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A STUDY ON BASİC HEALTHCARE SERVİCES İN TURKEY: CASE OF ÇORUM PROVİNCE*

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ABSTRACT

Today, it is accepted by everyone that all individuals should have access to healthcare services. In 1978, Alma Ata Conference was held by the United Nations with the participation of many states. It was aimed by participating states that everyone would have access to eight primary health services by 2000. Since then, other international meetings on health services have been held, however, Alma Ata is important because it is the first.

In the study, case of Çorum was analyzed using PCET scale, by which WHO measures basic healthcare services. Family Health Centers, where primary health care services are provided today, were examined over the data used. It was analyzed whether services provided met the accessibility, comprehensiveness, continuity and coordination criteria.

Keywords: health, basic health care, PCET scale

TÜRKİYE'DE TEMEL SAĞLIK HİZMETLERİ ÜZERİNE BİR İNCELEME: ÇORUM İLİ ÖRNEĞİ

Özet

Günümüzde tüm bireylerin sağlık hizmetlerine ulaşması gerektiği herkesçe kabul edilir olmuştur. 1978 yılında birçok devletin katılımıyla Birleşmiş Milletler tarafından Alma Ata Konferansı düzenlenmişti. Sağlık hizmetlerine, sekiz temel sağlık hizmetine 2000 yılına kadar herkesin erişiminin sağlanacağı katılan devletlerce hedeflenmişti. O günden bugüne sağlık hizmetlerine dair başka uluslararası toplantılarda yapılmıştır; ancak ilk olması sebebiyle Alma Ata önemlidir.

Çalışmada Dünya Sağlık Örgütü'nün temel sağlık hizmetlerini ölçtüğü PCET ölçeği kullanılarak, Çorum il örneği incelenmiştir. Kullanılan veriler üzerinden bugün itibariyle temel sağlık hizmetlerinin verildiği Aile Sağlığı Merkezleri'ne bakılmıştır. Yapılan hizmetin, erişilebilirlik, kapsamlılık, süreklilik ve koordinasyon ölçütlerini karşılayıp karşılamadığına bakılmıştır.

Anahtar Kelimeler: sağlık, temel sağlık hizmetleri, PCET ölçeği

1. INTRODUCTION

In the 1970s, the fact that underdeveloped countries were relatively poor was associated with excess populations or lack of technology. The newly founded states as a result of various political movements suggested that the distribution of resources was unfair and that there should be some changes made in this regard. The idea of redistribution of resources was implicitly accepted. Based on this, the words used were class vs class struggle, universal solidarity instead of imperialism, common interests, dialogue, etc. In 1978, a conference was held in the capital city of Kazakhstan, Alma Ata, under the leadership of the United Nations (UN) Children's Fund (UNICEF) and the World Health Organization (WHO). The final declaration is a letter of consensus, which comprises impositions and concessions. While they reflect the wars of the third world on the one hand, they reflect the traces of socialist countries on the other. It harbors the periodic power of new independent states, where the power of socialism falls and national liberation movements come to power (Soyer, 2002: 111). The Alma Ata Conference was a well-planned, well-attended, policy-related event of primary health services and "Health for All" until 2000 (Bryant and Richmond, 2008: 152). It is a snapshot of the power level of the working class and the capitalist class, with a socialist approach to health (academia.edu/37784779/Alma_Atadan_Astanaya_7_Akif_ Akal%C4%B1n, 2019). This is the declaration where the initial signals of neoliberal understanding about health are pronounced first (Pala, 2002: 101).

A broad consensus has been reached that health is a human right and that health inequalities are inadmissible (who.int/publications/almaatadeclaration. en. Pdf, 2017). The main elements in the perspective of Basic Health Care Services (BHS) are; equity, community participation/involvement, cross-sector cooperation, suitability of technology and affordable costs (ttb.org.tr/mevzuat/index.php?option=com_content &task=view&id=521&Itemid=36, 2019).

In the fifth article of the Alma Ata Declaration, it is stated that the following health services include the minimum and the lowest health care (minimal care) and cannot be renounce. It is emphasized that the BHS should contain the following items (apps.who.int/iris/handle/10665/62749, 2020):

- Regulation of food and proper nutrition,

- Providing sufficient amount of clean water,
- Improving environmental health services,
- Maternal and child healthcare services including family planning,
- Immunization against major infectious diseases,
- Prevention and control of local endemic diseases,
- Necessary treatment of common diseases and traumas,
- Services for the provision of essential drugs.

It constitutes the core of healthcare services in the country and is indispensable for socioeconomic development. BHS constitutes the ring of precedence for the healthcare system and the first contact place for the individual, family and society, as close as possible to the places where individuals maintain their lives and work (who. int/publications/almaata_declaration_en.pdf?ua=, 2020). It is understood that BHS refers to the health services that are mandatory and required to be offered to the public, covering the general society (Pala, 2002: 102-105).

In order to mitigate health inequalities and provide basic health services, 38 targets were set in Copenhagen in 1984. The considerations in Alma-Ata was taken one step further in the Ottawa Charter for Health Promotion signed in 1986. The Adelaide Conference on Healthy Public Policy identified actions in line with social justice, equity and different public health practices (women's health, food and nutrition, the environment, the battle against tobacco and alcohol). In 1996, the statements were made on the basis of meeting the health needs of the population, who cannot benefit from health services, in the Ljubljana Declaration. Actions were taken to tackle the health crisis brought on by globalization in the Jakarta Declaration of 1997 and in Savar, Bangladesh in 2000 (euro.who.int/__data/assets/pdf_file/0006/109779/WA_540_GA1_85TA. Pdf, 2019). In 2012, the WHO European Region Committee agreed on the subjects of increasing the health level of people, enhancing public health, modern, equal, continuous, quality and human-centered health systems, which are common goals for Health 2020 (Turkish Healthy Cities Association, 2019).

The United Nations Millennium Development Goals were signed in 2000 and included 8 goals decided to be achieved by 2015. These included world leaders' tackling poverty, hunger, disease, ignorance, environmental degradation and discrimination against women (who.int/topics/millennium_development_goals/en/, 2019). The conference convened in Astana, Kazakhstan in October 2018, aimed to refocus efforts on BHS in order to ensure that everyone can achieve the highest health standards all around the world. The main theme of the conference was determined as "Universal Health Coverage and Sustainable Development Goals" (who. int/primary-health/conference-phc/declaration, 2019). In the conference, it was emphasized that there are still individuals whose needs for health services cannot be met in most of the world despite the developments achieved in the last 40 years and especially poor and vulnerable groups have difficulty in maintaining their health, and it was stated that the existence of inequalities in health is inadmissible (saglik.gov.tr/TR,49852/temel-saglik-hizmetleri-kuresel-konferansi-astanada-gerceklestirildi. html, 2019).

In the Astana Declaration, countries acknowledged that the way to achieve the Sustainable Development Goals in 2030 is through BHS (who.int/docs/default-source/primary-health/declaration/gcphc-declaration. pdf, 2019). At the end of the intervening forty years, it is understood that inequalities in health persevere. According to the Conference held in Alma Ata, it was accepted that the Conference of Astana seemed to have given up providing "healthcare for all in 2000", and instead, health was no longer a right but an anticipated level of imagination (academia.edu/37689310/Alma_Atadan_Astanaya_3_Akif_Akal%C4%B1n, 2019).

Studies show that socioeconomic inequalities in health are decreasing in countries with relatively strong primary health care (Kringos et al., 2013, Grumbach et al., 1999). Regardless of the name of family physicians or primary healthcare service providers, who are the closest, long-lasting healthcare providers with the most frequent relationship to the community, the reality is that these people will have an important function in improving health, as patients will see them as the most reliable source of information (Bozhüyük, 2012: 13).

Primary healthcare services cover most of the health needs in our lives, including services such as the treatment and rehabilitation of diseases, personal and environmental protective services for health problems, as well as coordination with other levels of care (hasuder.org.tr/wp/2019/04/10/saglik-haktir-birinci-basamak-saglik-yapilanmasi-bu-hakki-saglayabilmenin-temelidir/, 2019).

More than ten million children under the age of five die each year in low- and middle-income countries due to the fact that health services have yet to be equalized. Nutritional insufficiency and lack of access to the necessary resources to produce food are the main underlying reasons of these deaths. Inability to access to clean and unsanitary water implies 1.5 million deaths. Studies addressing the unequal distribution of infectious diseases and injuries, which are related to poverty, economic insecurity and economic marginalization, are increasing each passing day (Labonte and Shrecker, 2011: 11-12).

2. MATERIALS AND METHODS

In the study, health level indicators of Çorum province used as a sample were obtained from TUIK. Then, it was examined whether the provided basic health services met the criteria in the PCET scale with the data obtained from the Public Health Directorate of Çorum Provincial Health Directorate. A generalization about Turkey was attempted by making an inference in the light of past studies and these data.

3. FINDINGS

Çorum ranks 50th among 81 provinces in terms of socioeconomic development in 2017 compared to the provinces in Turkey (Ministry of Industry and Technology, General Directorate of Development Agencies, 2020). When the demographic indicators are examined; In 2018, the total population is 536,483, the rural population ratio is 39.7, the urban population ratio is 60.3, 0-14 age population ratio is 19.9, 65 and over population ratio is 14.4, young-age (0-14 years) dependency ratio is 30.2, elderly (65+ age) dependency ratio is 22.0 and total age dependency ratio is 52.2 (Ministry of Health, Health Statistics Yearbook 2018 Newsletter, 2019). The country average GDP for 2018 (A Thousand TRY) is 3,724,387,936, while it is 15,397,085 Turkish Liras in Çorum. The population growth rate is -10.53 per thousand in Çorum in 2019, and it is below 13.94 per thousand, which is the country average (TUIK, Provincial Indicators, 2020).

When the share of Turkey's current health expenditure in GDP is compared internationally in 2017, it is observed that the country ranks last among OECD countries with 4.2%. The average for OECD member countries is 8.8. When the provinces are considered in terms of the infrastructure of health institutions in 2018; the number of hospitals is 16, the number of beds is 1662, the number of beds per 10,000 people is 31.0, the number of qualified

beds is 1,233, the number of intensive care beds is 245, the ratio of qualified beds is 87%, the number of intensive care beds per 10,000 people is 4.6. In 2018, the number of family practice units is 185 and the population per family medicine unit is 2900. In terms of service utilization, Turkey ranks sixth with 9.5 per capita among 35 OECD countries in 2017. Çorum is below the national average with 9.0 applications per person. In 2018, the total number of applications to primary healthcare services was 265,496,223, and the total number of applications to secondary and tertiary health services was 517,018,981. In 2018, the total number of applications for primary healthcare services in Çorum was 1,629,064, and 3,184,885 for secondary and tertiary health services. When considered in terms of healthcare manpower; In 2018, are a total of 768 physicians, including 378 specialist physicians, 348 general practitioners, 42 assistant physicians, 127 dentists, 208 pharmacists, 1,397 nurses, 478 midwives and 1,334 other healthcare personnel in Çorum (Ministry of Health, Health Statistics Yearbook 2018 News Bulletin, 2019).

We need to examine these data related to health infrastructure over the results obtained. As a matter of fact, infant mortality rate, which indicates the health status of the society, will be significant when examining the data on the mortality rate and life expectancy at birth for all individuals under the age of 5. When we look at the basic indicators about BHS; the infant mortality rate in Turkey is 9.1 per 1000 live births in 2019, and the province of Çorum is 9.2. Under-5 mortality rate for the same year was 11.2 per 1000 in Turkey and 10.7 in Çorum. In 2017, life expectancy at birth is 78 in Turkey and 78.6 in Çorum (TUIK, Provincial Indicators, 2020).

BHS was rebuilt on different dynamics by making a radical change about seventeen years ago. BHS was previously provided by the healthcare centers and health-houses, all of whom were charged from the general budge, with the efforts of employees who were all civil servants. The legal legislation of family medicine system, which has been implemented gradually since 2004, and community health centers (CHCs), which were established to provide services not offered in family health centers, could only be established approximately seven years after family health centers.

Today, family physicians are authorized by the Ministry of Health and have contracted with the social security institution, and they employ other personnel needed by family health through contracting. Inspection and consumable expenses were covered by public health

directorates until the amendment in article 52 of the Law amended by the decree law dated 02/01/2014. Later, family physicians began to cover these expenses themselves (Official Gazette, Date: 09/12/2004, Number: 25665).

The payment made to the family physician increases in proportion to the number of the registered population, the fact that the FHC is in a good grade (A, B, C, D, E with A being the best) when evaluated with the physical characteristics, the low socioeconomic development level of the population to be served, the distance of the place where mobile health service will be provided and the number of the population living on this place (Official Gazette, Date: 30/12/2010, Number: 27801). Unfortunately, the classification criteria do not measure the quality of the healthcare services (Social Security Institution, 2013). In order to improve the physical qualities, the physicians must spend on their fees received. Since such expenses can be regarded as an additional cost in the profit-oriented system (Ankara Chamber of Medicine, 2017), a choice will be made between the expenditure and the income to be obtained from the classification category that will be upgraded.

The total number of general practitioners in Çorum is 298, among them 179 physicians are working in primary care. Out of 179 physicians, 16 of them are family physicians who are not public officials in places where not preferred, that is, contracted physicians (Official Gazette, Date: 25/01/2013 Number:28539), 163 of them are family physicians. 135 physicians work in Community Health Centers. The ratio of the number of family physicians with a registered population of 2,000 or less to the total family physician is one third. The minimum population is in Bayat Eskialibey Family Health Center with 1047 and the highest population is in Zafer Family Health Center in Çorum with 3995. Two-thirds of family physicians serve more than the targeted population. In Çorum, there are 179 family physicians and they offer services together with 166 family healthcare personnel. There are 13 family physicians that do not employ family healthcare personnel. Throughout the province, there are 17 contracted auxiliary healthcare personnel to whom the Ministry of Finance allocates a budget as a non-public family medicine worker contracted by the governorship (Official Letter, Date: 28/ 07/ 2020, Number: 72716672-804. 01-39).

Çorum has 759 villages and 2 towns, 454 of which receive mobile service and the living population is 60,482 (Official Letter, Date: 28/ 07/ 2020, Number: 72716672-804. 01-39). The total population living in Çorum is 530,864 (TUIK, Population Statistics, 2020). The units with

the longest distance from the family health center to which the furthest settlement is affiliated are Bayat-Akseki (50 km) and Kargı-Çal (50 km). Mobile health service refers to family health professionals traveling to villages and towns on a certain day of the week and at certain time intervals to only examine patients; namely family physicians and family health personnel. The remainders of the health services are carried out by the assigned Community Health Centers. It is foreseen that one CHC will be established in each provincial centers of cities other than metropolitan areas and one in each district. Planning of mobile health service (Official Gazette, Date: 25.01.2013 Number: 28539) is determined by taking geography, climate and transportation into account, regardless of the time elapsed to reach the place where the service is provided. Mobile services will be regulated depending on the population of the destination. If the living population is less than 250, it is planned to visit once a month, if it is between 250-500 twice, and every week if the population is 500 and above. The place where the service is provided can be a health facility if there is such a facility belonging to the Ministry in the region, otherwise any place deemed appropriate at the destination can be an examination area. The scope of health service will be limited in terms of the physical conditions and equipment of the place where the service is provided. In a research conducted on family practice in Turkey (Öcek and Çiçeklioğlu, 2013: 60-61) it is demonstrated that the reason for citizens to apply to FHCs is to get a prescription. Apart from this, they are mostly visited for chronic disease examinations, pregnancy and baby follow-up, respectively.

Family physicians provide their services free of charge from the budget of the Ministry of Health. Regular premium payments will be important when the full operation of the system is financed through general health insurance (GSS) (Ataay, 2008: 175, Çakmak, 2017: 53).

Family medicine has a history of offering home nursing care in the prosperous Western and Central Europe (Aksakoğlu, 2003: 254). In addition to the social, economic and geographical aspects of these countries from which the system is transferred, their education levels, rural structures and cultural characteristics are different from Turkey (Öztek, 2006: 4). Unlike family practice, which is a field of specialization, general practitioners have a role in the health center, sharing the holistic perspective previously acquired in faculty education with their team and continuing with training, and taking on leading and supervisory roles, although their main duty is to take care of the patients. However, the concepts of region/area management in family practice are outside the field of specialization of the family physician (Aksakoğlu, 254). Family physicians are expected to adopt a holistic approach to the family, and to have a grasp

of and follow up on life style, housing, working environment and health problems of all family members (Öztek, 2).

The most important problem in Turkey is the high population per family physician due to the shortage of trained family physicians. There are efforts to close the gap by assigning family physicians in emergency services (TTB Public Health Branch, 5). Apart from emergency seizures (Uğurlu et al., 2012: 9), family physicians were assigned with the tasks of infant, child and adolescent follow-ups (Tezel & Aydın, 2018), school vaccinations for 1st and 8th grades (hsgm.saglik.gov.tr/tr/haberler/asilama-takviminde-degisiklik-yapildi. Html, 2020), controlling verbal statements made to the population directorate and preparing a healthy certificate for different reasons with history, physical examination and simple tests in the course of time (Uğurlu et al., 2012: 9). Taking tasks of vaccines from CHCs and assigning them to FHCs may cause various problems in accessing the population not registered with FHCs (seasonal workers, immigrants, refugees, etc.) and complying with the cold chain rules (ttb.org.tr/kollar/_ahek/haber_goster.php?Guid=dbd5ec98-ae10-11ea-a732-c115216aae2a, 2020).

The high number of patients registered in FHCs may benefit healthcare services by getting rid of compulsory works (Baltacı et al., 2011: 14), and it will be difficult for them to provide protective services for BHS as required. As a matter of fact, there is no incentive payment for the length of time allocated to the individuals, to listen to their complaints, and to find an effective solution for their illness.

When the number of currently registered individuals is reduced, the time allocated to patients will increase; however, the possibility of wages falling in parallel worries family health workers as well (drtus.com/forum/viewtopic.php?t=158451&start=15, 2019). The fact that the system is based on business management principles may raise objections to wage reductions in regulatory transactions (medihaber.com up-to-date / family-physician-fees-h4320. Html, 2017). Studies found that the most important reason for physicians to switch to family practice is the good wage. There may be a loss of a size that will cause trouble with the transfer of the dependent population, workload, deductions due to performance, reduced current service payment due to FHC classification, and the registered population, which determine how much the family physicians will be paid. Paying family physicians without taking into account the socioeconomic characteristics of the province and region may cause difficulties for FHCs in

terms of their expenses (Aktaş and Çakır, 2012: 27). In addition to low performance, incentive additional wages should be arranged rather than punitive practices such as warning scores and salary deductions (Uğurlu et al., 2021: 9). As a matter of fact, the penalty of deduction from salary is one of the most severe penal sanctions according to Public Servants Law numbered 657. It is legally wrong for the procedure called performance cut in family medicine to correspond to the penalty of deduction from salary, which is a heavy disciplinary punishment (Aktaş and Çakır, 2012: 27).

Since the family medicine system is founded on the principle of individual's preferring another physician when he/she is not satisfied, competition among physicians is inevitable (Öztek, 2006: 5). It may lead to a tendency for the emergence of irregular prescribing and resting reports in order to increase the registered population for the family physician.

The fact that the job descriptions of family physicians and family health professional working in FHCs are not included in legal regulations has caused the execution of affairs through personal relationships. Considering the division of labor and hierarchy, it is seen that family health professional will work more. Competition among employees, ethical corruption, workload and work stress increased, and the time devoted to business life, social life and professional development decreased (Baykan et al., 2014: 123, medimagazin.com.tr/hekim/aile-hekimligi/tr-aile-hekimleri-yeni-odeme-sozlesme-yonetmeligi-taslagindan-umutsuz-2-21-84510. Html, 2019).

4. DISCUSSION

Institutions responsible for running BHS are FHCs and Community Health Centers (CHCs). While CHCs are formed as one or more than one, considering the size of the province, FHCs are population-oriented. CHCs have many duties, but it is more difficult for citizens to reach CHCs compared to FHCs in terms of physical distance.

Below, practices in Çorum province will be evaluated according to the PCET scale developed by WHO to measure BHS. The scale measures BHS in the topics of accessibility, continuity of service, comprehensiveness and coordination.

Accessibility

The WHO defines the accessibility as ease of obtaining healthcare services. In terms of accessibility, there may be various barriers of psychological, sociocultural or financial nature, with the physical cost of transportation (mostly people with low income) (Tosun, 2018) (euro.who.int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool. Pdf, 2020). Studies show that primary care is preferred due to the low cost of transportation and examination interruptions, especially by the elderly population (Turgut et al., 2018: 78-91). Considering the aging population, it is important to provide BHS in an accessible and comprehensive way in primary care. Apart from the primary health care organization, BHS can achieve positive results with the joint action of all other public and private institutions. Especially coping with air, radiation and noise pollution is possible with the joint struggle of all institutions.

Accessibility to healthcare institutions is influenced by reasons such as the level of knowledge about benefiting from public services, not speaking the same language as service providers, not being able to access the healthcare unit due to pressure from the husband or mother-in-law, or not being able to perform the necessities of treatment after accessing and having children or patients they cannot leave at home. Those who cannot access healthcare are the most unconscious segments of the society with the highest risk; the system has put mobile health service into practice for this social segment. Healthcare centers and health houses, which had been implemented for more than forty years before the family medicine system, were organized population-based rather than treating the sick person. The health center working system involves keeping the records and characteristics of everyone, whether they apply to them or not, protecting the healthy person, ensuring the development of the person at risk, treating the sick (treatment, therapy for mental health diseases) and determining the situation on the spot and intervening before individuals are aware of their needs with a holistic (universal) approach. The main difference that distinguished the healthcare center from other service units was that the service was carried out at home. At this point, the essential healthcare worker was midwives. The goal was for midwives to go to individuals' homes and reach the elderly, women and children. The vehicle and driver to be assigned had critical importance (Aksakoğlu, 2008: 17). During these home visits, the individual was approached in a holistic manner with the environment he/she lived in, and health services were delivered to their homes. Home visits, which were missing in the previous practice of family medicine, were partly regulated in the Family Medicine Implementation Regulation in 2013 (Official Gazette, Date: 25/ 01/ 2013, Number: 28539.). It was stipulated that family physicians should see, check, or contact (in any

way) with these persons registered in their system within six months in order to make the first follow-up; however, no obligation was imposed on the control of persons in subsequent periods. However, the health of a person is certainly related to the socioeconomic conditions of the family in which he/she was born. Healthcare professionals, especially midwives, were required to make regular home visits with the Directive on the Execution of Old System Mobile Health Services (Öztek and Eren, 1996: 203-235). Midwives do the scheduling of their home visits one month in advance. They evaluate the visit of the previous month and write down to repeat what has not been done. During these visits, pregnancy, puerperal, child and patient monitoring, examination, laboratory examinations, vaccination, health education are performed, records of the procedures are taken and recommendations are made (Öztek and Eren, 1996: 146).

As a mobile service, family physicians are obliged to provide comprehensive and continuous diagnosis, treatment and rehabilitation services that should be done in primary care, with personal protective services, out of a specific location (Kavuncubaşı and Yıldırım, 2018: 54). However, the mentioned mobile service is limited to the provision of polyclinic services by visiting to the settlements for one or two days a week. Due to the reasons for providing the mobile service throughout the country, including Çorum, the possibility of having a pharmacy in these places cannot be expected as well. Due to the fact that there is no place to get medication after the examination in the settlement and the mobile service is unable to meet the needs in terms of time and frequency, services may be taken from the nearby town for examination and medication. Here, individual will be able to go to his/her own family physician or another family physician. Since each village is allocated to a physician in the FHC in the district or city center to which it is affiliated, the service is not provided continuously and the health service cannot be met when the need arises. The fact that everyone in a village is registered with a physician and that only that physician provides mobile services will automatically cease for a citizen to choose a physician and receive health services.

The average number of applications per capita to healthcare institutions in Turkey is 9.5 for 2018, and this number is 9.0 per person in Çorum. Among the total number of applications to physicians in 2018, the rate of applications to secondary and tertiary health services is 66%, on the other hand, the rate of primary health care services is 34%. While, family medicine unit referral rate was 22% in 2002, a rapid decline to 10.2% was experienced in 2005 and there was a gradual decrease below this rate as well. It was below 1% in 2010 (‰ 4) and from 2014 (‰ 4) until 2018 (‰ 2) with the latest data (Ministry of Health, Health Statistics Yearbook 2018

News Bulletin, 2019). These rates show us that primary health care services are unable to meet the needs and therefore, even if accessibility is difficult, it leads the citizen to apply to secondary and tertiary health services.

According to TUIK Life Satisfaction Survey, the satisfaction with health services achieved the highest satisfaction with 75.4% in 2016, but decreased both in 2017 (71.7) and in 2018 (70.4). It is observed that out-of-pocket health expenditures increased between 2002-2007 and decreased between 2007-2012; however, it followed a fluctuating course after 2013 and showed an upward trend until 2018 (Ministry of Health, Health Statistics Yearbook 2018 Newsletter, 2019).

There are two common forms of practice: primary care financing, tax and out-of-pocket payment. The practice of out-of-pocket payments causes the poor (Alcan, 2015: 132-133), marginals, immigrants and uneducated groups to not benefit sufficiently from the service (Soyer and Öcek, 2007: 17-19). In Turkey, primary health care services are required to pay out-of-pocket by charging (if more than three) over the number of medications prescribed under the name of prescription contribution, albeit less than the second and third level (Official Gazette, Date: 18/ 04/ 2014, Number: 28976). It is seen that it is essential for these segments of the society to ensure that health expenditures are fully covered by general budget tax revenues.

Another source of financing for health services is the social insurance system. The social insurance in the health system was restructured with the Health Transformation Program. The system has been shifted towards an axis where those who regularly pay their General Health Insurance (GHI) and private health insurance premiums can benefit (Official Gazette, Date: 10 November 2017, Number: 30236). The calculation over four different income levels was removed and reduced to two types with the regulation issued when premium debts accumulated. At this point, those whose income is less than one third of the minimum wage will remain within the scope of GHI, and it is planned to reflect premium debt to those who have not made an income test and are directly registered by the SSI. According to the household expenditures health survey, the health coverage rate of the population increased with GHI (Koruyucu and Oksay, 2018: 269).

It has been facilitated that the premium debts accumulated since the beginning of the GHI application can be paid in equal 12-month installments without delay increase and delay penalty by making a political disposition before the election. By making this change, it has been

enabled to benefit from health services for one year as of April 01, 2017 (Official Gazette, Date: 10/11/2017, Number: 30236). From this point, it is seen that the accumulated premium debts of the people at lower socioeconomic levels of the population included in the system are not paid and this debt is again reflected to the whole country. Although the GHI covers 95% of the population in the society, more than half of the society does not trust the current health system and do not think that it covers all of the health risks. As a matter of fact, citizens who are subject to GHI and their dependents are required to make out-of-pocket expenditures for some health services such as examination, medicine, prescription, orthosis and prosthesis (Çelikay and Gümüş, 2011: 75). Those who mostly use primary health care institutions are impoverished ones, lower class groups and the ones without social security (Beliner, 2007: 31). It has been observed that lower socioeconomic groups benefit less from healthcare compared to wealthy individuals in Turkey. Among the services that are least utilized are preventive health services and dental treatment, lens / glasses etc., which are considered as other health services (Alcan, 2015: 132-133). The rate of expenditures made by the poor in order to receive health services within their income increased during the period from 2003, when the HTP was implemented, to 2013 (Yereli et al., 2014: 276-293); public and private health expenditures per capita were in the direction of continuous increase in real terms until 2018 including the year of 2013 (Ministry of Health, Health Statistics Yearbook 2018, 2019: 260-270). There are many studies showing that out-of-pocket payments disrupt equity. It is recommended to apply progressive taxation (people with high income pay more tax, while, people with low income pay less) practice in reducing inequality (Öcek and Çiçeklioğlu, 2013: 13-14).

Because family physicians are organized based on individuals rather than population based, seasonal workers, immigrants and unregistered people need to make their own efforts so that they could benefit from health services. Due to the low income of the migrants and their distance to the city centers where health services are provided, they cannot access such services (Şentaş, 2018: 107-134). It is highly difficult for patients coming from outside the region to be examined by CHCs in places where tourism and migration are intense (Öztek, 2006: 5).

Comprehensiveness

Comprehensiveness is the provision of a range of services in the prevention, treatment, rehabilitation, supportive care as well as promotion of the health. Th term refers not only to the provision of a specific range of services, but also to the professional skill level of the primary

healthcare provider, as well as the application conditions, facilities and equipment (euro.who.int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool. Pdf, 2020). In the current system, curative medicine was assigned to family physicians, preventive medicine was, on the other hand, assigned to CHCSs (ttb.org.tr/halk_sagligi/2011/01/12/saglik-hizmetlerinde-piyasalastirma-degil-kamucu-esitlikci-sosyallestirme/, 2011). Preventive medicine and preventive medicine for society is not an issue that can be separated with sharp boundaries. While modern health services are aiming to solve health problems in a multidisciplinary manner, it will be difficult for the family physician to achieve success with an individual-specific treatment method (Kılıç, 2003: 21-24).

The healthcare personnel, who work 24 hours a day in the healthcare home system and reside in the location where they are personally located, provide the treatment service in this system by family health center employees who come once or several times a week and issue more prescriptions. Preventive health services are provided to citizens living in rural areas by CHCs located in the city or district center. Personal preventive health services are provided in subjects such as medication protection, immunization, health education, early diagnosis, reproductive health, healthy nutrition and hygiene (Kartal, 2016: 53). Transferring accessibility to family health centers, which are the closest service units, will increase the accessibility of the service.

Providing diagnosis, treatment, rehabilitation and counseling services (article 4/g) to individuals with disabilities, bedridden and similar situations to the extent of primary health care services are listed among the duties of family physicians in the Family Medicine Implementation Regulation. However, healthcare services cannot be provided as required due to the fact that the physicians are not allowed to leave the family health center without finding a replacement physician, the system's performance criteria are differently regulated and the workload (ahef.org.tr/Haber/2021/AHEF-Hatay-Ili-Aile-Hekimleri-Dernegini-ve-Aile-Sagligi-Merkezlerini-Ziyaret-Ett. Aspx, 2018). The fact that regular health visits cannot be conducted in the family medicine system (Çetinkaya et al., 2013: 55) has shown that those living in regions with rapid urbanization, those with lower education and lower income are unable to receive services even in essential matters such as prenatal and postnatal care (Durusoy et al., 2011: 13.).

If preventive health services and outpatient services in family medicine are expanded, applications to higher levels will decrease. The scope of the service can be expanded by increasing the type of specialization (physical therapy, dentist, social worker and dietician) (Akman, 2014: 76, İlgün and Şahin: 2016: 127). Increasing the level of health related to these topics will be possible when a physician undertaking leadership qualification collectively produces solutions together with a team of increased expertise. The BHS issues listed require the cooperation of other public and private sectors operating outside the field of health.

The comprehensive range of services is closely related to the professional skill level of the primary healthcare provider (euro.who.int/__ data /assets/pdf_file / 0004/107851 / PrimaryCareEvalTool. Pdf, 2020). Family medicine is a field of specialization in Turkey, but unlike similar countries that implement this system, an employment mostly consisting of general practitioners have been created due to the lack of adequately trained specialists (Ağdemir, 2012: 103).

Pursuant to Article 3 of the Family Medicine Law; Family health workers start to be employed by signing a contract with the recommendation of the Ministry of Health and the approval of the Ministry of Finance. In the Family Medicine Law No. 5258, it is enacted that family physicians can employ personnel individually and jointly and thus become employers in the paragraph added with Article 26 of the Law No. 7151 dated 15/11/2018 (Official Gazette, Date: 09/12/2004, Number: 25665). They will employ the amount of allied health personnel required by the family health center to carry out cleaning and other works by signing a contract. At this point, the physician must share the fee obtained over the number of registered patients. Therefore, the allied health personnel, who are qualified employees, will be able to receive a wage as much as possible by the bargaining determined by the labor supply in the market. Although the main determinant is the physician, the personnel whose contracts expires will become insecure and will have to look for a job again as a result of the regulation (Official Gazette, Date: 30/12/ 2010, Number: 27801).

Employees in CHCs work by constantly changing places. This situation may lead to their inability to feel any belonging to the workplace, not being used to the functioning of place they go, providing the service slowly/not being able to provide the service or providing wrong service. For the Class A FHCs, employing family health personnel at the minimum wage level with the agreement made with subcontractor companies and frequently sending those, who are

employed, to different FHCs according to the need may cause them to feel alienated to the place of work and not to adapt to the workplace. In order to reduce the workload of FHCs in Çorum, 17 allied health personnel are employed on a provincial basis with an annual contract. In addition, allied health personnel receive different wages due to different employment styles although they receive the same training and work in the same workplace. This situation may result in disrupting the justice and labor peace in wages.

When determining the scope of basic health care, the provision of a specific range of services, as well as the application conditions, facilities and equipment status should also be taken into account (euro.who.int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool.Pdf, 2020). The reasons were that the concepts and framework of the basic care were not formed, the primary care was not taken seriously enough, the expectation about the patient was at a higher level, the technological equipment and personnel were not at the level to meet the expectations (Algan, 2004: 270).

The services that should be provided together with the preventive services are planned to be carried out by separate units. The only thing the family physician faced with an infectious disease has to do is to report the case. Pregnancy, puerperium, immunization, infant and child follow-ups are mostly carried out by applying and calling them. Preventive services are not evaluated in terms of the place where the individual lives his or her life or the dimensions related to this place. Home visits are an extraordinary activity and are only due to the physician's record of the population (ttb.org.tr/halk_sagligi/2011/01/12/saglik-hizmetlerinde-piyasalastirma-degil-kamucu-esitlikci-sosyallestirme/, 2011: 8).

The professional freedom of the allied healthcare personnel is being made the assistant of the family physician staff, causing the profession to be unqualified. As a matter of fact, it was observed that those working in primary health care services were not satisfied with the family medicine practice. Occupational identities of midwives and nurses have disappeared, they carry out secretariat duties as family health personnel, and their jobs have concentrated on multitasking. Since the use of annual paid leaves in the wage system determined according to performance decreases the income, there is a tendency not to take annual paid leave. Since family health personnel is asked to work actively during the job interview, their age, marital status and whether they have children or their private life related to these matters are questioned. Payments are interrupted in cases that are not caused by the employee himself in the

performance payment, such as the pregnant or the baby getting sick and being hospitalized, going out of town, moving to a different place, inaccessibility due to wrong address or phone number (saglikcalisanisagligi.org/scssunumlar/ailehekimligiebeler-ummahanyucel-ayseyuksel.pdf, 2020). Professional titles were ignored and they became non-physician healthcare workers. While the physician remains in the identity of the operator, the family health worker assists the physician with limited technical skills in their work, thus teamwork has been destroyed (Ceylan et al., 2015).

When we look at the content of the service provided by the institutions that offer BHS, 34% of the number of physician applications per capita in 2018 was made to institutions providing primary health care, while 66% were made to secondary and tertiary health institutions (Ceylan et al., 2015). This number shows that primary healthcare institutions cannot produce solutions to health problems. As a matter of fact, it is illogical for the citizen to go to the more distant institution by spending time and money, when there is already an institution close to their location. In order for primary healthcare institutions to function as gate-keeping, they must have reinforcement such as examination, treatment, equipment, tools and supplies as well as competence in the field of expertise.

Üstü and Uğurlu (Üstü and Uğurlu, 2015: 247) recommend that it should be aimed to at least double the number of family healthcare personnel considering that the need for home care will increase with the growth of the elderly population in the social sense, in addition to the current jobs of the family healthcare personnel. If the goal is achieved; unnecessary referrals are expected to decrease. However, considering that there are two family physicians working without family healthcare personnel and even units that do not employ any family healthcare personnel in Çorum, it would not be wrong to state that this is an important deficiency for primary healthcare services. When the necessary materials, supplies and devices are given and the workload is reduced some services will be available. To this end, performance payment should be reformulated as pay-per-service in an incentive form. It may be considered to expand the service offered by opening fields such as psychologists, dieticians and physiotherapists, who are among the non-physician healthcare personnel. Apart from these occupational fields, space should also be opened for social workers to fight more effectively against the use of addictive substances and domestic violence or cooperation should be made in this sense (Üstü and Uğurlu, 2015: 247).

Comprehensiveness should be the services provided in the BHS environment including health promotion and disease prevention, as well as curative, rehabilitative, supportive care. People working in these units must play a community-oriented role (euro.who.int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool. pdf, 2020). Family healthcare workers are paid based on the number of persons registered to them, and if there are places such as prisons, correctional centers, nursing homes, nursery schools and orphanages in their regions, they are held responsible for their health (Official Gazette, Date: 30/ 12/ 2010, Number:27801). It is stated in the Regulation (Article 3) that no fee will be paid for more than 4000 registered persons (Official Gazette, Date: 30/ 12/ 2010, Number:27801). The Family Medicine Implementation Regulation was amended in 2017 (Official Gazette, Date:16/ 05/ 2017, Number: 30068), and the number of people registered with a family doctor was reduced to 2000, however, it was added that the number would increase when necessary. It is aimed to reduce the number of registered people above this number to less than 3000 in 2023 (ahef.org.tr/Detay/2020/AHEF-SAGLIK-BAKANI-ILE-GORUSTU.aspx, 2018). New family medicine zones should be planned and also this population should be reduced (Ağdemir, 2012: 100).

Continuity in Service

The concept of continuity in service is the regulation of healthcare interventions according to the healthcare needs of patients over a long period of time. Continuity is the ability to deliver interventions that are consistent at short intervals or that are uninterrupted series of contact over the long term. It is necessary to have an organized medical and social history structure and related continuity of information about the patient (https: //www. euro. who. int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool.pdf,, 2020). It is possible to achieve the above-mentioned social history when the individual can be observed by the same healthcare team for a long time at the nearest health institution with their family. If the family physician was replaced and other members of the family were registered with a different physician, these conditions would be eliminated.

While the people living in the cities were allowed to choose their family physicians, those living in the villages were guided to the closest family health center by the provincial administration. In this respect, it reminds the practice of health centers, but contradicts the principle of "freedom to choose physician" of the family medicine model (Öztek, 2006: 4).

When individuals can choose a family physician in family medicine, each member of the family can be registered with a different family physician. Therefore, it does not seem possible to take a holistic view of the family. Family physician payments were associated with their performance, their performance was dependent on the population registered with them. In the competitive system, patients are measured with the satisfaction of the patient like a customer. This will be possible by fulfilling all kinds of requests of the patient. Physicians wishing to increase their registered population will be able to resort to ethical violations (Kılıç, 2003: 21-24).

The right to choose and replace physicians in the family medicine system prevents people from being evaluated together with the environment they live in. This may make it difficult to intervene and take a holistic view of risks that may arise due to environmental conditions (Kol, 2015: 158).

There are 759 villages and 2 towns in Çorum, 454 of which receive mobile service from family healthcare centers. 60,482 out of 530,864 people of the total population receive mobile healthcare services (Official Letter, Date: 28/ 07/ 2020, Number: 72716672-804. 01-39). Providing mobile health service indicates that healthcare services are not provided continuously when needed, however, this service can be used in health problems that could be delayed.

Coordination

At the BHS level, coordination is essential in terms of the entry point to healthcare, a gate-keeping function for other levels of care, and the responsiveness of the healthcare delivery and healthcare system. Coordination should result in consistent treatment plans as a social interaction technique where various processes are handled simultaneously (euro.who.int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool. Pdf, 2020). The WHO describes the concept as making consistent treatment plans as a result of handling various processes at the same time. Since January 1, 2015, Turkey features an e-Pulse system where individuals' past health information can be viewed by both themselves and their physicians (saglik.gov.tr/TR,1261/mehmet-muezzinoglu-e-nabiz-sistemini-tanitti. html, 2015). There should be coordination between two health units in the same institution (Durusoy et al., 2011: 13) rather than different institutions. If coordination is improved, many unnecessary examination, diagnosis and treatment expenses will be eliminated as well.

Coordination concept in BHS involves cooperation between BHS and other levels through referral systems or without referral chain (euro.who.int/__data/assets/pdf_file/0004/107851/PrimaryCareEvalTool.pdf, 2020) It is the need for institutions to cooperate for the health of the patient. BHS gate-keeping is offered by primary health care institutions due to their characteristics of being closest to the society, the fastest and easiest accessible. The effective and gradual referral chain implementation, which is included in scales other than PCET measuring the BHS and is counted in the Health Transformation Program, was initiated in pilot provinces; but was later revoked by the judiciary. In Article 3 of the Family Medicine Law No. 5258, the section where the payment rate would be reduced in case "… the patient referral rate is high", that is, it could be considered as a performance decrease, was revoked by the judiciary. The Constitutional Court annulled the referral chain due to the deviation from the limitation of the right to benefit from healthcare services in line with the principle of proportionality. Moreover, this also contradicts with the provision in Article 90 of the Constitution, "If the articles of international agreements on fundamental rights and freedoms conflict with the laws of the country, the provisions of international law shall apply". As a matter of fact, it does not comply with the definition made in the European Social Charter within the scope of the right to benefit from the measures that enable everyone to benefit from the best accessible health level which is also adopted by Turkey (Official Gazette, Date: 07/11/2008, Number: 27047).

In a staged healthcare organization, patients are registered with a general practitioner of their choice in countries that fully run the referral chain for family medicine practitioners. When patients need healthcare services other than emergency, they first apply to primary care. If the issue cannot be resolved here, they are referred to the secondary and tertiary levels. If they do not follow this order, they will have to pay a price. Referral chain has not been implemented in Turkey. Therefore, primary health care services cannot function as a gate-keeping element sufficiently (Soysal et al., 2016: 76-88). As a result, the high number of applications made to the secondary step increases the number of daily examinations and unnecessary procedures together with the low number of physicians. It is determined that there is an unnecessary waste of resources in Turkey and the country ranks first among OECD countries in this sense. The solution is to raise the awareness of public and strengthen primary healthcare services (Loş, 2016: 112-113).

5. CONCLUSION

Primary health care services were defined as the minimum and lowest level of health care agreed on by all countries around the world exactly forty-two years ago. As is described, primary healthcare services can achieve their goals with the cooperation of the society, private and public organizations, especially family health centers and community health centers serving in primary health care. Community Health Centers do not correspond to the definition of the place where primary healthcare services should be performed in terms of their locations despite fulfilling the meaning of their function. Although the Community Health Centers are assigned to carry out preventive health services and Family Health Centers are assigned for curative health services, it is not always possible to separate these two health services. Contracts concluded with family physicians are made according to the class in which the family health center is located. The criteria in the classification are the physical characteristics of the place to be a family health center. Lack of family medicine graduates causes the staffing pattern to be filled by general practitioners. As such, family physicians have enough difficulty with being assigned to the vacant emergency services and other jobs that are assigned later.

Family Health Centers, on the other hand, have deficiencies in terms of accessibility, comprehensiveness, coordination and continuity in terms of PCET criteria. The fact that the high population is registered with family physicians shows the access to healthcare services is achieved quantitatively, however, this makes it difficult to access qualitatively. The treatment and care provided to the applicant patient causes that inadequate time is allocated for health education in terms of preventive measures, pregnancy follow-up and child follow-up, etc. When examined in terms of settlements, it is observed that 454 of 759 villages and 2 towns in Çorum receive mobile service; it is possible for those living here to access healthcare services on certain days and hours. The content of the health service provided during this time is limited due to its mobile nature and not being performed in the health facility. Primary healthcare institutions that will implement primary healthcare services do not have a continuity of mobile service, on the other hand, the scope of the service provided is also limited. In family health centers, the lack of job description of the family healthcare personnel, contracting with the physician and the lack of job security when the contract ends, causes the occupational expertise to be ignored. The form of application leads to the determination of job descriptions in line with the physician's directives. In the family health center, the physician and family health personnel are a team of two. Whereas; the content of the service provided will determine whether the primary level is comprehensive and gate-keeping. Having both professional areas and the necessary

equipment in family health centers will facilitate this function. While the goal in the family medicine system is to prioritize the family, the fact that each member of the family can choose a different physician with the right to choose a physician contradicts this goal. If another physician is chosen by using this right in places where mobile services are provided; although it is limited, it will cause the person not to receive the health service that is almost offered at their doorstep. The establishment of the family medicine system on the basis of population-oriented and patients' referral to the doctor's office creates an obstacle to taking a holistic approach to healthcare. E-Pulse is ensuring coordination between health units, however; is not enough. When the coordination is prioritized, primary healthcare services will be strengthened and waste of resources can be prevented. In addition to all these, the basic health services mentioned are not an issue that can be solved by providing healthcare services alone. A public political stance and the cooperation of other actors are required in order to provide the determined primary healthcare services.

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