model in which certain services are provided free of charge. These services include: preventive and therapeutic services, immunization, prenatal care, child delivery, family planning, prevention of risky pregnancies, struggle with infectious diseases, health education and therapeutic and rehabilitative services. The defined basic health care services will be guaranteed to be delivered free of charge even in the pilot implementations before the introduction of general health insurance which means a health coverage for all citizens of the Republic of Turkey.

Service contract qualifications must be the same in all over the country; but, on the basis of province and/or region, additional conditions may be added on the demand of the Ministry of Health.

When the practice of family medicine will be established, the health expenses will be more controlled in the country.

Family physicians will life long follow the health situation and life setting of the individuals and the role of preventive and informative services will prevent expensive health care expenses. The expenses of the patients who are treated in the hospitals as in- or out-patients will be reduced with the practice of family medicine. And, because of the increase of the preventive services for individuals, doctors' being more easily accessible and early diagnosis, the disease burden and health expences will be reduced.

The income of the family physician will be constituted of the sum of the payment per capita and the service support payments. The dynamics that play a role in setting the salaries of the family physicians will result the limitation of the expenses through a better organization and personnel management. That is, doctor-administrators, will shift to a model in which they can use space, energy, medical equipments and personnel more efficiently. As they have the right to choose the diagnosis and treatment tools, specialty fields and hospitals and to orient their patients, family physicians will establish coordination between those service providers.

Encouraging the hard-working personnel must be essential. Due to the regional disparities, it might be hard to employ family physicians in certain regions of the country, as it is the situation today. In order to make the personnel distribution well-balanced, payment coefficients set according to the development level of the regions will play a role in setting the salaries.

Monitoring the patient referral rates and rewarding the decreasing those rates are essential. In areas where there is one doctor and where mobile services bear importance, as freedom of choosing one's own doctor cannot be maintained, monitoring the performance criteria, the physicians are promoted. Payment per one unit of service and addtional points other than fixed premium per capita serves as a promotion in the direction of the policies set to make the system more qualified and efficient.

6.15. Controlled local practices and gradual transition

In the first place, practice of family medicine has begun in an middle-scale province, and after the practice model will be maintained to become functional in a short time, the pilot implementation will be continued in five provinces, from among different regions, with different characteristics and different scales. That they reflect different characteristics of our country will provide an important experience for the expansion attempts. After the necessary organizations, a gradual expansion will take place. This gradual expansion will give the opportunity to evaluate experiences acquired from the controlled local practices and to adapt itself into the different conditions of the country. In the provinces where pilot implementations will take place there being faculties of medicine with family medicine specialty is being regarded as a facilitating factor to have a continual communication with and support from the training institutions.

After the implementations, started in certain provinces, cover the whole province, in the second phase, will be expanded to the provinces with similiar characteristics with those provinces. In that way, family medicine practice will be gradually extended to cover more population in different regions of the country. Such a gradual expansion will be beneficial in the performance of the implementation in terms of evaluating the experiences acquired, taking measures to improve the effectiveness and efficiency of the system, increasing the motivation and the number of the family physicians

This process will take some years. However, expanding the system in a secure manner is important for the continual stability of the system.

This transitional period will enable the public to embrace the system. On the other hand, in this period, the patient behaviour will improve according with the new model; and the behavior pattern of the health care professionals will take on a shape, approprite to the practive of family medicine. Moreover, in this period, surveillance and control mechanisms will be improved. This period is also important with respect to the transition to the general health insurance and its expansion. In order that the practice of family medicine is expanded to the whole country, a package of guarantees covering basic health care services must be offered free of charge for all citizens.

6.16. Workplace and institution practice

The goal of workplace medicine to keep work and workplace health under surveillance and to perform diagnosis, follow-up and examinations of occupational illnesses. Employers, legally, must provide their workers with occupational health services and regulate them. It means that the employers must provide necessary health care services to prevent health dangers arising from the work performed. Moreover, they have to train

the workers about the dangers and preventing from them.

When a referral is necessary, the workplace physician directs the worker and informs his/her family doctor. Persons must be followed-up by the family physicians. When a preventive or therapeutic health care service is needed, the workplace physician and family physician have those services performed, in cooperation. Routine primary health care services provided in health care facilities under governmental institutions has no relation with family medicine. And infirmary-like health units in common shared facilites such as prison, dormitory school, etc. are independent from family medicine.

7. CONCLUSION

In spite of the economical successes achieved, the level of health of our citizens is under than the country can afford or maintain.

The intensifying problems of our health sector clearly display the reconstruction of the sector and its undelayability. As a natural consequence of this, we face the qualitative and quantitative insufficiency of the existing health care supply, negative results in the health indicators and a general displeasure.

In order to resolve these negativities, the works started in transformation in health and the reorganization of primary health care, which is most important part of these works, and the transion to family medicine will be completed as soon as possible.

This booklet, is a document prepared to shed light on the practice of family medicine in our country. In Turkey, Family Medicine Pilot Implementation Act, prepared to introduce family medicine to Turkey, was passed from the Turkish Parliament on November 24, 2004 and

announced in the Official Gazette on December 9, 2004. The implementation will start in the provinces chosen by the Ministry of Health after the infrastructure works are completed. By means of evaluation of the feedbacks, the expansion of the implementation will be possible.

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Family Medicine The Turkish Model

Maintenance of the right of health requires a very complex process, ranging from individual health concerns to public health. In many countries general medicine has been successfully implemented, especially in Europe, and the importance of primary health care has shown a marked improvement through reforms, and its positive impact on the cost has been more and more realized.

Through the Health Transformation Programme, the family medicine, one of the most important strides made in solving the problems that has not been solved so far, is finally being launched with a new approach.

The Ministry Of Health Of Turkey