Strong primary care for the sustainability of the health system

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ABSTRACT

Although the name of all health systems in the changing world has changed, primary health care practices, whose central role has not changed, should take the place they deserve with determined health policies. A cost-effective health service delivery is provided in health systems where all patients are the first point of reference, with a strong door-holding family medicine practice. This is the key to sustainability in subsidizing health services. With a good primary care, nearly 90% of common diseases in the community are treated. Countries with a strong primary care structure and referral chain have lower health-related costs and higher clinical success in diseases. Providing easy preventive health services locally; If this cannot be done before the diseases appear, it allows the earliest diagnosis and clinical regulation before complications occur.

Keywords: strong primary care, family medicine practices, deficiencies in family medicine practice, family medicine

The provision of health services is generally given under three main headings as primary, secondary and tertiary care providers. With a strong primary care, nearly 90% of common diseases in the community are treated. In primary care-based healthcare settings, unit patient costs are less because less laboratory and imaging examinations are required [1].

According to many researchers, consumer groups and public advisors, there is a consensus that primary care should be the basis of providing fair health care [2]. The reason for this consensus is that family medicine is the easiest way to provide health services to a large part of the society with less cost and less workforce [3].

In countries with a strong primary care structure and referral chain, health-related costs are lower and clinical success is higher in diseases [1, 4]. Providing easy preventive health services locally; If this cannot be done before the diseases appear, it allows the earliest diagnosis and clinical regulation before complications occur. As long as there is no disease, there is a patient, every patient needs to be evaluated from a multifactorial point of view, according to the genetic burden from the family and the risk factors that may be specific to the society in which they live. In order to meet this need on time and in the most complete way, it seems to be the most correct philosophy to form the basis of family medicine health services [5].

In primary care, patients are evaluated with an inclusive approach, which is one of the most basic approaches of fam-

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ily medicine specialists. In the differential diagnosis of a patient, the diseases with the highest incidence in the community are considered in the foreground. Today, when dozens of specializations are formed in the medical profession, the need to determine which complaint of the patient will be related to which region and branch has increased. Contrary to all medical disciplines, family medicine treats patients of all ages and genders holistically, from birth to death [6].

Another basic feature of primary care is its quality of being the first point of reference. Regardless of what the complaints are, a differential diagnosis made according to the prevalence in the community, from the most common to the rarest, brings the possibility of accurate diagnosis and treatment at low cost [7]. This feature, which defines the necessity for the patient to be the entry point to the health system in every new health need, becomes active in the use of resources in health. The strength of the first step increases the effectiveness of the second and third steps. It should not be forgotten that every health need that is not met on site and locally will lead to the need to receive services at a higher level, which will make it difficult for the individual with specialty need to access health services.

It is another teaching of family medicine, with its person-oriented continuous care, to provide health services to every individual in need without discrimination in every period of human life, starting from the fetal period to death [8]. Less diagnostic examinations enable the prevention or delay of diseases with earlier diagnosis and intervention, and the continuity of health care with less treatment prescriptions and lower drug costs.

The state of primary care in the World

Medicine has existed since the first day of humanity. Renaissance was brought to the agenda by Francis Peabody in 1923, with the need for comprehensive general medicine service, where patients were left in the middle as a result of the development and branching in the scientific field and medicine, as well as many developments in the technical field, which the Industrial Revolution initiated. Family medicine, which entered the maturation process with its coming to the agenda, was first recognized as a specialty in England in 1965. It was recognized in America in 1966, and in 1969 it was determined as a specialty. The trend, which started in England and America, gained its central role in the provision of health services with the title of health for everyone in 2000 with the Alma Ata declaration in 1978. In 1995, the family medicine specialization was normalized by the European community to be obtained with a minimum of 2 years and then at least 3 years of education after graduation from medical school. In the 2000 World Health Organization report, in the "Recommendations for Creating a Health Service and Medical Education System that Considers the Needs of the Society", the articles that outline the recognition of family medicine as a specialty discipline were reported [9]. Although there are differences in general practices and naming in the world in the days we have come, Family Medicine practice constitutes the center of primary health care services, which are at the center of health service delivery.

The first practices of family medicine in the USA started in 15 pilot regions in 1969, and today they have reached the largest number of specialists after internal medicine specialists. It is the branch that takes care of the most patients in one day, and with various incentives, cooperation with primary care personnel is provided, and with this cooperation, preventive medicine is provided. In 2000, 25% of the total examinations performed in the USA belonged to family physicians [10].

The first family medicine department in Germany was opened in 1976. Since 1994, physicians who will work in primary care have been required to specialize, and primary care services have been entrusted to family physicians. The ratio of family physicians to other physicians is approximately 40-50%. In Germany, unlike other countries, it is obligatory to provide services by family physicians, who are registered 24/7 in case of emergency [11].

National health insurance in Canada covers all individuals, and family medicine is at the center of primary care. Family physicians make up half of all physicians, and their education period should be 2-3 years. Keeping this process long, geriatrics, emergency, etc. provides additional specialization opportunities in their fields. The striking difference in Canada is that family physicians follow up the patients referred to the next level [10, 11].

There is a health practice in England that is subsidized by general taxes. General medicine, which has been known since 1600 years, was named family medicine as of 1947. They are trained with a 3-year training in practice to work with family physicians who have received 2 years of theoretical and 1 year training on the faculties of family medicine, which is the current specialization in all medical faculties. In

practice in the UK, it is not possible to apply to secondary care, except for emergencies, without a primary care physician referral [12].

In Norway, the practice of family medicine was accepted in 1985 and the specialization training is 1 year theoretical and 4 years working with a family physician for 5 years. Family medicine is the center of primary care services. There are also incentive payments for protective services [13].

The first family medicine department was established in Portugal in 1982, and five years later, it was decided that all primary care physicians should receive family medicine specialization training. The training period is 3 years. It is obligatory for each individual to be registered with a family physician, and the average population per family physician is 1500 [10, 11].

In Israel, the duration of family medicine residency is 4 years, and in other countries, the difference seems to be that the medical organization has an active role in the supervision of education and family medicine practice. Effective imaging and laboratory services are also provided in primary care services, and the average population per physician is around 2500 [13].

Family medicine practice in Turkey

In our country, with the constitution of 1960, the understanding of the social state came to the fore, and with the laws of 1961, the first step was laid for the primary health care services for all citizens to benefit from general practice services. Following the primary care-based transformation all over the world, the family medicine pilot application was started in Düzce in 2005, and this practice has spread throughout Turkey with the reform called health transformation after a five-year transition period [14]. With the excuse of the transition period, family physicians were trained and included in the system with a 3-week training system in which all specialists and general practitioners can apply. There are physicians from many different branches in the system. Every citizen is obliged to register with a family doctor. In our country, family medicine specialists, which were added to the specialty charter in medicine in 1983, have been trained since 1985. The minimum duration of education is determined as 3 years [10, 15]. In our country, there is a requirement for a referral system designed according to the UK model at the planning stage of family medicine practice, and it could not be implemented due to the open door policy of the referral chain and the newness of the practice of family medicine.

Some steps should be taken to improve family medicine practices in our country. In this sense;

•Specialization training content should be integrated with trainings in Europe and the World.

•The general disease diagnosis statistics of the country should be made and the family physician specialty training curriculum should be developed to cover at least 85%.

•Different forms of purchases for family medicine specialties, such as contracted family medicine specialists, should be removed. A system that receives similar training at similar times and is exposed to the same application chosen by the exam should be established. There should be a uniform order in education.

•All physicians working in the family health center should be provided with family medicine training in all faculties in order to become family medicine specialists.

•In order to monitor professional development and competency, it should be ensured that professional scoring and trainings, congresses and continuous development, where scoring related to professional development can be made, should be followed at least once every five years. Family medicine practice of physicians who do not meet the development criteria should be suspended.

•For the sake of populist policies in the planned family medicine system, the open-door practice should be abandoned immediately, and applications to the second and third level should be stopped without a family physician referral, except for emergencies.

•After the implementation of the unfulfilled referral chain, a referral rate of 15% should be determined and the rules should be followed.

•A reasonable payment regulation should be implemented in which the importance and incentives given to preventive services and screening services are increased.

•The population per physician should be reduced to the range of 1500-2000 and each physician should be given the opportunity to evaluate all registered individuals in an inclusive way.

•The primary level of imaging services should be strengthened, and basal radiological practices such as x-ray reading and hand doppler should be added to the specialty curriculum.

•Group medicine practice should be encouraged for family health centers and establishment of family health centers where ten physicians can work together should be encouraged.

•Education In order not to have a family medicine department without a Family Health Center, planning

should be made in accordance with the number of family physician assistants in each province and practical training should be provided during the assistantship.

•Necessary training staff should be provided to the staff of the Ministry of Health and Higher Education Institution on behalf of the missing educators in the departments of family medicine.

•A dentist and a dietitian should be planned for each family health center, so that diet programs that can be applied at the beginning of chronic diseases should be planned and followed. In addition to the practice of dentistry and general medicine-based family medicine, it should be ensured that a holistic health service delivery is provided by providing oral and dental health services locally.

With the feasibility of recommendations, timely follow-up of chronic diseases, standardization of education and indexing to the developments in the world can be ensured and a sustainable health service delivery can be established in a fair way.

CONCLUSION

Although the name of all health systems in the changing world has changed, primary health care practices, whose central role has not changed, should take the place they deserve with determined health policies. A cost-effective health service delivery is provided in health systems where all patients are the first point of reference, with a strong door-holding family medicine practice. This is the key to sustainability in subsidizing health services. As long as the open door policy continues, the problem of finding an appointment for all physicians in these steps will continue to be full of emergencies in secondary and tertiary hospitals. This is the biggest obstacle for the required patient to reach the relevant branch. Thanks to the execution of this system with the referral chain, the problems we have mentioned will be prevented, and together with the decrease in the patient load in the secondary and tertiary care levels, the time problem before the detailed examination of the patients referred to this level by the physicians will be overcome.

Authors' Contribution

Study Conception: SM,; Study Design: SM,; Supervision: OS, SO, LU,; Materials: SM,; Data Collection and/or Processing: SM,; Statistical Analysis and/or Data Interpretation: SM,; Literature Review: SM,; Manuscript Preparation: SM and Critical Review: SM.

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Ethical approval

Ethics committee approval was not required as this study was written as a reviwer.

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