EVALUATION OF THE ORGANIZATIONAL MODEL OF PRIMARY CARE IN

TURKEY

- a survey-based pilot project in two provinces of Turkey -

Primary care in the WHO European Region

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ABSTRACT

In many countries in transition, health reforms are part of profound and comprehensive changes in essential societal functions and values. Reforms of (primary) care are not always based on evidence, and progress is often driven by political arguments or the interests of specific professional groups, rather than by the results of sound evaluations. However, policy-makers and managers nowadays increasingly demand evidence of the progress of reforms and the responsiveness of services. The implementation of the WHO Primary Care Evaluation Tool (PCET) aims to provide a structured approach towards this by drawing on the health systems functions such as governance, financing and resource generation, as well as the characteristics of a good primary care service delivery system: accessibility, comprehensiveness, coordination and continuity. This report gives an overview on the findings for Turkey.

The project was implemented on a pilot basis in Turkey in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Turkey, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherland Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre for Primary Care – and other stakeholders in the Turkish health system, such as national policy experts, managers, family doctors and their patients.

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TABLE OF CONTENTS

ABBREVIATIONS

FD   family doctor
GP   general practitioner
FMC   family medicine centre
IUD   intrauterine device
MoH   Ministry of Health
NGO   nongovernmental organization
NIVEL   Netherlands Institute for Health Services Research
PC   primary care
PCET   primary care evaluation tool
STI   sexually transmitted infection
WHO   World Health Organization

ACKNOWLEDGEMENTS

FOREWORD

Primary health care embodies the values and principles that WHO pursues in its worldwide effort to helping countries strengthen their health systems efficiently and equitably. WHO renewed its commitment to global improvements in health, especially for the most disadvantaged populations, in the recent World health report 2008, which urges countries to act on evidence that access to primary care services forms the core of an efficient and appropriate health care system. The title of the report underscores the urgency of its message: Primary health care – Now more than ever.

Over the past 30 years, health in the 53 Member States in the WHO European Region has improved considerably overall, despite significant changes in the patterns and trends in disease occurrence, demographic profiles and exposure to major risks and hazards in a rapidly evolving socioeconomic environment. In addition, the Region has seen trends towards more integrated models of care and greater pluralism in the financing and organization of health systems. Governments are continuing to rethink their roles and responsibilities in population health and the organization and delivery of health care, thereby changing the context for framing and implementing health policy.

This report evaluates developments in primary care in Turkey, using a methodology that characterizes a good primary care system as one that is comprehensive, accessible, coordinated and integrated; that ensures continuity; and that recognizes that all health-system functions outlined in the WHO framework are equally considered in work to improve the overall health system. This means that the financing arrangements, service delivery, human and other resources (such as appropriate facilities, equipment and drugs) and finally all necessary legal frameworks and regulations are in place, and the system is steered by the right leader. The report thus offers a structured overview of the strengths and weaknesses of a country's organizational model for primary care services – including the voices of the professionals and patients concerned – to interested policy-makers and stakeholders. The report focuses on structural performance, and provides for a list of proxy indicators. It does not, however, examine the process or outcome of care itself, and thus its quality. The aim of pilot-testing the tool in Turkey was to learn more about the structure and the organizational model of primary care in a given country. This is a first and very important step, a baseline, towards discovering how primary care processes and outcomes can be improved. While the validation of the tool was the main objective of the evaluation, we at the WHO Regional Office for Europe hope that this report contributes to the primary care reform under way in Turkey.

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EXECUTIVE SUMMARY

This report summarizes the main results of the WHO Primary Care Evaluation Tool, which was implemented on a pilot basis in Turkey in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Turkey, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherlands Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre for Primary Care – and other stakeholders in the Turkish health system, such as national policy experts, managers, family doctors and their patients.

Introduction
The Primary Care Evaluation Tool (PCET) addresses both supply-and demand-side aspects of primary care. It is intended to support ministries of health and other stakeholders in the health system to monitor the progress of their primary care-related policies and reforms and to set new priorities on the basis of evidence-based information with the aim of further strengthening the primary care level.

Methods
The underlying methodology for the design of the PCET was derived from the WHO 2000 Health Systems Framework *(1)*, which indicates that the performance of a health system is determined by the way in which its functions are organized. The health system functions are: stewardship, resource generation, financing and service provision. The framework of the Primary Care Evaluation Tool encompasses these four functions, together with the key characteristics of primary care services, including: accessibility to services, continuity of care, coordination of care and comprehensiveness. Furthermore, for each of the primary care functions and characteristics, a number of key dimensions and subthemes are identified, and, in a second step, translated into one or more indicators or appropriate proxies. In order to evaluate the complexity of any primary care system, information is gathered on different levels, and from the demand side and the supply side. The Tool therefore consisted of three questionnaires: a questionnaire concerning the status of primary care at national level, a questionnaire for family doctors (FDs) and a questionnaire for patients. Together, the three questionnaires covered all the primary care functions identified and the dimensions and items derived from the Framework. Each questionnaire was prestructured, with precoded answers.

The Tool was been pilot tested in 2007 in two provinces of Turkey: Bolu and Eskişehir. Questionnaires were completed by national policy experts and other stakeholders in the health system, family doctors and their patients. The results rely on self reported behaviour or experiences rather than on direct observations or the systematic analysis of routine data.

Results
- *At national level, based on interviews with national policy experts*
  Stewardship: primary care is a national priority. A comprehensive primary care model based on family medicine has been actively implemented since 2003 (in 13 provinces out of 81 by early 2008). The Ministry of Health plays a strong coordinating role in the reform process and the reforms are being rolled out systematically.

Primary care provider and patient organizations do not yet have a formal role in the policy-making process. Furthermore, regulations on the patients' rights could be improved, for example with regard to obligatory patient complaint procedures in family health centres, as well as their implementation.

Financing: primary care is funded and provided mostly by the state. All primary care services are free of charge, except for medicines, for which co-payments exist. Most primary care providers are state-employed and are paid on the basis of capitation fees. The recent introduction of a mixed payment scheme, allowing for more performance-related elements seems to be a major step towards a more comprehensive, efficient and responsive care system – although adjustments are needed to avoid overproduction.

Resources: over the past years, there has been a systematic increase in the availability of family doctors working in primary care (13.8% of all active physicians in Turkey are primary care doctors). However, compared to the overall number of physicians, there are still severe shortages of physicians and nurses in primary care. Besides, primary care physicians are very unevenly distributed geographically. With regard to the overall framework for professional development, quality improvement mechanisms and a policy for systematically enhancing the skills and knowledge of health care workers are not well developed yet. Although the equipment available to family doctors is usually sufficient, access to X-ray services seems to be more problematic.

- *At family doctor and patient level, based on experiences and opinions of the respondents, and routine data*
  Accessibility of care: the geographical distribution of primary care services is uneven (but good in Bolu and Eskişehir). Family health centres are staffed by family doctors, practice nurses and, in most cases, midwifes. The centres are easily accessible during working hours. However, visiting a family doctor outside normal office hours, in the evening, or at the weekend, is only possible in rare cases. Patients reported their satisfaction with the way treated by the staff and the services received. Practices are very large, with an average of 2484 patients per family doctor, but there are also large variations across the country (in Bolu and Eskişehir for example, the average was 3700). As a result, the number of consultations per day is high (an average of 47) but modest compared to the practice size. Home visits are rarely made.

  Coordination of care: Coordination of care seems to be a major problem. A structured approach towards multidisciplinary teamwork for the benefit of patients for example with chronic diseases does not exist yet. There are generally no mechanisms for improving coordination between the primary and secondary levels. The gatekeeping role in primary care is not yet properly assured and it is unusual to refer patients back to primary care after hospitalization.

  Continuity of care: patients report that they are assigned to a family doctor. They are mostly positive about their relationship with their primary care physician in respect to the terms of treatment provided, consultation duration and social skills. However, patients also reported that family doctors are not prepared to make home visits. Computers are generally used by primary care physicians, including for clinical records. However, medical records are not routinely kept.

Comprehensiveness of care: family doctors have a strong position as doctor of first contact for women and children. However, they are not the obvious entry point for nonmedical problems. The involvement of family doctors in the treatment of diseases could be improved, if compared to colleagues in western Europe. However, compared to the situation in Turkey 15 years ago (16), the position is much better now. Family doctors are moderately involved in the provision of preventive care and care for specific patient groups. There were also few links with the community in which primary care is provided.

Recommended policy action
- Involve associations of health professionals and nongovernmental organizations (NGOs) more formally into the process of health policy development and in aspects of its implementation.

  » The evaluation has shown that organizations of professionals and patients are already involved in the policy making process but rather on an ad-hoc basis. The inclusion of stakeholders on a more formal basis for example in the form of a standing committee or by officially delegating health policy and implementation responsibilities to them might be considered.

- Further develop and formalize the role of patients in primary care, for instance by improving complaint procedures in health centres, better communication about referral rules and the right to choose a family doctor, by promoting patients' responsibilities in prevention or by monitoring patients' needs on a regular basis.

  » The evaluation has shown that the important role and position of patients has been formally acknowledged, but patients were not always aware of their rights and the new functioning of the system, nor do patients and FDs realize fully the potential of informed and active patients for better health outcomes. A public information campaign targeting the population as well as physicians with differentiated messages and using mass media such as radio or TV might be beneficial.

- Take measures to reduce the shortages among FDs and nurses and to realize a more equal distribution of primary care providers over the whole country. This may also reduce the current high workload of FDs.

  » The evaluation has shown that much has been done since the start of the reforms – however, nation-wide the proportion of family doctors to other specialities is still only 10%. Consider fully using existing capacities in the residential programmes (about 500 places per year in 40 medical universities; but only 80% occupation) - and even whether this capacity can be expanded. Continue with the new payment scheme that keeps family medicine attractive for new students and consider adding other incentives such as free internet connections and e-learning programs for doctors in rural areas. Enhance the reputation of FDs by subsidizing and supporting research for FDs (for example in drawing up clinical guidelines) or extending the task profile of FDs. Keep the register of primary care professionals' up-to date and use it for active human resources planning.

Table 1:   **Overview of selected indicators by primary care function for the pilot areas in Turkey**

Functions	Selected dimensions/proxy indicators	Findings FDs (N=78) Patients (N=1548)
Stewardship/ Governance	Department in Ministry of Health (MoH) specifically dealing with primary care (PC)	yes
	% family medicine (FM) centres with patient complaint procedure in place	78%
Financing	Employment status of FDs	100% state employed
	% patients reporting copayments for drugs prescribed in PC	57%
Resource generation	% of all active physicians working in PC *	13.8%
	% provinces with FM being introduced *	16%
	% FDs among all PC doctors in provinces with FM being introduced*	72%
	Average age of FDs	39 years
	Hours FDs spend on professional reading (per month)	9.5 hours
	% medical universities with department of family medicine*	74%
	Average number of items of medical equipment available to FDs (from a list of 29 items)	21 items
	% of FDs reporting no or insufficient access to a laboratory	3.8%
	% of FDs reporting no or insufficient access to X-ray equipment	45%
	% of FDs with a computer in the centre/practice	97%
Service delivery		
Access to services	% of patients living within 20 minutes travel from PC facility	79%
	Average number of registered patients per FD	3715
	Average number of patient consultations per day	47
	Average number of home visits per day	1.7
	Average working hours of FD per week	46
	Average length of patient consultations (minutes)	11
	Reported average utilization rate (frequency) by patient per year	7.6
	% of FDs using an appointment system	1%
Coordination	% of FDs sharing premises with other FD(s)	90%
	% of FDs having regular meetings with practice nurses	77%
Continuity	% FDs keeping medical records routinely	43%
	% of patients assigned to their FD (not chosen)	71%
	% of patients with their FD for at least 1 year	59%

Evaluation of the organizational model of primary care in Turkey

Functions	Selected dimensions/proxy indicators	Findings FDs (N=78) Patients (N=1548)
Comprehensiveness	% of FDs frequently using clinical guidelines	16%
	Score for FDs' role in first contact care for a selection of 17 health problems (range of score 1 (never) - 4 (always))	2.47
	Score for FDs' involvement in the treatment of a selection of 18 diseases (range of score 1 (never) – 4 (always))	2.59
	Score for FDs' or team members involvement in the provision of a selection of 16 preventive and medical-technical procedures (range of score 1 (never) – 4 (always))	2.41
	% of FDs having regular meetings with local authorities	26%
* at national level		

- Improve the coordinating role of FDs by removing obstacles to collaboration and working relations between FDs and medical specialists from the secondary level (strengthening of the gatekeeping role of FDs), as well as further support cooperation and teamwork within primary care.

  » The evaluation has shown that formalized multidisciplinary team work within primary care or between levels of care for the benefit of for example patients with chronic diseases or multi-morbidities hardly exist. Referral letters are poorly used and secondary specialists are not informing FDs routinely about their treatment. Discharge reporting from the hospital is not formalized. Consider introducing clear reporting rules and link it to the new IT software and by that, enhance the coordinating role of the FD. Introduce team working schemes for the core primary care team and provide training on it. Consider introducing new disciplines in primary care such as nurse practitioners and others that can support the network of an extended general practice model, or include existing ones more closely, for example pharmacists, physiotherapists and dentists. Stimulate stronger links between primary health care facilities and the community to enhance coordination between health and social services.

- Continue to introduce incentives for good performance, focusing in particular on improving the quality of services.

  » The evaluation has shown that the introduction of performance elements into the payment scheme for FDs has been a successful first step, however with too much impact on quantity and little on quality. Consider a national strategy to systematically establishing quality improvement mechanisms that build on each other: certification and re-certification schemes, continuous medical education programs based on the need of doctors, practice inspections and medical audits, peer review circles, routine electronic patient records, participation in the development of clinical guidelines etc.

1 EVALUATING PRIMARY CARE: AN INTRODUCTION

Why evaluate primary care?

Although the strengthening of primary care services is a priority of health reforms in many countries, in both central/eastern and western Europe, the backgrounds to and reasons for the reforms are not similar. In western Europe, emphasis on primary care is expected to provide an answer to questions of rising costs and changing demand resulting from demographic and epidemiological trends. Central and eastern European countries, as well as countries of the former Soviet Union, are struggling to fundamentally improve the performance of their entire health systems. Primary care, which used to be poorly developed or nonexistent in these countries, is now being developed to bring adequate and responsive health services closer to the population.

In many countries in transition, health reforms are part of profound and comprehensive changes in essential societal functions and values *(2)*. Reforms of (primary) care are not always based on evidence, and progress is often driven by political arguments or the interests of specific professional groups, rather than by the results of sound evaluations.

However, policy-makers and managers nowadays increasingly demand evidence of the progress of reforms and the responsiveness of services. Health systems continue to cope with old problems, like tuberculosis, but also need to adapt to changing needs and demands that require the development of new services and new models of delivery. A relatively new feature is evaluation of the responsiveness of health services from the patients' perspective. Such evaluations generate information about responsiveness, access and convenience of services, aspects of treatment by staff and the quality of information and coordination. This shows that the evaluation of primary care needs a framework, as there are so many aspects that are important to monitor.

Evaluating primary care and the health systems framework

A health system can be defined as a structured set of resources, actors and institutions related to the financing, regulation and provision of health actions that provide health care to a given population. Health action is conceived as any set of activities whose primary intent is to improve or maintain health. The overall objective of a health system is to optimize the health status of an entire population throughout the life cycle, while taking account of both premature mortality and disability *(3)*.

Health systems aim to achieve three fundamental objectives *(1,3)* as shown below.

- *Improved health* (for instance, better health status and reduced health inequalities).

- *Enhanced responsiveness to the expectations of the population*, encompassing:

  » respect for the individual (including dignity, confidentiality and autonomy);

    » client orientation (including prompt attention, access to services, quality of basic amenities and choice of provider);

- *Guaranteed financial fairness* (including households paying a fair share of the national health bill; and protecti*on from financial risks resulting from health care).*

The level of attainment of these goals reflects the performance of the system as a whole. However, as there are variations in health conditions and health systems across countries, the country context needs to be taken into account when comparing the performance of health systems. Thus, the measurement of performance connects goal attainment to available resources.

The WHO health system performance framework (see Fig. 1) indicates that performance is determined by the way in which the following four key functions are organized (3):

- *stewardship*

- *generating resources*

- *financing*

- *service provision.*

Other approaches to performance measurement can be found in the international literature *(4,5,6,7)*. However, they all use similar insights or related concepts. The four functions can be applied to the whole health system of a country – or, for example, to the primary care level only – with specific subcharacteristics for the service provision function.

Figure 1:   WHO health system functions and objectives

Functions the health care system performs

Stewardship

Creating resouces

Delivering services

Financing

Objectives of a health care system

Responsiveness

Health

Fair (financial) contribution
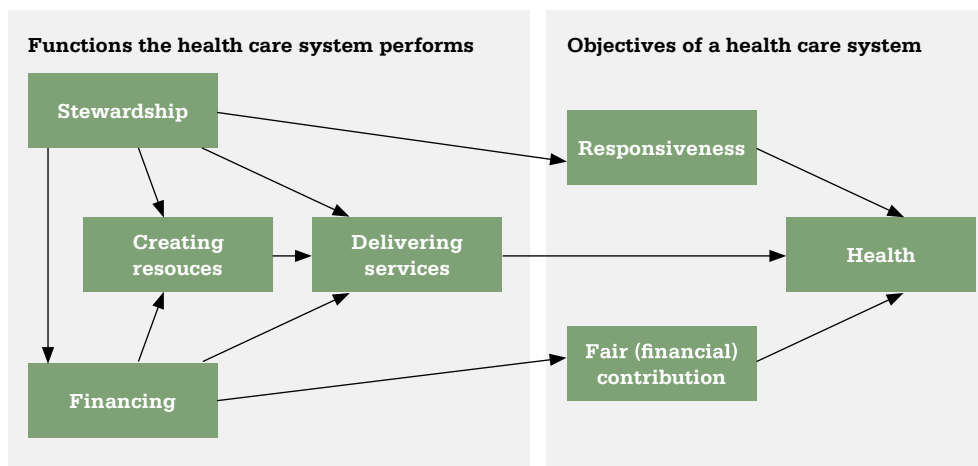
What is the meaning of the four system functions?

Stewardship

Stewardship is an overriding function (but broader than regulation), in that it oversees all basic health system functions. It has direct and indirect effects on the outcomes of a health system *(1)*. Stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. It covers three main aspects: a) setting, implementing and monitoring the rules for the health system; b) assuring a level playing field for purchasers, providers and patients; and c) defining strategic directions for the health system as a whole. Stewardship can be subdivided into six subfunctions: overall system design, performance assessment, priority setting, regulation, intersectoral advocacy and consumer protection *(3)*. In short, stewardship deals with: governance, information dissemination, coordination, and regulation of the health system at various levels.

Resource generation

Any level of a health system needs a balanced variety of resources to function properly, but these have to be further developed (and expanded) in order to sustain health services over time and across levels and geographical areas. The resources needed encompass physical assets (equipment, facilities), consumable supplies, human resources and knowledge/information. It is crucial that the quantity and quality of human resources is adequately matched to the demand for services across the various levels of health care and equitably distributed across the country. Naturally, to ensure quality of care, the skills and knowledge of health providers need to be up-to-date and compatible with developments in technology and evidence-based medicine. Policy development concerning human/physical resource planning, and a regulatory framework for assuring high quality service provision and consumer protection falls under the stewardship function – however, the actual state of affairs relating to workforce volume and distribution and professional development (training, continuous medical education, research, knowledge production) is usually measured under the resource generation function.

Financing

In general, financing deals with the mobilization, accumulation and allocation of funds to cover the health needs of the people, individually and collectively, in the health system *(8)*. The financing function in health systems is defined by Murray and Frenk *(3)* as "the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities". Three subfunctions can be distinguished: revenue collection, fund pooling, and purchasing. Revenue collection means the mobilization of funds from primary sources (households, firms) and secondary sources (governments, donor agencies). There are a number of mechanisms through which funds can be mobilized, varying by health systems context, e.g. out-of-pocket payments, voluntary insurance rated by income, voluntary insurance rated by risk, compulsory insurance, general taxes, earmarked taxes, donations from NGOs and transfers from donor agencies. In order to share and reduce health risks, funds can be pooled through various forms of health insurance. The allocation of funds to cover the costs (staff, durables and running costs) of specific health service interventions by health providers (institutional or individual) is purchasing *(3)*. The way these subfunctions are organized and executed has an impact on the access to health services.

Service delivery

Service provision involves the mix of inputs needed for the production process within a specific organizational setting leading to the delivery of health interventions *(3)*. It relates to preventive, curative and rehabilitative services delivered to individual patients and to services aimed at larger populations (e.g. health education, promotion) through public and private institutions. Providing services is something that the health system does (and there are four key characteristics that define "good provision"; see below) - it is not what the health system is.

The Primary Care Evaluation Framework

The characteristics of primary care vary from country to country, and there are different definitions of what constitutes primary care (see also Annex 1). However, a comprehensive "good" primary care system has the following characteristics:

> Primary care is that level of a health system that provides entry into the system for all new needs and problems, provides person-focused (not disease-oriented) care over time, provides care for all but very uncommon or unusual conditions, and coordinates or integrates care provided elsewhere or by others *(9)*.

The Primary Care Evaluation Framework (see Fig. 2) from which the Primary Care Evaluation Tool (PCET) is developed, encompasses the four functions of a health care system (as mentioned above), combined with the four key characteristics of primary care services that are part of service delivery, as derived from the above definition.

Figure 2:   Primary Care Evaluation Framework

| Stewardship |
| Responsiveness |

Resource generation	Delivery of primary care services	
	Access to services	Continuity of care
Financing & incentives	Comprehensiveness	Coordination of care
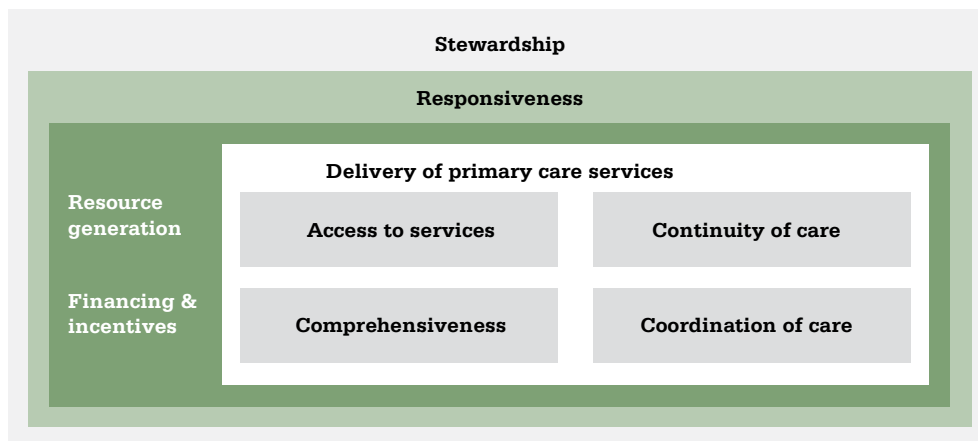
What is the meaning of the four key characteristics of a "good" primary care system?

Access to services

In general, access to health services can be defined as the ease with which health care is obtained *(5)*. Alternatively, it can be defined as "the patients' ability to receive care where and when it is needed" *(10)*. There are various barriers of a physical, psychological, sociocultural or financial nature that can restrict accessibility. Included in the PCET scheme are, for instance, geographical limitations (distance to and distribution

of general practices = geographical access), and factors related to the organization of primary care practice (office opening hours, distant consultations, timeliness = organizational access), as well as the costs incurred by patients (cost-sharing, co-payments = financial access).

Continuity of services

An important feature of primary care is that health care interventions should be geared to patients' health care needs over a longer period and cover successive episodes of care/treatment. A general definition of continuity is the "follow-up from one visit to the next" *(11)*. WHO provides a more comprehensive definition, which takes into account the (possible) involvement of various health care providers. It is described as "the ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional continuity), or are an uninterrupted series of contacts over the long term (longitudinal continuity)" *(10)*.

Several levels of continuity can be distinguished *(12)*: first, informational continuity that relates to an organized body of medical and social history about each patient, accessible to any health care professional caring for the patient. Second, there is longitudinal continuity, which points to a specific locus where a patient customarily receives health care from an organized team of providers in an accessible and familiar environment. Third, interpersonal continuity, which is defined as an ongoing personal relationship between the patient and the care provider, is characterized by personal trust and respect *(12)*. Furthermore, Reid et al. (13) add another level, namely, management continuity: the provision of timely and complementary services within a shared management plan. The PCET scheme includes informational, longitudinal and interpersonal continuity of care.

Coordination of delivery

Particularly because primary care is the entry point to health care and often serves a gatekeeping function to other levels of care, the coordination of services at primary care level is an important determining element in the responsiveness of health services provision and the health system as a whole. The potential for problems in coordination are particularly evident at the interface between primary and secondary care, or between curative care and other (public health) services in the field of health promotion *(14)*. A general definition of coordination is "a technique of social interaction where various processes are considered simultaneously and their evolution arranged for the optimum benefit of the whole" *(8)*. More specifically, it can be defined as "a service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and necessary and effective interventions, no more and no less. Cross-sectional coordination means the coordination of information and services within an episode of care. Longitudinal coordination means the interlinkages among staff members and agencies over a longer period of treatment" *(10)*. In the PCET scheme, the various dimensions of coordination encompass collaboration within the same primary care practice, within the same level between primary care providers (e.g. FDs, district nurses, physiotherapists, etc.) and between primary care and other levels of care through referral systems.

Comprehensiveness

Comprehensiveness can be defined as the extent to which a full range of services is either directly provided by a primary care physician or specifically arranged elsewhere *(15)*. In the primary care setting, comprehensiveness refers to the fact that services comprise curative, rehabilitative and supportive care, as well as health promotion and disease prevention *(14,16)*. The comprehensiveness of services is not only manifested in the specific range of services provided but also, and related to that, in the practice conditions, facilities and equipment, as well as the professional skills level of the primary health service provider. In addition, the community orientation of primary care workers plays a role. All these dimensions have been taken into consideration for the PCET scheme.

The Primary Care Evaluation Scheme

Taking the Primary Care Evaluation Framework *(1)* as its basis, the Primary Care Evaluation Scheme focuses on specific issues, policies and health care priorities relevant to countries, and consists of measurable topics and items related to current national priorities for change in primary care and the facilitating conditions. The primary care evaluation scheme forms the basis of the Primary Care Evaluation Tool (PCET).

The scheme is structured as follows:

- stewardship

- financing and incentives

- resource generation

- delivery of primary care, subdivided into:

    » accessibility
    » continuity care
    » coordination of care
    » comprehensiveness of services.

Table 2 shows that, for every primary care system function, a number of key dimensions have been identified, reflecting subthemes. Each dimension has, in its turn, been translated into one or more information items or proxy indicators for the dimension.

Table 2:   Overview of selected functions, dimensions and information items

Function	Subfunction	Dimension	Selected items/proxies
Stewardship		Policy development	PC policy priorities
		Professional development	(RE-) Accreditation system for PC
			Quality assurance mechanisms for PC
		Conditions for the care process	Laws and regulations
			Human resources planning
		Conditions for responsive-ness	Involvement of professionals and patients in the policy process
			Patient rights; complaint procedures
Resource gen-eration		Workforce volume	Numbers and density
		Professional development	Role and organization for professionals
			Education in PC
			Scientific development and quality of care
		Professional morale	Job satisfaction
		Facilities and equipment	Medical equipment
			Other equipment
Financing and incentives		Health care/PC financing	PC funding
		Health care expenditures	Expenditures on PC
		Incentives for professionals	Entrepreneurship
			Mode of remuneration
		Financial access for pa-tients	Cost sharing/co-payment for PC
Delivery of care	Access to services	Geographical access	Distance to PC practice
			Distribution of PC physicians
		Organizational access	List size
			PC provider workload
			PC outside office hours
			Home visits in PC
			Electronic access
			Planning of non-acute consultations
		Responsiveness	Timeliness of care
			Service aspects

Evaluation of the organizational model of primary care in Turkey

Function	Subfunction	Dimension	Selected items/proxies
			Clinics for specific patient groups
	Continuity	Informational continuity	Computerization of the practice
			Medical records
		Longitudinal continuity	Patient lists
			Patient habits with first contact visits/ referrals
			Endurance of patient-provider relationship
		Interpersonal continuity	Patient-provider relationship
	Coordination	Cohesion within PC	PC practice management
			Collaboration among general practitioners/family doctors
			Collaboration of PC physician with other primary care workers
		Coordination with other care levels	Referral system/gatekeeping
			Shared care arrangements
	Comprehensiveness	Practice conditions	Premises, equipment
		Service delivery	Medical procedures
			Preventive, rehabilitative, educational activities
			Disease management
		Community orientation	Practice policy
			Monitoring and evaluation
			Community links
		Professional skills	Technical skills

In order to evaluate the complexity of any primary care system, information is gathered on different (administrative) levels, and from the supply and demand sides, i.e. from health providers and patients (including both objective and subjective measures). Therefore, the Primary Care Evaluation Tool consists of three separate questionnaires: a questionnaire concerning the situation of primary care policies at national level, a questionnaire for family doctors, and a questionnaire for patients. Together, the three questionnaires cover all identified primary care functions, their dimensions and information items, as derived from the scheme. Each questionnaire has been prestructured with precoded answers.

2 EVALUATING PRIMARY CARE IN TURKEY: SOME RESULTS FROM A PILOT PROJECT

2.1. Overview of the implementation process of the project in Turkey

The activities of the pilot project began in February 2007 and were completed in March 2008. The project partner of the WHO Regional Office for Europe – besides the Ministry of Health of Turkey – was the Netherlands Institute for Health Services Research (NIVEL), in its capacity as WHO Collaborating Centre for Primary Health Care.

The results and conclusions were discussed at a review meeting with international experts at the WHO Regional Office for Europe in Copenhagen on 14 and 15 April 2008. Experiences in using the Tool during the pilot studies, and comments and recommendations made at the review meeting resulted in a revision of the three questionnaires. A second pilot study was conducted in the Russian Federation – the results are described in a separate country report. The following gives a short overview of the implementation process.

2.1.1. Preparatory phase

Literature review
Using the WHO performance framework as a conceptual basis for the Primary Care Evaluation Scheme, a directed literature review was conducted by the researchers at NIVEL. The literature review aimed to gather information on possible ways to operationalize the identified and selected key primary care system functions. Particular attention was paid to useful primary care indicators and existing (primary care) performance measurement and evaluation tools and questionnaires.

For this purpose, PubMed, Google Scholar and the NIVEL library were consulted. The search was conducted by using free text terms such as "primary health care" in combination with "performance tool", "performance assessment", "performance indicators", "task performance and analysis", "quality indicators", "patient satisfaction", "stewardship", "reform", "policy", "evaluation", "financing", "resources", "coordination of care", "continuity of care", "comprehensiveness of care", "access", "preventive care", "accreditation", "integration", "medical records", "professionalism", "gatekeeping", and "list system". The search resulted in 350 hits, of which the most relevant were selected.

Preparatory meeting
After the first draft version of the Primary Care Evaluation Scheme was developed, an international preparatory meeting was held in March 2007 with, the participation of inter alia, representatives from Turkey. The objectives of the meeting were as follows:

• to strengthen commitment among stakeholders to the development, implementation and application of the Primary Care Evaluation Tool;

- to learn about international experiences and existing instruments;

- to discuss and reach consensus on key concepts and definitions used;

- to discuss and validate the provisional set of dimensions, proxy indicators and information items and to improve the first version of the scheme in order to develop the questions for the questionnaires;

- to prepare first steps for the pilot implementation of the questionnaires.

The general requirements, possible approaches and preliminary timing of activities were discussed and two countries were selected for the pilots to take place: Turkey and the Russian Federation.

Drafting, validation and translation of questionnaires

On the basis of the information and feedback from the preparatory meeting, the draft versions of the questionnaires were developed. These were then forwarded to the meeting participants for comment and possible suggestions for change (clarity, omissions, terminology). This revision round also offered the experts the possibility of involving and consulting with other experts in their country and thus broadening the basis for validation. When all comments and inputs for revision were processed, the final versions in English of the three questionnaires were established. As the questionnaires were tailored to the national situations, the versions developed for Turkey and the Russian Federation were slightly different: for example, the final version of the national level questionnaire contained 60 questions for the Russian Federation and 54 for Turkey covering: primary care policy, legislation and rules; workforce volume, training and education; health financing; and coordination. An annex was also included, with questions on statistical data to be filled in by experts from the Ministry of Health. This annex contained 18 questions for the Russian Federation and 14 for Turkey, mainly on baseline health care and workforce data, funding sources, budgets and payments. Similarly, the final version of the primary care provider questionnaire had 55 questions for the Russian Federation and 54 for Turkey, with the following sections: basic provider information, including education, and professional association membership; location of and number of patients covered by the practice; workload and practice staff; accessibility; quality improvement and research; patient information; employment and income of the provider; coordination and teamwork; and equipment and clinical tasks. The final version of the patient questionnaire had 26 questions for the Russian Federation and 25 for Turkey, with the following main content areas: basic patient information; visiting behaviour and continuity of care; payment for services; and patient opinion on access, responsiveness and quality of primary care services; patient opinion on the cooperation between health care providers.

Subsequently, these final versions were translated into the respective country languages in a check and double-check procedure. The translations were first made into the local language with inputs from an expert in primary care. Subsequently, a back-translation was made and compared with the original version.

2.1.2.   Implementation phase and field work

Meetings in Turkey

The international project team met twice in Turkey (in May and October 2007) with the local partners to prepare the implementation of the Tool and to organize the collection of data. The following activities were carried out during these visits:

- discussion of final details of the questionnaires, resulting in (minor) changes;

- information to and exchange with national working groups that had been established for the guidance of the project and dissemination of results;

- information to regional health authorities about the pilot study and the planned activities;

- site visits in the selected regions;

- instruction/training of field workers (for instance, in respect of the confidential nature of the surveys);

- discussion of details of the sampling and recruitment procedure with the national coordinator and others;

- discussion of details of the data collection strategy and logistics;

- preparation for data entry and related instruction;

- facilitating the meeting with the national experts who filled in the national level questionnaire, in order to achieve consensus on "factual" questions (the "consensus meeting").

Choice of pilot areas, sampling, data collection and processing

The Turkish partners suggested including two provinces into the project: Bolu and Eskişehir. The background to this choice is that Turkey is in the middle of a transition towards a nationwide system of family medicine, and the two selected provinces are representative of Turkey as a whole, one province being more rural, one more urban. By early 2008, 13 Turkish provinces (out of 81), including Bolu and Eskişehir, had introduced the concept of family medicine. Training in family medicine is provided at 20 universities and involves a three-year specialization after graduation from the regular four-year medical training. Parallel to this, a retraining programme for physicians in general practice was developed with three phases: a ten-day retraining course; a one-year distance learning course and then three-years of training/practice on site. By May 2007, all general practitioners (GPs) and the auxiliary/practice nurses in 12 pilot provinces had completed the first phase. By early 2008, an additional province will have begun the transition to the new family medicine system.

Bolu province is situated in north-western Turkey in the Black Sea region and lies midway between the large cities of Istanbul and Ankara. It covers an area of 7410 km² and has a population of 263 619 (17). Bolu province is predominantly rural. Bolu town is the

administrative centre of the province and, in 2004, had a population of 85 000. The second pilot area is in Eskişehir province, also in north-western Turkey. Eskişehir province is more urbanized and industrialized, and the provincial capital of Eskişehir had a population of around 700 000 in 2004.

A random sample of (retrained) FDs was taken, based on lists of active practitioners in Bolu and Eskişehir made available by the Ministry of Health. On the basis of the available data – and taking into account the available resources and capacities of the health authorities - the following sample was decided upon: in Bolu, the total number of newly trained FDs was limited (69); one third of them (every third FD) was randomly included in the survey. The number of newly trained FDs in Eskişehir was larger (208), so a smaller proportion (one sixth) was included. This resulted in a total sample of 55 FDs for both provinces. It was agreed that, in case of illness or unavailability, the next FD on the list should be included.

For the patient questionnaire, it was decided to interview the first 20 patients of the selected FD on the given data collection day, and that, for logistic reasons, interviews would take place in the health centre/practice. This resulted in a total of 1100 targeted patients (460 in Bolu; 640 in Eskişehir). For both FDs and patients, the actual response rate exceeded the minimum required sample size, because of the preferences of the local partner and the actual interest of health workers and patients in being included.

Given the large distances between the pilot areas and the time available, it was decided to work with locally recruited field workers. This also had the advantage of reducing transportation costs. A local health administration/institute was selected where the field workers received their training, and where the questionnaires were distributed and collected. The training of field workers was carried out by NIVEL and WHO staff and consisted of clarifications and instructions concerning:

- the objectives of the survey, including the importance of monitoring primary care and the usefulness of the survey outcomes for policy-making;

- the basic principles and structure of the Tool, the type of questions used and how answers should be given;

- the specific contents of the tool, i.e. topics of the system checklist, and provider and patient questionnaires;

- selection of the research locations, primary care providers and patients;

- how to conduct the field work, including how to approach and assist respondents; how to establish a good rapport by clearly explaining the purpose of the survey and stressing confidentiality; how to deal with non-response; and how to minimize bias caused by the field worker (neutrality, patience, aloofness);

- selecting a suitable environment for patients to fill in the questionnaire, guaranteeing minimum interference by third parties and unbiased answers;

- how to check the quality and completeness of responses;

- how to record any questions/problems encountered during field work.

To safeguard confidentiality, the completed questionnaires were collected by the field-workers, checked and than dispatched in a sealed envelope to the collection point at the national health administration. Thus, although the local health authorities had a facilitating role, they did not have direct access to the information provided by individual doctors and patients.

The consensus meeting with national experts from various stakeholders in the health system, such as the Ministry, regional health authorities, respresentatives of health professional organizations, consumer protection organizations and researchers from the medical university, took place in October 2007, facilitated by WHO and NIVEL staff and based on the national level questionnaire/checklist. The meeting resulted in the collection of relevant background data on primary care reforms – however, it also resulted in substantive discussions on primary care developments in Turkey, especially when the experts' answers varied on specific topics.

To facilitate the data processing, a tailor-made data-entry programme was designed, using SPSS Data Entry Station version 3.0.3. For the Turkish questionnaires, the data entry, the cleaning of the data files and the analysis was done by NIVEL in the Netherlands. Details on the implementation process in Turkey are summarized in Table 3 below.

Table 3:   Overview of the implementation process in Turkey

Features of data collection	Explanation
Target groups	- FDs - Patients - National primary care policy experts
Locations	- Eskişehir province - Bolu province
Type of data collection	- FDs: survey using prestructured questionnaires disseminated by field workers - Patients: survey using prestructured questionnaires disseminated by field workers - National experts: prestructured questionnaires and discussion/consensus meeting
Period of data collection	22 – 25 October 2007
Sampling method	- FDs: random sample in 2 provinces - Patients: the first 20 patients visiting the selected FD - National experts: selected by local partner and WHO country office

Sample size planned/realized*	- FDs: Eskişehir: 32/ 41
	           Bolu: 23/ 37 - Patients: Eskişehir: 640/ 810
	           Bolu: 460/ 738 - National experts: 5-10

Instructions	- Local coordinator and health authorities instructed on details of sampling procedure and recruitment. - Field workers instructed and trained how to approach and assist respondents. - Questionnaires contained instructions on completion.

Features of data collection	Explanation
Coordination and support of fieldwork	• Local coordinator and health authorities coordinated overall data collection, supported by the international team members. • Field workers shared experiences with local coordinator and international team members during fieldwork phase (debriefing).
Data entry	By NIVEL in the Netherlands
Data analysis and reporting	At NIVEL

* The actual response exceeded the minimum required sample size because of the preferences of the local partner.

2.2 Policy experts on developments in primary care in Turkey: some results of the survey

This is a snapshot of the current context of primary care in Turkey. This chapter will look at aspects of legislation and regulation, financial arrangements, workforce, education of providers and coordination of care. It is based on the experiences and opinions of Turkish policy experts, collected by means of a questionnaire (national level system checklist). All the experts who filled out the questionnaire were subsequently invited to a meeting with the international team members to discuss their answers, especially those that conflicted, to try to reach consensus and to obtain clarification and background information. Statistical background information was provided separately by the Ministry of Health. Where indicated, some additional information has been added from the publication Health Care Systems in Transition, Turkey *(18)*; however, since this publication dates from 2002, some aspects might be outdated.

This chapter provides the context for the results of the surveys of general practitioners and patients in the provinces of Bolu and Eskişehir. In describing the results, reference has been made to the health systems functions and selected dimensions of the Primary Care Evaluation Scheme outlined in Table 2.

2.2.1. Stewardship aspects of primary care developments

• Dimension: policy development

Early legislation
The first major legislative basis for primary health care was the 1961 Law on the Nationalization of Health Care Delivery. This law introduced the concept of integrated primary health care provided by health centres serving a population of 5000 to 10 000 and staffed by general practitioners, nurses, midwives and health officers. Service provision in rural areas would come from health posts. From that year onwards, primary health care was given its own budget in the Ministry of Health. Two years later, in 1963, a department for primary health care was created in the Ministry. Despite massive efforts, however, the planned establishment of integrated primary health care was not fully realized. Funding schemes (a tax-based system supported by income-related contributions) were not implemented and an accompanying human resources plan and curriculum were not developed. Doctors continued to be trained as specialists rather than as general practitioners and shortages of nurses and midwives in primary care ap-

peared. In addition to this, as a result of the rapid urbanization of the previous decades, primary care infrastructure in urban areas lagged behind. This meant that hospital outpatient departments and private specialists continued to be strongly involved in the provision of first-level care.

Developments in the 1990s

The population's health status and the quality of the health care system, which were both far below the country's general level of development in those days, gave rise to major health reforms in the early 1990s. These were intended to improve the health status and better meet the needs of the population by reducing geographical inequalities, and increasing the effectiveness and efficiency of the health care system. The First National Health Congress, held in 1992, was a major step in a reform process that required a radical overhaul of legislation, much of which dated from the 1920s and 1930s *(18)*. Proposed changes included the delegation of powers to regional health administrations, the introduction of a gatekeeping model in urban areas, a postgraduate and retraining programme for family doctors and health care managers and the implementation of management information systems. However, attempts to provide integrated primary health care in eight pilot provinces (through the First Health Project) were not successful. Further steps were taken with the 1996 health care reform programme, which covered the period until 2000. The programme included the implementation of family medicine in primary health care (which should be well distinguished in Turkey from general practice). The adoption of the family medicine model was actually very controversial. In contrast to general practitioners, family doctors were recognized as being specialists. But, despite the opposition to the family doctor scheme, the number of family doctors has increased since *(18)*.

Central and provincial powers

The Ministry of Health is the major provider of primary and secondary health care[1] and the only provider of preventive health services in Turkey. At the central level, the Ministry of Health is responsible for Turkey's health policy and health services. The General Directorate of Primary Health Care in the Ministry is in charge of the strategic and operational management of health centres and health posts. Provincial health directorates manage the health services at the provincial level. Staff in each of the 81 provincial health directorates are appointed by the Ministry of Health, with the approval of the provincial governor. The directorates make technical decisions concerning the scope and volume of health services and, furthermore, have responsibility for matters of personnel and estate management. Health care units at the provincial level mainly consist of: health centres, (rural) health posts, mother and child health and family planning centres, tuberculosis dispensaries, and hospitals. In the past, the relationship between the central and provincial levels has been characterized by poor communication and lack of coordination, which has resulted in more regional diversity in the provision of health services than might be expected from the centralized structure of the health care system *(18)*. However, the national policy experts assembled for this project believe that there is no longer so much variation between provinces in primary care policy or specific priorities. They pointed out that there are now uniform standards of implementation and that provinces pay attention to them. They admitted however that there is one – big – exception in this respect, namely Istanbul. Other differences

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1   *About 75% of primary care facilities are under the responsibility of the Ministry of Health. About 25% are managed by universities, the Turkish army and private providers.*

do still exist between provinces; for instance, in the prevalence of family doctors and in the payment system for primary care physicians. However, these differences are not the result of diversity in provincial health policy, but are related to the phased introduction of family medicine. The experts stated clearly that there are no regional differences in terms of tasks and responsibilities for family doctors, coverage (such as co-payments for patients) or norms for the target population per family doctor.

- **Dimension: conditions for the care process**

Current policy on primary care

The government's vision of current and future primary health care has been published in laws, policy strategies and other formal statements. The following can be mentioned in particular:

- the second five-year strategic plan

- the health transformation document

- the law No. 5258 on pilot implementation of family medicine.

Experts were asked whether all relevant and current laws and policy documents concerning primary care contain a number of defined aspects. From a total of 17 listed aspects, experts were unanimously positive on 14, as show below.

Laws, regulations and policy documents in Turkey have clearly defined:

- the disciplines responsible for the provision of primary care;

- responsibilities and tasks of family doctors, nurses and other primary care disciplines (experts noted, however, these were not sufficiently detailed);

- educational requirements for family doctors;

- requirements for the (re-)accreditation of family doctors;

- minimum norms for the availability of family doctors in a population;

- minimum norms for the availability of primary care facilities in rural areas;

- requirements on keeping medical records in primary care;

- requirements on monitoring the performance of primary care.

Concerning the existence of specific primary care policy targets (including date of achievement), experts agreed that the relevant document has not been officially published yet. Experts were divided on whether official documents have mentioned interprofessional cooperation as a priority for primary care. They agreed that the issue of co-payments for patients has not been specified in any health policy document or law. And finally, they also agreed that relevant health policy documents or laws do not assign any

role to organizations of (medical) professionals or organizations representing patients or consumers. Experts pointed out however, that these and other NGOs are involved with the Ministry in practical and ad-hoc terms and, for example, in the implementation of specific projects. It is expected that, in the future, the roles of these organizations will be formalized legally or in policy documents.

- **Dimension: conditions for responsiveness**

Patient rights are fundamental to ensuring that a health system is "responsive". In almost all health facilities and units in Turkey, responsibilities concerning patients' rights are currently being designated. The official acknowledgement of patients' rights is in the 1998 statute of patient rights. The statute contains a basic declaration, stating that patients have the right to make use of all health services according to their needs, in accordance with principles of justice and fairness. The document also mentions a number of more specific rights, including the patient's rights:

- to feel safe and secure in health institutions

- to choose facilities and staff

- to be informed about their own case by the provider

- to ask for a second opinion

- to be accompanied during consultations

- to be informed about the identities, duties, and titles of providers

- to receive state-of-the-art treatment

- to have access to their medical records

- to be informed about diseases

- to give informed consent

- to privacy and confidentiality of medical information *(19)*.

At the expert meeting for this project, participants agreed that laws and regulations as mentioned above, do exist and that patient are free to choose their health centre and provider. On the other hand, however, they admitted that there is no obligatory patient complaint procedure for health centres at the primary care level to allow the actual enforcement of these rights. However, patients' rights units are now being established in hospitals to enforce the exisiting legislation. Therefore, the regulatory framework for patients' rights is probably ahead of actual practice, especially in primary care.

2.2.2.   Resource generation aspects of primary care developments

- **Dimension: professional development**

Quality improvement mechanisms

The Ministry of Health is responsible for the certification of primary care physicians. To be certified as a family doctor, candidates are currently required to complete a retraining course, which has been developed by the relevant medical university departments in collaboration with the Association of Family Physicians. At present, there is no periodical recertification scheme for primary care, so that there are, as yet, no criteria for recertification such as a minimum volume of continuous medical education activities or having practiced as FD for a certain period of time.

Currently, no medical specialization is needed to work as a general practitioner (which is not a family doctor). Similarly, for nurses, no special primary care training is needed. There are, however, regulations for primary care facilities concerning minimum standards for the design of premises, equipment and hygiene. Concerning the quality and confidentiality of medical records, the only requirement is that records must be kept electronically. Independent physicians need formal permission to practice from a health authority.

No national norm exists for the (maximum) number of patients a GP/FD should work for. However, in the PC pilot areas/provinces, the following standard is applied: the number of patients per family doctor should not be lower than 1000 and not exceed 4000.

Quality improvement mechanisms are being implemented gradually in primary care. From a list of five, the experts assembled for this project found that none of the proposed mechanisms were used frequently but, rather, on an ad-hoc basis. Internal practice checks and practice inspections by health authorities and external clinical audits were reported to be applied but infrequently. Each health facility is required to submit monthly reports to the provincial authorities – but the experts judged them as insufficient to qualify as an internal quality improvement instrument. Informal practice assessment visits by colleagues do occur (for instance from the Chamber of Physicians), but are rare. Obligatory periodic tests of professional knowledge and skills of primary care providers are not used.

The experts eventually agreed that statistical data are used for the regular monitoring of primary care performance. The reservation expressed by two experts was related to whether this was true for all provinces. Quality improvement and performance measurement has become an important topic in primary care since the stepwise introduction of performance related payments in 2003 (only in the pilot provinces so far). Performance indicators and criteria have been developed to promote clinical effectiveness, patient orientation, efficiency, productivity, security and professional development; they are measured both at individual and at facility levels.

The Ministry of Health coordinates the development and implementation of clinical guidelines for primary care. The approach seems to be hierarchical. Topics are determined by the Ministry, which assigns medical specialists to draft the guidelines. Efforts are being made to involve GPs and FDs into this process. The prepared guidelines are

subsequently distributed by the Ministry to all health centres. The current situation of the development and implementation of clinical guidelines in primary care is not a point of debate in Turkey.

Workforce and human resources planning

There are registers of primary care professionals, such as GPs/FDs, nurses, pharmacists, physiotherapists and midwives. The experts did, however, question whether they were always up to date.

In terms of workforce numbers, about 29 000 physicians are registered as working in primary care, 2775 as trained family doctors and the rest as GPs. This is 13.8% of all active physicians in Turkey. The geographical distribution of primary care physicians is very uneven. A complete overview on the number of GPs and FDs in all provinces is given in Annex 2. Fig. 3 below summarizes the large variation in the availability of physicians in primary care in the 81 Turkish provinces.

Figure 3: Population per primary care physician in Turkey
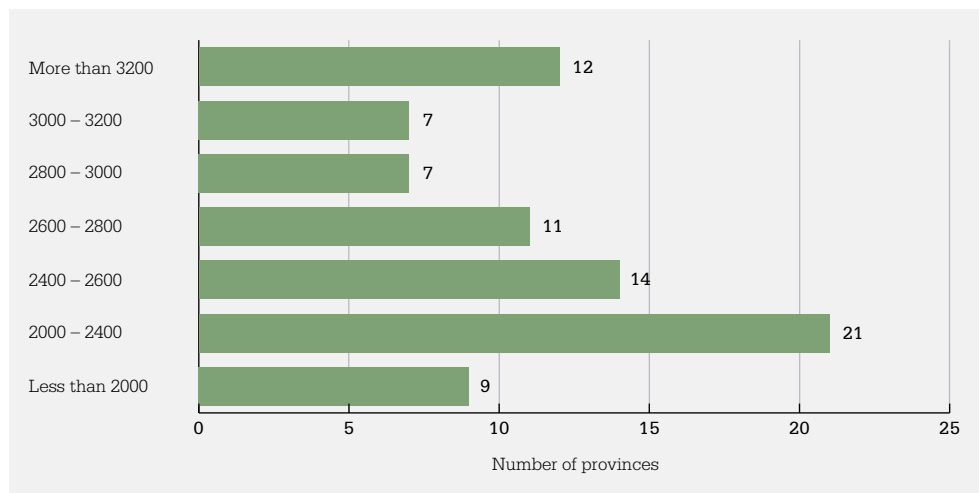
The average population per primary care physician in Turkey is 2484. However, in the province with the lowest density of physicians, the average is threefold that in provinces with the highest density. In nine provinces, primary care physicians on average serve a population of less than 2000, while there are 12 provinces in which the average is above more than 3200. In about one quarter of the provinces, the average population per GP/FD is between 2000 and 2400.

A family medicine model has been introduced in primary care in Turkey. Family medicine departments have been established in three quarters of the medical universities (currently 40 out of the total of 54). They are involved in education as well as scientific research. Most of the postgraduate training programmes in family medicine have a duration of three years. In all universities, part of the residency programme in family medicine is spent in primary care practice; the duration varies between six months and one year. The family medicine specialization in primary care is increasingly becoming a career perspective. In the past, being a (non-specialized) general practitioner used to be the first step towards becoming a secondary medical specialist. Now, family medicine is more appreciated as a full speciality and as a career. According to the experts

Evaluation of the organizational model of primary care in Turkey

assembled for this project, the capacity for specialization in family medicine amounts to about 500 places per year (which is about 11% of the total number of places for specialization). About 80% of family medicine university places are occupied. To date, about 300 family doctors have completed the postgraduate training each year. When they start working in one of the pilot provinces, the working situation is usually conform to the new requirements. In other provinces, however, they may have to work in the old model, with limited tasks and medical equipment. In addition to the postgraduate programme, a shorter retraining course has been developed to allow active general practitioners from the old system to become family doctors. This is why the overall number of family doctors is much higher than the number who have a postgraduate diploma.

The table below gives an overview of the proportion of primary care doctors to family doctors in the 13 pilot provinces.

Table 4: Primary care physicians and family doctors (FDs) in 13 pilot provinces in Turkey

Province	PC physicians (incl. emergency care)	FDs	% FDs
Adıyaman	194	163	84.0
Bartın	68	57	83.8
Bolu	106	69	65.0
Denizli	369	260	70.4
Düzce	143	104	72.7
Edirne	141	110	78.0
Elazığ	220	168	76.3
Eskişehir	275	208	75.6
Gümüşhane	52	35	67.3
Isparta	151	117	77.4
İzmir	1650	1087	65.8
Samsun	436	342	78.4
Sinop	72	55	76.4
TOTAL	**3877**	**2775**	**71.57**

In early 2008, there was a total of 2775 newly trained family doctors (postgraduates and retrained GPs). In the13 pilot provinces, an average of 72% of primary care physicians were family doctors.

With regard to shortages in health staff compared to the overall demand, for data are available. The experts estimated that the most severe shortages exist in primary care – compared to other levels of care – but could not provide any actual data. Furthermore, they reported that regional shortages are known to exist of: gynaecologists, cardiolo-

gists, surgeons, dentists, pharmacists and hospital nurses. Shortages seem to more severe in the eastern provinces than in the west.

- **Dimension: professional organizations**

The national professional organization of general practitioners and family doctors is TA-HUD (Türkiye Aile Hekimleri Uzmanlık Derneği), which has about 1200 members. TA-HUD's activities include: defence and advocacy of its members' material interests, professional development, education and scientific activities. It publishes a four-monthly journal for its members. Provincial associations of family doctors have also been set up in eight provinces.

2.2.3 Financing aspects of primary care developments

- **Dimension: incentives**

Family doctors are usually state-employed. The payment scheme is based on capitation, meaning that their income is related to the number of people they care for. Compared to other medical specialities, the income of family doctors in Turkey is lower: for instance, GPs earn about 50% of the income of gynaecologists and cardiologists, 70% of the income of a specialist in internal medicine and about 90% of that of a general surgeon.

Since 2003, as part of the primary care reform, a performance-related payment system is gradually being introduced in the primary care facilities under the responsibility of the Ministry of Health[2]. The aim of the new payment scheme is, on the one hand, to improve the efficiency, effectiveness, fairness and responsiveness of primary care services and, on the other, to foster the individual professional development of staff. The new scheme relates the salary level of primary care staff (both medical and nonmedical) to the performance of their health centre (or, actually, to the joint performance of the physicians). Performance indicators and criteria have been established by the Ministry of Health.

The introduction started in 2003 with a pilot study; the individual performance evaluation started in 2004, and was followed in 2005 by the institutional component. In 2007, the scheme was extended to include the management staff of health centres. Point values were established for a large set of procedures, forming the basis for bonuses. In each province, broadly composed commissions are responsible for the correct application of the scheme in each facility. Examples of services for which targets are specified in the scheme are:

- neonatal screening

- preventive services for mother and child

- immunization

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2   *This covers about 75% of primary care facilities in the country, with 28 000 physicians and 90 000 other staff.*

- modern family planning

- physical examinations

- medical procedures

- referrals to secondary care.

Bonus points can be earned even if performance remains below a set target (for instance, for vaccination coverage), as long as there is improvement compared to the previous year. The points system is also adjusted, for example, to the distance of the health centres from a city centre and the level of socioeconomic development of the population served.

Every month, the points accumulated by the health centre and its staff are added up and averaged; this is then the basis score for the physicians. For other staff, this score is multiplied by a fixed coefficient: for head physicians, for example, by 1.25; for nurses, 0.40; and for officers and management staff, 0.35.

Evaluations after the first year of implementation have shown a rise in the number of consultations, physical examinations and medical procedures, while the number of referrals has decreased slightly. Preventive services have increased and the quality of facilities and equipment were improved. Furthermore, the proportion of physicians working on a part-time basis has fallen. On the other hand, and not surprisingly, the overall expenditure on staff salaries has increased considerably – income of staff was higher than in the previous year. The evaluation therefore showed that one impact of the points performance system is that it gives health staff and incentive to produce more services than before. It is probably still too early to say whether this has resulted in unnecessary overproduction. The Ministry of Health has, in the meantime, decided to adjust the new payment scheme to include more indicators for quality of care.

- **Dimension: financial access**

In Turkey, the population is covered for all costs for primary care services, including the services of general practitioners and family doctors. Co-payments exist only for certain medicines (certain disadvantaged groups are exempt).

2.2.4.   Service delivery aspects of primary care developments

The group of experts assembled for this project agreed that poor coordination, both within primary care and between primary and other levels of care, is one of the major problems in the Turkish health care system. The discussion with the expert group was structured around a list of specific coordination methods as part of the national level questionnaire – and they were asked if these are relevant for Turkey. The experts agreed that only one of the methods mentioned of strengthening coordination between levels of care is currently applied: strong encouragement of the introduction of primary care group practices by the Ministry of Health and provincial authorities. The formation of group practices aims primarily to strengthen coordination and cooperation within primary care. However, they also expressed their concern that this might be no more

than an aim at present. At the same time, experts agreed that multidisciplinary teams for long-term care (for instance, chronic care for diabetic patients) do not exist. Also, there were no mechanisms to improve coordination and collaboration with the hospital sector such as: stimulating primary care physicians to act as gatekeepers, allowing them to care for their patients while in hospital or ensuring that patients are referred back to primary care after hospitalization.

2.2.5. Perceived actual topics in primary care developments

Ten possible topics with relevance for primary care were listed in the national level questionnaire and the expert group was asked to indicate to what extent these were currently a subject of discussion in Turkey. They agreed that the most important topics currently impacting on primary care development were: the shortages of physicians and nurses, the efficiency of services, and finding ways to achiever a more equal distribution of physicians throughout the country (especially in rural areas). Improving the coordination function by strengthening the gatekeeping role of the general practitioner/family doctor was also considered important, as was improving facilities and equipment in primary care. Topics such as quality improvement through the implementation of clinical guidelines, further implementation of health promotion and health education and encouraging patients' self-care were considered less important.

2.3. Family doctors about primary care services in Bolu and Eskişehir: some results of the survey

The results presented in this section come from the survey of family doctors in the Turkish provinces of Bolu and Eskişehir. The descriptions are based on their experiences and opinions. The survey looked at the following topics: workload and use of time, access and availability of services to patients, aspects of quality of care, use of clinical information, coordination and cooperation, available medical equipment, and several dimensions of clinical task profiles. In describing the results, reference is made to the health systems functions and selected dimensions of the Primary Care Evaluation Scheme as outlined in Table 2.

2.3.1 Background information on respondents

The study was conducted in the provinces of Bolu and Eskişehir. Bolu is located in north-western Turkey, halfway between Ankara and Istanbul. The province covers an area of 7410 km² and has a population of 264 000. Bolu town is the administrative centre of the province, and has a population of 85 000. Eskişehir province, situated south of Bolu, has an area of 13 652 km² and a population of 720 000, of whom 483 000 live in the provincial capital, Eskişehir. Compared to Bolu, Eskişehir is a more urbanized and industrialized province.

Bolu and Eskişehir were selected as the pilot provinces for the Primary Care Evaluation Tool because they were among the first provinces to introduce the primary care reforms.

Figure 4:   Provinces in Turkey
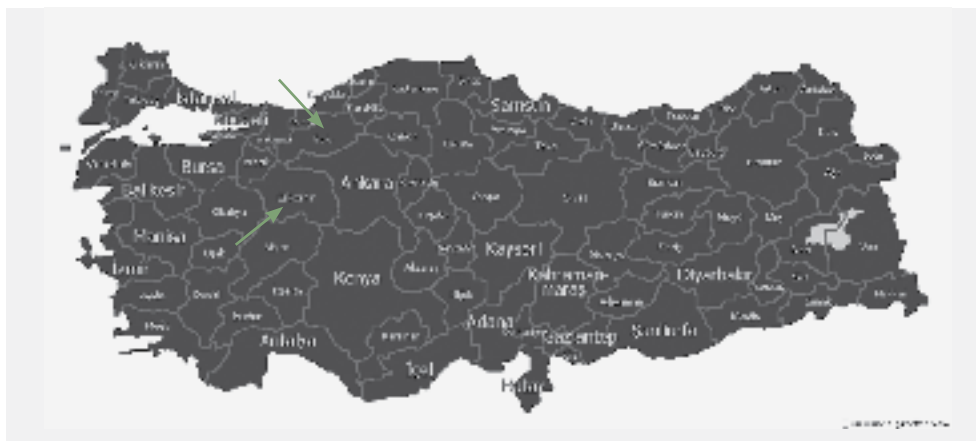
The survey included 78 family doctors (FDs) – 37 in Bolu and 41 in Eskişehir. In both provinces, most physicians were from urban practices; however this proportion was greater in Eskişehir (81%) than in Bolu (68%). The gender distribution was equal in both provinces: two thirds of the FDs were male and one third female. Respondents were relatively young and had little experience as family doctors. The average age was 39, with FDs in Bolu somewhat younger than the average and FDs in Eskişehir somewhat older. The average age was higher among FDs in urban areas than those in rural areas. The recent introduction of the family medicine model was well demonstrated by the length of time respondents had been working as FDs, with an average of less than two years. In Eskişehir, FDs had a bit more experience (2.5 years) than in Bolu (1.5 years).

Table 5:   Key characteristics of family doctors (FDs) in Bolu and Eskişehir

Characteristics		Bolu			Eskişehir		
		Urban	Rural *	*Total*	Urban	Rural*	*Total*
		N (%)	N (%)	*N (%)*	N (%)	N (%)	*N (%)*
Gender	Male	17 (68)	8 (67)	*25 (68)*	21 (64)	6 (75)	*27 (66)*
	Female	8 (32)	3 (25)	*11 (29)*	12 (36)	2 (25)	*14 (34)*
	unknown	0	1 (8)	*1 (3)*			
Total	FDs	25 (68)	12 (32)	*37 (100)*	33 (81)	8 (19)	*41 (100)*
Age	average in years	38	32	*36*	43	35	*41*
Experience	years working as re-trained FD	1.7	1.0	*1.5yr*	2.5	2.4	*2.5*
* Including small towns and rural areas							

Primary care is provided in family health centres by one or more FDs, depending on the size of the centre. From Table 6, it furthermore appears that teams of three or more FDs are the dominant organizational model of practice. In Eskişehir, almost all FDs work in group practices. In Bolu, one fifth of the FDs work with at least one colleague, and single-doctor practices are rare. None of the FDs answered that one or more medical specialists were working in the centre.

Table 6:   FDs working in single and group practice

Model of practice	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	%	Abs.	%
Single	3	8	–	–
2 FDs	7	19	–	–
3 or more FDs	24	65	37	95
Other	3	8	2	5
TOTAL	**37**	**100**	**41**	**100**

From Table 7, it can be seen that all FDs were state employed and almost all were sala-ried. In addition, capitation elements of payment were reported by 59% of the FDs in Bolu and 35% in Eskişehir. Most FDs had completed either the postgraduate training or the retraining course in family medicine. This was not (yet) the case with nine FDs in Bolu and eight in Eskişehir. By far most of the newly trained FDs had completed the retraining course. One third of the FDs in both provinces were members of a profes-sional association in family medicine. All FDs indicated that their practice population consisted of all age groups, including children, and both sexes.

Table 7:   Situation of family doctors

Model of practice	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	%	Abs.	%
State employed	37	100	41	100
Source of income: salary	29	90	33	89
Source of income: capitation payments	19	59	13	35
Family medicine postgraduate training completed	3	9	1	2
Retraining course completed	25	78	32	78
FDs who are a member of a professional association	13	35	13	32
FDs practice population including adults and children	37	100	41	100

2.3.2   Accessibility of care

• **Organizational access**

Workload

With an average of 3700 patients, family practices were very large, in comparison to practices of family doctors in western Europe (see Table 8). There was little variation in practice size. Only in Eskişehir were there seven practices with fewer than 3000 patients. In each province, no more than two FDs said that they served a population of more than 4400.

Evaluation of the organizational model of primary care in Turkey

Not surprisingly, the number of consultations per day was also high, at 47, although this was still modest in relation to the size of the practice. Only the rural practices in Eskişehir had much lower numbers of consultations. Not all FDs were equally busy. Some saw just around 10 patients a day, while others said that they saw more than 70.

Making home visits was clearly not a core task for FDs. Around 40% of the FDs said they did not make home visits, or did not answer this question. Those who made home visits normally did so only once or twice a day.

Working hours per week were around the average of 45. About 40% said that they worked 40 hours, which is probably the official number. In Bolu, there was a difference between urban and rural FDs in their reported working hours. Rural FDs said that they worked four hours more than their urban colleagues.

FDs were asked to estimate the number of hours per week they spent on the following professional activities: face-to-face consultations with patients; other clinical activities; meetings with other health workers; administration and management; and travel for meetings, home visits, etc. Except for the rural FDs in Eskişehir, the addition of time spent on these activities resulted in more working hours than reported above. In rural Bolu, the additional time exceeded 9 hours, or one extra working day. Patient care and other clinical work together made up over 80% of this time. Travelling took between 8% and 10% of the time.

Table 8:   Workload and use of time of family doctors

	Bolu (N=37)		Eskişehir (N=41)	
Aspects of workload	urban	rural	urban	rural
List size (number of patients)	3857	3793	3742	3143
Patient consultations per day (number)	47	49	54	35
Home visits • no home visits/no answer (%) • if yes: number of visits per day	44% 1.7	42% 2.0	33% 1.7	63% 1.4
Working hours per week (number)	44	48	45	46
Calculated number of working hours per week *) from below items	46	57	49	40
Number of hours per week spent on: • Face-to-face patient care • Other clinical activities • Meetings with health workers • Administration/management • Travel (home visits/meetings)	27.8 10.1 2.1 2.1 3.9	32.4 14.0 2.0 3.3 5.1	35.7 5.1 2.4 2.5 4.0	27.6 4.9 2.4 1.6 4.1

*) This is the sum of the average number of hours spent on activities specified in the following rows of this table.

Figure 5: Self-reported time spent on professional activities (in hours per week)

Legend: Bolu urban | Bolu ural | Eskişehir urban | Eskişehir urban
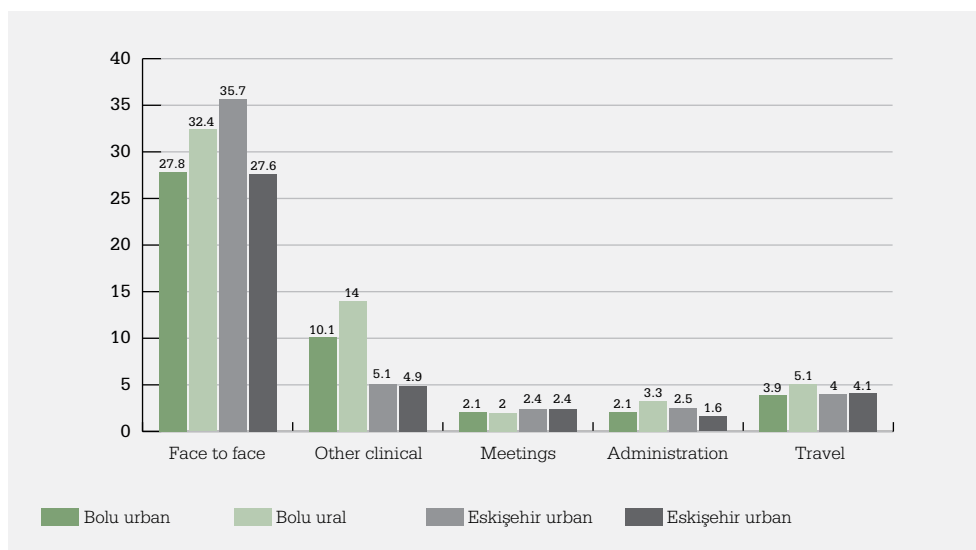
Patients' access and availability of primary care services

Practically all FDs answered that their family health centre had fixed opening hours (see Table 9). However, there was great diversity in the number of weekly hours, from 40 to more than 100. When the practice is open, patients can generally visit the FD the same day. Making an appointment was usually not required, and only a very small proportion of consultations took place by appointment. Half of the FDs in Bolu and one third in Eskişehir indicated that they did not use an appointment system at all. When patients visit their family health centre, they do not need to wait for long; waiting times of more than 30 minutes seemed to be exceptional.

Opening of the family health centres outside the usual office hours was not usual. The possibility of visiting the centre in the evening (at least once per week, after 18.00 hrs) was reported by only one third of the FDs. Such opening hours were more common in Eskişehir than in Bolu. The same was true of weekends (opening at least once per month) with about one third offering this possibility. When the centre is closed, in many cases a telephone number is available for patients if they need help or advice, but this is not routine. A quarter of FDs – one third in Bolu town – said that mp such telephone number was available. In general, the health centres did not use the Internet for information or communication with the population. Only four FDs in Bolu and one in Eskişehir mentioned that the centre had a website.

Reflecting the young age structure of the population in Turkey, the most frequently reported clinics for particular groups of patients were those for family planning and pregnant women. These were reported by half to three quarters of the FDs (assuming that 'not filled in' means 'no clinic available'). Clinics for patients with hypertension were mentioned by about half of the FDs in Bolu and a quarter in Eskişehir. The prevalence of clinics for diabetics and elderly people was somewhat lower.

Table 9:   Aspects of patients' access to family health centres

Aspects of patients' access	Bolu (N=37)		Eskişehir (N=41)	
	Urban (%)	Rural (%)	Urban (%)	Rural (%)
Fixed opening hours	25 (100)	11 (92)	32 (97)	8 (100)
Same day visits possible	25 (100)	11 (92)	32 (97)	7 (88)
Evening opening at least once per week	3 (12)	4 (33)	13 (39)	3 (38)
Weekend day opening at least once per month	3 (12)	8 (67)	14 (42)	3 (38)
Phone number available for patients when practice is closed	16 (64)	12 (100)	25 (76)	6 (75)
Practice operates a web site	3 (12)	1 (8)	1 (3)	–
Appointment system • not in use • for most consultations (> 50%) • estimated % of consultations	11 (44) – 7.0%	5 (42) 1 (8) 17.0%	11 (33) – 3.6%	2 (25) – 4.3%
Short waiting time in practice before consultation (no more than 30 min.)	22 (88)	11 (92)	27 (82)	8 (100)
Clinics or sessions in use for special patient groups • for diabetes patients • for hypertension patients • for family planning • pregnant women • for the elderly	12 (48) 12(48) 15 (60 18 (72) 12 (48)	4 (33) 7 (58) 7 (58) 8 (67) 2 (17)	7 (21) 7 (21) 17 (52) 20 (61) 4 (12)	2 (25) 2 (25) 4 (50) 4 (50) 2 (25)

2.3.3   Continuity of care

• Informational continuity

The findings summarized in Table 10 point to good conditions for clinical and other information in the family health centres but, at the same time, to suboptimal use of the existing possibilities as well as poor working relations between the primary and secondary levels of health care.

Table 10:   Availability and use of clinical information

Items	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Keeping patients' medical records				
• routinely	13	35	20	49
• with some reservation	24	65	21	51
Generating a list of patients by diagnosis or health risk				
• easy	10	28	11	27
• somewhat difficult	14	39	14	34
• very difficult/impossible	12	33	16	39
Using referral letters for all or most referred patients	20	56	5	12
Information from medical specialist after treatment				
• usually	1	3	1	2
• in minority of cases	8	22	5	12
• seldom/never	28	75	35	86
Discharge report after hospitalization				
• within 30 days	3	8	4	10
• seldom or never	30	81	30	73
Use of a computer for:				
• making appointments	6	16	14	34
• medicine prescriptions	8	22	15	37
• keeping patients med. records	37	100	37	90
• writing referral letters	2	5	9	22
• searching information	21	57	30	73
• not using a computer	–	–	2	5

It was positive that practically all FDs (there were only two exceptions in Eskişehir) were working with a computer and that all of them used the computer for keeping medical records of their patients. A problem is, however, that these records were not kept routinely by all FDs. Half of the FDs in Eskişehir and two thirds in Bolu did not always keep record all events. Many said they did not keep complete records if they were too busy. Other FDs only updated medical records routinely for patients tey saw frequently or did not register minor complaints and conditions.

Despite the general use of computers, it turned out to be difficult to produce lists of patients on the basis of common diagnosis or health risks. Such lists can be helpful for preventive outreach activities and monitoring. Only a quarter of the respondents could easily generate such lists and for about one third, it was very difficult or impossible to do.

The poor communication with medical specialists and hospitals was evident. In Eskişehir, FDs only exceptionally sent information letters to specialists in case of referral. In Bolu such letters were sent by about half of the FDs. Communication in the other direction was even worse. In each province, only one FD reported usually receiving information from medical specialists after completion of a course of treatment. A large majority of FDs seldom or never heard anything back from a specialist who had treated a patient. The same was true of discharge reports after hospitalization.

As mentioned above, computers were most widely used for keeping patients' medical records. Other purposes were: searching for information on the Internet (by half to three

quarters of respondents) and producing medicine prescriptions (reported by a quarter to one third). As mentioned earlier, only few consultations were made by appointment, except in Eskişehir, where one third of the FDs used the computer for booking appointments. In Bolu, the figure was only 16%.

2.3.4 Coordination of care

- **Cohesion within primary care**

Family doctors usually constitute the core staff of family health centres. Table 6 shows that FDs usually work in groups of three or more. To what extent other disciplines are part of the family medicine team can been seen in Table 11.

Practice nurses were the most frequently mentioned other discipline in the centres. However, one quarter of the FDs in Bolu and one fifth in Eskişehir seemed not to work with a practice nurse. Well over half of the FDs indicated that midwives were part of the team. Community nurses and dentists were only sparsely represented in the centres. It seems that pharmacies are usually not integrated in the health centres; only one FD mentioned the presence of a pharmacist. Finally, physiotherapists were not part of any centre.

Table 11:   Other disciplines and support staff in family medicine centres (FMCs)

Other disciplines/staff	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Practice nurse	27	73	32	80
Community nurse	4	11	8	20
Midwife	20	54	22	55
Physiotherapist	–	–	–	–
Dentist	4	11	2	5
Pharmacist	1	3	–	–
Other	5	14	8	20

Not all practice nurses had completed the retraining course. In Bolu 19% and in Eskişehir 37% of the FDs answered that their nurse had not completed this course. FDs working with a retrained nurse were asked to indicate to what extent the nurse was involved in a number of specific tasks. Findings are shown in Fig. 6.

Table 12:   Qualifications and (additional) tasks of practice nurses

Items	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Practice nurse retrained for primary care	29	81	26	63
Retrained nurses performing following (additional) tasks:				
• maternal care	26	90	18	69
• immunization	27	93	24	92
• home care for chronic patients	13	45	3	12
• health promotion/education	24	83	18	69

In Bolu, retrained practice nurses were somewhat more involved in the provision of specific services, as shown in Table 12 and Fig. 6. In both provinces nurses, were generally involved in immunization. In Bolu, this was also true for maternal care and slightly less so for health promotion and health education. In Eskişehir, 69% of nurses were involved in these two services. Home care for chronic patients was mentioned by 45% of the FDs in Bolu as a task of their nurse and by 12% of those in Eskişehir.

Figure 6:   Involvement of retrained practice nurses in specific tasks
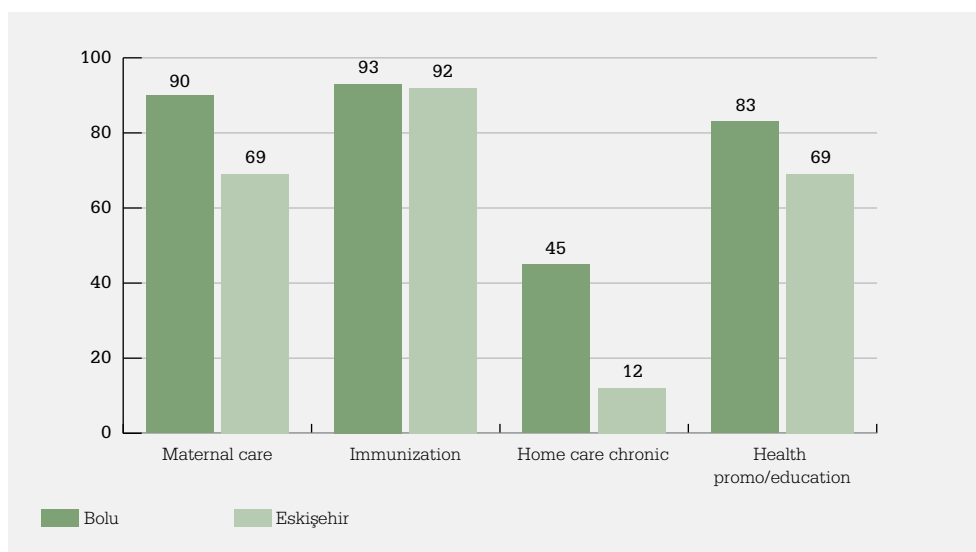
In both Bolu and Eskişehir, about one third of the FDs were working in a centre with a full-time coordinator or manager (see Table 13). When this was not the case, managerial tasks were most frequently taken over by one of the FDs in Eskişehir, whereas in Bolu, the coordination function was not formalized. Only two FDs mentioned that the centre was managed from another (larger) facility.

Table 13: Coordination function in family health centres

Model of coordination	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	%	Abs.	%
One FD coordinates	4	11	14	34
Full time coordinator/manager available	11	30	14	34
External management (from larger facility)	2	5	2	5
Coordination function not explicit	17	46	8	20
Don't know/not answered	3	8	3	7
TOTAL	**37**	**100**	**41**	**100**

Table 14 provides indications of cooperation of FDs with other primary care workers. Personal meetings with other FDs and, to a lesser extent, with the practice nurses were most frequently mentioned. It may be worth mentioning that one quarter of the FDs had no regular (at least monthly) meetings with their practice nurse. Given the importance of midwives in primary care, the frequency of reported regular meetings was low. In Bolu 41% and in Eskişehir only 20% said that they had face-to-face meetings with midwives at least once a month. No regular meetings with physiotherapists were mentioned. Meetings with pharmacists were infrequent, especially in Eskişehir.

Table 14: Face-to-face meetings with other primary care workers *

Meeting face-to-face at least 1x per month with:	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
(Other) FD	31	84	36	88
Practice nurse	28	76	30	73
Community nurse	–	–	–	–
Midwife	15	41	8	20
Physiotherapist	–	–	–	–
Pharmacist	5	14	3	7

* Not having filled in an item has been taken as 'no' (no meetings).

• **Coordination with other care levels**

Regular consultation and advice relationships between FDs and medical specialists, as listed in Table 15, were infrequently reported, in Eskişehir even less frequently than in Bolu. In Eskişehir, there were no cases of more than three FDs meeting with or asking advice of any of the medical specialties on a routine basis, for example, to discuss a specific case or patient. In Bolu, paediatricians were most frequently mentioned: 7 FDs (19%) usually had consultations with paediatricians and 16 (43%) occasionally.

Table 15: Consultation with and asking advice from medical specialists *

Asking advice from:	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Paediatricians • always/usually • occasionally	7 16	19 43	2 16	5 39
Internists • always/usually • occasionally	4 18	11 49	2 15	5 37
Gynaecologists • always/usually • occasionally	4 17	11 46	3 9	7 22
Surgeons • always/usually • occasionally	3 10	8 27	2 8	5 20
Neurologists • always/usually • occasionally	1 10	3 27	2 5	5 12
Dermatologists • always/usually • occasionally	1 9	3 24	– 5	– 12
Geriatrists • always/usually • occasionally	1 3	3 8	– 1	– 2

* Not having filled in an item has been taken as 'no' (not asking advice).

The conditions – geographical, at least – for consulting with colleagues are good: In both Bolu and Eskişehir, most family health centres are situated not far from a hospital where specialists work. In Bolu 70% and in Eskişehir 80% of the FDs were working less than 5 kilometres away from a general hospital; some even in the same building. Only 10% of the FDs said they were located more than 20 kilometres from the nearest hospital.

2.3.5 Comprehensiveness of care

• Material for preventive care

More than 80% of the FDs in both provinces answered that written information on vaccinations was available in their waiting room. Other materials frequently mentioned (by at least 63%) covered cardiovascular diseases, healthy diet, smoking cessation and diabetes. Information on contraception was mentioned by more FDs in Bolu (70%) than in Eskişehir (49%) – whereas for self-treatment of colds, it was the other way around (46% in Eskişehir and 27% in Bolu). Waiting room materials on obesity were reported by 41% in Bolu and 32% in Eskişehir. According to around a quarter of the respondents, information on sexually transmitted diseases could be found in their waiting room. Information available on social services was likewise not frequently reported: only by a quarter of the Bolu FDs and by one third of those in Eskişehir.

Table 16: **Availability of information materials for patients in the waiting room ***

	Bolu (N=37)		Eskişehir (N=41)	
Cardiovascular diseases	31	84	26	63
Healthy diet	28	76	28	68
Smoking cessation	26	70	27	66
Obesity	15	41	13	32
Diabetes	28	76	27	66
Sexually transmitted diseases	8	22	11	27
Vaccinations	30	81	33	89
Contraception	26	70	20	49
Self-treatment for colds/coughs	10	27	19	46
Social services	9	24	14	34

* Not having filled in an item has been taken as 'no' (not available).

- **Medical equipment**

One of the preconditions for comprehensive care is the availability of a minimum set of medical equipment. For this project, a list of 30 items was defined and tested for general availability, meaning that the listed items are either part of the FDs' own practice or are shared with a colleague next door – therefore within easy reach when needed for a patient.

The question on the availability of an emergency kit was generally misunderstood and it has been decided to exclude this item from the analysis of the findings for Turkey.

Table 17 shows that an average of 21 out of 29 items were available to family doctors in Bolu and Eskişehir. The variation around this average was higher in Bolu than in Eskişehir (not in the table). In Bolu, 43% of FDs had between 16 and 20 items available; in Eskişehir, the majority of FDs had 21 to 25 items available. Fig. 7 shows the availability per item.

Table 17: **Number of items of practice equipment available to FDs**

	Bolu (N=37)		Eskişehir (N=41)	
10 – 15	4	11	2	5
16 – 20	16	43	13	32
21 – 25	13	35	23	56
26 – 29	4	11	3	7
TOTAL	**37**	**100**	**41**	**100**
Average number of items per FD (from af list of 29)	20		22	

Figure 7:   Availability of practice equpment for FDs (%)

Data values (Bolu, Eskişehir):
- Aspirator: 49, 71
- Tuning fork: 15, 0
- Emergency kit: 61, 71
- Ultrasound (abdomen): 13, 3
- Hemoglob. Meter: 90, 50
- Peak flow meter: 9, 6
- Ophthalmoscope: 76, 67
- Speculum: 92, 54
- Gynaec. coach: 92, 60
- Nasal specula: 67, 68
- Reflex hammer: 92, 83
- Ear syringe: 63, 52
- Wound stitch mat.: 97, 91
- Enema: 56, 22
- Urine test strips: 90, 75
- Vision chart: 47, 44
- ECG: 90, 74
- Otoscope: 95, 100
- Car for home visits: 61,
- Dressing/bandages: 100, 100
- Height measure: 100, 100
- Blood sugar test kit: 95, 100
- Scales (infants): 100, 100
- Scales (adults): 100, 100
- Tape measures: 100, 100
- Syringer/needles: 100, 100
- Tongue depressor: 100, 100
- Thermometer: 97, 100
- Stethoscope: 100, 100
- Sphygmomano-meter: 57, 63

Legend: Bolu, Eskişehir

Fig. 7 shows that 13 items of medical equipment were generally or almost generally available to FDs in Bolu as well as Eskişehir, particularly those reported in the lower half of the diagram. Five more items were generally available in Eskişehir but less so in Bolu. In contrast, a car for home visits was available to almost all FDs in Bolu but to far fewer in Eskişehir. Three items from the list were not or only rarely available to FDs in both provinces: the peakflow meter, the tuning fork and ultrasound equipment.

Furthermore, 40% of the FDs did not have a sphygmomanometer at their disposal. Haemoglobin meters were part of the standard equipment in Eskişehir, whereas half of FDs in Bolu did not have them. Otoscopes were generally available, but this was not true for ophthalmoscopes. Vision charts were available to only half of the respondents. FDs in Eskişehir were better equipped for gynaecological services than FDs in Bolu. Specula and a gynaecological chair were available to almost all FDs in Eskişehir and about 60% in Bolu.

In addition, FDs were asked about the availability of laboratory and X-ray diagnostics, either inside the centre or elsewhere. As Table 18 shows, laboratory facilities in Eskişehir were usually fully available within the centres whereas, in Bolu, they were predominantly available elsewhere. Most FDs answered that laboratory facilities were sufficiently available.

However, the FDs were not satisfied with the availability of X-ray facilities, with half of FDs in Eskişehir and one third in Bolu indicating that they did not have sufficient access. Whee X-ray facilities were well available, in Bolu, they were mostly outside the health centre and, in Eskişehir, some were in and some outside the centre.

Table 18:   FDs' access to X-ray and laboratory facilities

Type of facility and mode of access	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Availability of *laboratory*				
• Full in practice	8	22	29	71
• Full outside practice	25	72	10	24
• Not/insufficient	2	6	2	5
Availability of *X-ray*				
• Full in practice	3	8	9	23
• Full outside practice	20	56	9	23
• Not/insufficient	13	36	22	54

• **Services delivery**

Clinical task profiles

The clinical task profiles of family doctors consist of three distinct elements: the role of FDs as the first contact for patients' health problems; the provision of medical technical procedures; and the treatment and follow-up of diseases. Each of these elements has been measured against the mean of a specific list that represents the typical tasks of a FD in the country concerned: the content of the lists was discussed with the national working group to ensure its proper adaptation to the country. For the analysis, the items on the list were weighted and scored in order to better indicate the degree of involvement of FDs in each of the tasks (see also explanation under each table).

The role as the first contact for patients' health problems

The role as first contact was measured using 17 events related to a variety of health problems with men, women and children. FDs could indicate whether their patients would consult them with these problems 'always', 'usually', 'occasionally', or 'seldom/never'. Table 19 gives an overview of the findings. Numbers and percentages refer to FDs who estimated that they would always or usually be the doctor of first contact.

The findings show relatively small differences between FDs in Bolu and Eskişehir, as is also reflected in the total scores. The first contact role of FDs was strongest in relation to health problems of children (except concerning hearing), and women (such as family planning, fertility problems, pregnancy). For problems that include strong social and psychological components, the answers were mixed. For example, most FDs (69% in Bolu and 85% in Eskişehir) considered that they would be the first contact for a middle-aged anxious man. Almost half of the FDs in Bolu and one third in Eskişehir saw themselves as the first contact for a woman with work-related psychosocial problems. On the other hand, for sexual problems, threat of suicide, relationship problems or a physically abused child, FDs did not see themselves as the first choice for people seeking help.

Involvement of FDs in the treatment of diseases

The involvement of FDs in the treatment and follow-up of chronic and other diseases in their practice populations was measured by 18 diagnoses, as listed in Table 20. The total scores for FDs' treatment tasks in Bolu and Eskişehir were not far apart, pointing to little difference between the provinces in this respect.

Most FDs said that they were the usual doctor patients would consult for the following five health conditions: chronic bronchitis, hordeolum, peptic ulcer, diabetes type II and depression. For another five health conditions, half to two thirds of FDs said that they were the usual doctor to treat patients with: hyperthyroidism, herniated disc lesion, pneumonia, peritonsilar abscess and rheumatoid arthritis. About 40% would usually be consulted for congestive heart failure and about 30% for ulcerative colitis. Involvement was small in the treatment of acute cerebrovascular accident, myocardial infarct, pelvic inflammatory disease, Parkinson's disease and brain concussion. FDs did not seem to have a significant role in providing palliative care for patients with cancer.

Table 19: FDs' self-reported role as point of first contact for patients with health problems

'Always' or 'usually' the first contact in case of:	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Child with rash	36	97	39	95
Child with severe cough	34	94	39	95
Child aged 7 with enuresis	27	73	31	76
Child aged 8 with hearing problem	12	34	11	28
Woman aged 18 asking for oral contraception	30	86	27	90
Woman aged 20 for confirmation of pregnancy	24	71	31	78
Woman aged 35 with irregular menstruation	24	65	22	60
Woman aged 50 with lump in the breast	18	50	19	49
Woman aged 60 with poly-uria	27	73	29	73
Anxious man aged 45	25	69	33	83
Man aged 28 with a first convulsion	10	28	5	13
Physically abused child	3	8	1	3
Couple with relationship problems	4	11	5	12
Man with suicidal inclination	3	8	3	8
Woman aged 35 with psycho-social problems related to work	17	46	15	37
Man aged 32 with sexual problems	8	22	5	13
Man aged 52 with alcohol addiction problems	1	3	3	8
Total score for 'First contact' (range 1 - 4) **)	2.48		2.43	

* Percentages calculated over number of valid cases; these may fluctuate per item.
** For the calculation of the score, answers have been weighted as follows: seldom/never = 1; occasionally = 2; usually = 3; (almost) always = 4.

Table 20: FDs' self-reported involvement in treatment and follow-up of diseases

'Always' or 'usually' involved in the treatment of:	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Hyperthyroidism	23	66	20	50
Chronic bronchitis	33	89	37	90
Hordeolum (stye)	34	92	35	88
Peptic ulcer	36	100	39	95
Herniated disc lesion	20	56	24	59
Acute cerebrovascular accident	2	6	8	20
Congestive heart failure	16	43	16	41
Pneumonia	21	57	28	68
Peritonsilar abscess	25	69	26	63
Ulcerative colitis	12	33	12	29
Salpingitis/pelvic inflammatory disease	6	17	6	15
Concussion of the brain	--	--	5	12
Parkinson's disease	8	22	10	25
Uncomplicated diabetes (type II)	32	87	34	83
Rheumatoid arthritis	24	65	25	63
Depression	33	89	33	81
Myocardial infarction	6	17	6	15
Palliative care	7	19	8	22
Total score for 'Treatment tasks' (range 1 - 4) **)	2.48		2.43	
('Corrected' score - based on comparative items from 1994) ***)	(2.26)		(2.28)	

* Percentages calculated over number of valid cases; these may fluctuate by the item.
** For the calculation of the score, answers have been given the following weights: seldom/never = 1; occasionally = 2; usually = 3; (almost) always = 4.
*** The corrected score is based on the 12 identical (and discriminating) items from the 1994 European GP Task Profile study (16,20). In 1994, the score of Turkish primary care physicians for these treatment tasks was 1.65 (which was the lowest among 30 European countries; the European average score was 2.6 in 1994).

Since most of the items in Table 20 derived from a 1994 European study on general practice that included Turkey, comparison was possible for 12 of them. The current total score for those 12 items is given in the bottom line of the table. In 1994, Turkish primary care physicians had the lowest ranking among 30 countries on 'treatment tasks', with only 1.65. With a current average of 2.27, FDs in Turkey are now doing considerably better (16,20).

Evaluation of the organizational model of primary care in Turkey

Preventive and medical technical procedures provided in health centres

The questions on the provision of preventive and technical procedures, such as vaccinations and minor surgery, were worded differently from the previous ones: instead of asking whether the FDs were personally involved, the question asked whether the service was provided either at the health centre by the FD or a team member, or by a specialist. A total of 16 items were included.

From the list of 16, only five or six items could be regarded as regular services provided by most of the family health centres, either by the FD or by someone else in the team. The commonest were immunization against influenza or tetanus, intravenous infusions and wound suturing and, to a lesser extent, ankle strapping and allergy vaccinations. In Eskişehir, the inserting of intrauterine devices (IUDs) was also reported by three quarters of the FDs. Minor surgical procedures, like wedge resection of an ingrown toenail, removal of a rusty spot from the eye and removing warts were mentioned by a solid minority of FDs (between 30% and 50%).

Table 21: Self-reported involvement of FDs or practice staff in the provision of preventive and medical-technical procedures

'Always' or 'usually' provided by FD or practice staff:	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Wedge resection of ingrown toe nail	15	42	12	31
Removal of sebaceous cyst from hairy scalp	6	16	3	8
Wound suturing	32	91	36	88
Excision of warts	5	15	9	23
IUD insertion	15	43	28	72
Removal of rusty spot from cornea	13	37	13	33
Fundoscopy	3	8	3	8
Joint injection	2	6	2	5
Maxillary (sinus) puncture	--	--	1	3
Myringotomy of eardrum (paracentesis)	--	--	2	5
Applying plaster cast	4	11	7	18
Strapping an ankle	27	75	28	72
Cryotherapy (warts)	13	39	17	50
Setting up intravenous infusion	34	92	37	93
Immunizations for flu or tetanus	36	100	39	98
Allergy vaccinations	27	75	25	68
TOTAL SCORE for 'Medical procedures/prevention'	2.46		2.38	

* Percentages calculated over number of valid cases; valid cases may fluctuate by the item.

Involvement of FDs in public health activities

Activities aimed at specific groups can involve FDs in screening programmes, collective vaccination and monitoring of population categories. Fourteen public health activities are listed in Table 22. FDs were asked whether they were involved or not in each of those activities.

The average family doctor in both provinces was involved in seven to eight of the activities mentioned in Table 22. These almost always included: routine antenatal care, immunization and routine surveillance of young children, family planning and contraception and preventive mother and child health care. Involvement was also important (reported by 50%-70% of FDs) with school health services, breast cancer screening programmes and programmatic vaccination of high risk groups against influenza. About 40% of the respondents said they were involved in rehabilitative care and one third in a mental health programme. However, FDs were hardly ever active in targeted screenings for sexually transmitted infections (STIs), HIV/AIDS, tuberculosis or cervical cancer.

Table 22:   FDs' self-reported involvement in activities aimed at specific groups

FDs involved in:	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
Screening for STIs	4	12	1	3
Screening for HIV/AIDS	3	9	4	11
Mother and child health programmes	32	89	34	87
Tuberculosis screening programme	5	15	6	16
Influenza vaccination programme for high-risk groups	20	57	23	61
Rehabilitative care	14	42	14	41
School health programmes	25	71	20	54
Mental health programmes	13	39	11	31
Cervical cancer screening programmes	3	9	2	6
Breast cancer screening programmes	23	68	19	51
Family planning/contraception **	36	100	39	95
Routine antenatal care **	36	97	39	95
Normal immunizations to children under 4 years old **	37	100	40	98
Routine paediatric surveillance (until age of 4) **	36	97	38	95
Coverage for 'Specific groups' (range 0-100%)	57.5%		53.1%	

* Percentages calculated over number of valid cases; valid cases may fluctuate by the item.
** Provided to at least most of those eligible for this service.

Evaluation of the organizational model of primary care in Turkey

All FDs were very active in mother and child health care and issues related to family planning. These tasks used to be covered by separate categories but have been integrated into the regular primary care services.

Family doctors were asked how they estimated their knowledge and skills in these areas: In Bolu, more than 80% of FDs answered that they 'definitely' had sufficient knowledge of and skills in the four topics mentioned in Table 23. In Eskişehir, the level was somewhat lower: in family planning, contraception and routine antenatal care, in particular, there might be room for improvement among FDs in Eskişehir.

Table 23: FDs' perceived knowledge and skills on family planning and child health

	Bolu (N=37)		Eskişehir (N=41)	
'Definitely sufficient knowledge and skills' in:	Abs.	(%)	Abs.	(%)
Family planning and contraception	30	83	25	61
Routine antenatal care	29	81	25	61
Normal immunizations for children under 4 years old	35	97	34	83
Routine paediatric surveillance (until age of 4)	31	86	30	73

- **Quality of care and improvement mechanisms**

A number of dimensions relevant to the quality improvement of medical and organizational services for patients are included under this heading. Family doctors were asked to report on their personal situation, and how the issue was dealt with in their health centres and provinces.

A majority of FDs seemed to have difficulties in keeping up-to-date with the latest professional developments and research findings related to treatment and disease; in Eskişehir, only 30% said they were always or usually able to keep up-to-date (see Table 24). Also, clinical guidelines were not frequently used: in Bolu 28% and in Eskişehir 44% of FDs said they did not use guidelines. In addition to the use of guidelines, the time that FDs spend on professional reading may serve as an indicator for keeping up-to-date. In Eskişehir, FDs reported spending 65% more time (almost 12 hours in total) on professional reading than their colleagues in Bolu (about 7 hours).

In the European context, patients can usually make use of a complaint procedure when dissatisfied with services received. The existence of such a procedure was reported by three quarters of FDs in Eskişehir and 80% in Bolu. More active approaches to learning about the experiences of services users, such as population satisfaction surveys or interviews with community organizations, were less usual. Half of the FDs in Eskişehir and 20% in Bolu said that a satisfaction survey had taken place in their practice.

Interviews with community organizations about their satisfaction with the services provided by their health centre took place in about one third of the centres included in the sample in both provinces. However, feedback from the health centres to the com-

munity, for example on local health data or vital statistics, was provided by 60% of the respondents; and in Bolu more frequently than in Eskişehir.

In addition to external quality improvement mechanisms, internal mechanisms can be explored. Job satisfaction interviews may generate inside information that can be used to improve services. Such interviews with staff of the health centres were mentioned by about 60% of the FDs in both Bolu and Eskişehir.

Table 24: FDs' perceived competence; use of mechanisms for quality improvement

Items	Bolu (N=37)		Eskişehir (N=41)	
	Abs.	(%)	Abs.	(%)
FDs feeling able to keep up with latest medical developments • always/usually • occasionally/seldom/never	17 20	46 54	12 28	30 70
FDs' use of guidelines • not used • sparsely used • frequently used	9 17 6	28 53 19	16 15 5	44 42 14
Any complaint procedure in place for dissatisfied patients	28	80	31	76
Satisfaction survey held among practice population	7	20	21	53
Interview held with community organization(s) about satisfaction with the health centre or practice	13	39	14	38
Reporting of local health data or vital statistics	25	71	20	51
Job satisfaction interviews held with practice staff	21	58	23	61
	hours		hours	
Average number of hours *per month* spent on reading journals, other professional information incl. internet	7.1		11.7	

• **Community orientation**

As already indicated in Table 24, health centres in Bolu seemed to have closer links to their community than those in Eskişehir. In line with this, family doctors in Bolu mentioned more frequent formal community connections than family doctors in Eskişehir (see Table 25). In Bolu, 41% of FDs reported regular meetings with local authorities and 30% had regular meetings with social workers. These percentages were much lower in Eskişehir. Links with religious groups or institutions were much less common: only 19% of FDs in Bolu and just 2% in Eskişehir indicated that such meetings were scheduled regularly. Other formalized coordination mechanisms, for example, community representatives as members of the board of the health centre, were only sparsely used: in 27% of health centres in Bolu and only 15% of centres in Eskişehir.

Table 25:   Connections with the community *

Type of relationships	Bolu (N=37) Abs.	(%)	Eskişehir (N=41) Abs.	(%)
Regular meetings with local authorities	15	41	5	12
Regular meetings with social workers	11	30	4	10
Links with religious groups	7	19	1	2
Community representatives on the board of the centre	10	27	6	15

* Not having filled in an item has been taken as 'no' (no connection).

2.4   Patients about primary care services in Bolu and Eskişehir: some results of the survey

The patient survey was carried out in the practices of the family doctors in Bolu and Eskişehir who participated in the doctor's survey. The aim was to include 20 patients per doctor. Field workers who visited the practices to collect the data asked patients there to participate in the survey until the target of 20 completed questionnaires was achieved. Consequently, the information gained from the patient survey applies to the same health centres as the information from the survey of family doctors. The results are based on the experiences and opinions of patients.

2.4.1   Background information on respondents

The total number of patient respondents in the study was 1548. In Bolu, the response rate was 738 and in Eskişehir 810. Characteristics that might be of interest for the further interpretation of the findings are as follows: the majority of respondents seeing the primary care doctors were women. About three quarters of the patients were from urban centres; in Eskişehir, the proportion of urban patients was larger than in Bolu. The average age of the attending patients was around 40 years in both provinces, and in both urban and rural centres.

Table 26:   Gender and age distribution of patients in Bolu and Eskişehir

Characteristics		Bolu Urban	Rural *	Total	Eskişehir Urban	Rural*	Total
		N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Gender	Male	177 (36)	105 (44)	282 (38)	189 (29)	62 (41)	251 (31)
	Female	316 (63)	132 (55)	448 (61)	468 (71)	82 (55)	550 (68)
	unknown	6 (1)	2 (1)	8 (1)	3 (1)	6 (4)	9 (1)
Total		499 (68)	239 (32)	738 (100)	660 (81)	150 (19)	810 (100)
Age	average in years	40 yr	40 yr	40 yr	41 yr	41 yr	41 yr

* Including small towns and rural areas

Evaluation of the organizational model of primary care in Turkey

The educational and occupational backgrounds and the living situation of the patients are summarized in Table 27. The majority of the patients had only primary education. In Bolu, the figure was slightly more than half of the respondents and in Eskişehir 43%. About one quarter of the patients had completed a technical or vocational high school. The most frequently mentioned occupations were employee, looking after the family, and retiree. Together, these made 70% to 75% of all respondents in both provinces. Only a few of the respondents were pupils, unemployed or unable to work.

Almost all respondents lived together with one or more persons. Living alone was extremely rare. Well over half of the patients lived in a family with a partner and children. A quarter lived with a partner without children. Around 10% were living with their parents. The overall living situation of respondents was similar in the two provinces.

Table 27:   Education, occupation and living situation of patients in Bolu and Eskişehir

	Bolu (N=738)		Eskişehir (N=810)	
Patients' backgrounds	Abs.	(%)	Abs.	(%)
Education				
• literate/primary school	381	53	346	43
• secondary school	72	10	109	14
• high school	165	23	215	27
• higher education/university	105	14	129	16
Total	723	100	799	100
Occupation				
• in school	44	6	48	6
• unemployed/unable to work	39	7	51	7
• looking after family	160	23	237	31
• employee	180	26	166	21
• retired	135	19	179	23
• other	139	19	96	12
Total	697	100	777	100
Living situation				
• alone	30	4	45	6
• with parents	73	10	95	12
• with husband/wife	161	23	187	23
• with family (inc. children)	382	54	438	55
• other	61	9	35	4
Total	707	100	800	100

2.4.2   Accessibility of care

• Financial access

With one major exception, there seemed to be no considerable financial barrier to the use of primary care services as listed in Table 28. The important exception was the cost of injections and other medicines prescribed by family doctors. In both provinces, almost 60% of patients said they would have to pay (usually a co-payment) for them if prescribed by the family doctor. Some (2.7%) said they would need to pay the full amount for medicines or injections.

Home visits were not frequently made, but it seems they were not always free of charge. Ten percent of the patients in Bolu and 13% of those in Eskişehir said they had to pay for a home visit. Payments for visits to medical specialists on referral from the family doctor were reported by 10% in Bolu and 8% in Eskişehir.

As Table 29 shows, the existence of co-payments was also perceived by some patients as a real obstacle to access to health services. One fifth of the respondents from Eskişehir answered that they had decided not to visit a medical specialist during the previous year because they could not pay for the visit or the medicines. In Bolu, 13% gave this answer. Since this only applied to those respondents with a referral to a specialist over the previous year, the overall percentages would have probably been higher.

Ten percent of patients in Bolu and 12% in Eskişehir reported having had financial difficulties in the previous year in getting prescribed medicines. Finally, abstinence from a visit to the FD was not frequently reported, but still this was mentioned by 8% in Bolu and 10% in Eskişehir.

Table 28:   Patients' reporting to pay co-payments for (primary) health care services

Type of service	Bolu (N=738)		Eskişehir (N=810)	
	Abs.	(%)	Abs.	(%)
Visit to family doctor (FD)	16	2	30	4
Injection or medicines prescribed by FD	396	58	422	57
Home visit by FD	49	10	58	13
Regular check up of baby or young child	20	4	26	5
Getting sickness certificate or health license	16	3	50	8
Visit to specialist on referral by FD	66	10	57	8

Table 29:   Patients reporting obstacles to the use of services related to co-payment and availability of medicines

Event in past year	Bolu (N=738)		Eskişehir (N=810)	
	Abs.	(%)	Abs.	(%)
Abstinence from visit to FD for financial reasons	61	8	80	10
Abstinence from visit to medical specialist for financial reasons	93	13	172	21
Financial difficulty in getting medicines prescribed by FD	75	10	95	12

• **Geographical access/responsiveness**

Table 30 specifies the time that respondents needed to travel to the following facilities: their family doctor and their preferred pharmacist, dentist, physiotherapist and hospi-

tal. Family doctors and pharmacists were closest: three quarters or more of the respondents could reach them within 20 minutes (see also Fig. 8). Second closest health carers were dentists and hospitals – although these were nearer in Bolu than in Eskişehir. In Bolu, almost half of the patients could reach the dentist and the hospital within 20 minutes, while in Eskişehir only a quarter could reach the dentist in 20 minutes and one third could be at the hospital within that time. Travel to the physiotherapist took more time. Most people needed between 20 and 60 minutes but, for a quarter of the patients, it took more than one hour to reach the physiotherapist. Travel times of more than one hour were rare for FDs and pharmacists, and infrequent (answered by no more than 15%) for visits to dentists and the hospital.

The travel time refers to the usual means of transportation available to patients: if they normally used the bus, it would be the time needed for that; equally for car or by foot.

Table 30:   Travel time to primary care providers

Provider and distance	Bolu (N=738)		Eskişehir (N=810)	
	Abs.	(%)	Abs.	(%)
Family doctor				
• up to 20 minutes	596	82	625	78
• 20-40 minutes	107	15	148	18
• 40-60 minutes	16	2	25	3
• more than 1 hour	8	1	4	1
Total	727	100	802	100
Pharmacist				
• up to 20 minutes	571	81	571	75
• 20-40 minutes	105	15	144	19
• 40-60 minutes	19	3	35	4
• more than 1 hour	9	1	13	2
Total	704	100	763	100
Dentist				
• up to 20 minutes	305	46	166	25
• 20-40 minutes	245	37	212	32
• 40-60 minutes	80	12	193	29
• more than 1 hour	32	5	93	14
Total	662	100	664	100
Physiotherapist				
• up to 20 minutes	124	24	103	18
• 20-40 minutes	134	26	170	30
• 40-60 minutes	114	22	150	27
• more than 1 hour	149	28	142	25
Total	521	100	565	100
Hospital				
• up to 20 minutes	339	48	254	33
• 20-40 minutes	233	33	229	30
• 40-60 minutes	76	11	186	24
• more than 1 hour	57	8	94	13
Total	705	100	763	100

Figure 8: Patients with travel time of up to 20 minutes to health care facilities (%)
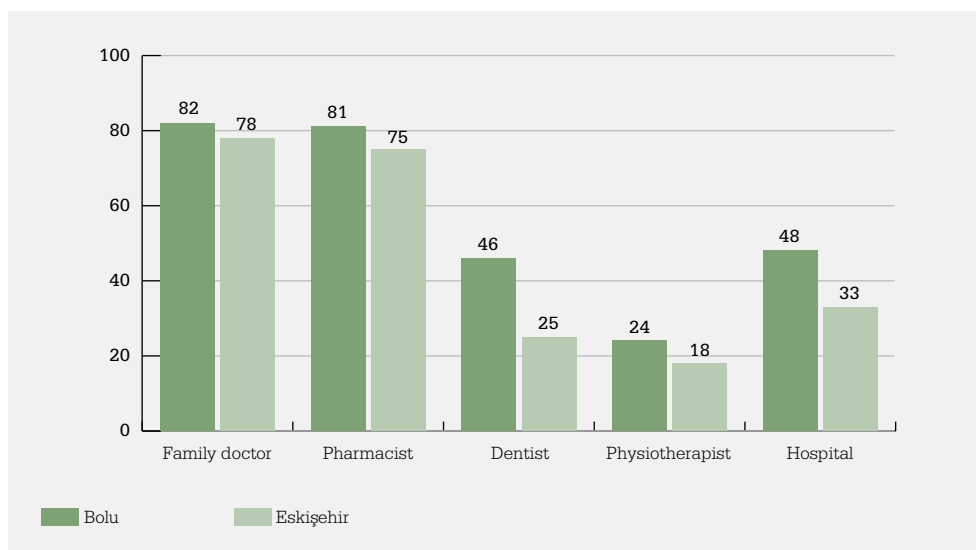
Responses to the statements listed in Table 31 indicate how patients appreciated the services of family health centres, such as the attainability and comfort of the facilities, the personal treatment by staff, and how long they had to wait to be treated.

Overall, health centres could be reached easily by public transport according to three quarters of the respondents in Bolu and 85% in Eskişehir. Access to family health centres for disabled persons and those using a wheelchair seemed to be problematic. Only a minority of 38% answered that their health centre was easily accessible for these groups; 21% did not know.

However, waiting rooms were convenient according to 85% of the respondents in Bolu and 75% in Eskişehir. Centres hardly ever used the Internet for their communication and information to the patients and the population. Only very few people mentioned that their centre had a website. Two thirds said that they did not know. A small majority of the patients said they know they could submit an official complaint if they were dissatisfied with treatment in the health centre.

Although most patients (83%) were satisfied with the current opening hours of the family health centres, most of them did not actually know the details. No more than 40% said they were well informed about opening hours and how to get evening, night and weekend services. An equal proportion responded they did not know the answer.

Around 80% to 85% of the patients were satisfied with the availability of family doctors during opening hours, which was measured by three items. Half of the respondents said that it was easy during opening hours to get a doctor on the phone for medical advice or questions. Thirty percent probably had no experience with calling the centre, because they answered that they did not know. Of all respondents, 84% had the experience that there was always a doctor available in the centre when they made a visit. About the same proportion (81%) said that it was possible to see the FD the same day if they wanted to. Patients were more critical, however, about the time they needed to

spend in the waiting room before they could see the FD. Around one quarter said that the waiting time was too long.

Although making an appointment to see a FD was not usual, 15% said that it took too long to make such appointments. However, among those who did make appointments, it seemed to be exceptional if it could not be for the same day. Half of those making appointments answered that the waiting time was less than 15 minutes; another 35% needed to wait no longer than half an hour (not in the table).

There seemed to be room for improvement of telephone access during evenings, nights and weekends. Less than one third said there was a telephone number available for patients who fall ill when the centre was closed. It was rarely possible to see a FD outside normal office hours, either in the evening or on Saturday or Sunday. Only one fifth of the patients in Eskişehir and somewhat fewer in Bolu reported that to be possible in their health centre.

Patients were very positive about the reception function in the family health centres. Staffs at the reception were kind and helpful – and three quarters of respondents in both provinces agreed that waiting times at the reception desk were short.

Table 31: The quality of family health centres experienced by patients

Statements	Bolu (N=738)		Eskişehir (N=810)	
	Abs.	% *)	Abs.	% *)
I can easily reach the centre by public transport	551	77	659	85
The centre is easily accessible for the disabled and people in wheelchairs (don't know: 21%)	244	34	315	41
The waiting room for patients is convenient	610	84	587	75
My centre has a website (don't know: 68%)	54	8	102	14
If I am not satisfied with the treatment in my centre there is a possibility to submit a complaint officially (don't know: 33%)	430	59	425	55
I am well informed about opening hours and how to get evening, night, weekend services (don't know: 39%)	241	34	336	43
During opening hours it is easy to get a doctor on the phone for medical advice or questions (don't know: 30%)	359	50	365	48
When I visit the centre there is always at least one doctor available	618	86	623	82
I have to wait too long in the waiting room to see the FD	195	27	168	22
When the centre is closed there is a telephone number to call if I fall ill (don't know: 34%)	212	29	244	32
In my centre it is possible to visit a family doctor on Saturdays or Sundays (don't know: 26%)	93	13	152	20
In my centre it is possible to visit a family doctor after 18:00 (at least once per week) (31%)	120	17	164	21
I am satisfied with current opening hours	601	84	644	83
Staff at the reception desk are kind and helpful	665	91	661	85
Waiting times are short at the reception desk	526	73	597	76
I have to wait too long to make an appointment with my FD	111	16	116	15

* If 10% or more indicated that they did not know, the percentage has been added in brackets in the first column.

2.4.3 Continuity of care

- **Longitudinal continuity**

Table 32 provides an indication of patients' utilization of primary care services, in particular the services provided by FDs and nurses. Almost all respondents had contacted their FD in the previous 12 months. Only 1% had not used primary care services in the previous year. (If not having answered this question is understood as 'no visit', then this category amounts to about 5%).

The average annual visit rate to FDs is between 7 and 8 in Bolu and between 8 and 9 in Eskişehir. The difference between urban and rural populations is opposite in the two provinces. In Eskişehir, the average number of contacts with FDs is much higher in the urban centres (9.2) than in the rural ones (6.3). In Bolu, the difference is much smaller, but rural patients saw their FD slightly more frequently (7.8) than patients from FDs in urban centres.

Not having contacted a nurse in the previous year was less exceptional than the situation with FDs, but almost three quarters of the patients had visited a nurse in that period. (If not answering is taken as 'no contact' this proportion drops to 60%). Therefore, most people see primary care nurses regularly. The difference in contact frequency with FDs between the provinces and between urban and rural centres was also found for nurses. The average visit frequency with primary care nurses was between 4 and 5 in Bolu and almost 6 in Eskişehir. In Eskişehir, in particular, nurses were seen more often by the urban than by the rural population.

Table 32: **Patients' frequency of visits to their family doctor and nurse during the previous 12 months (utilization rate)**

	Bolu (N=738)		Eskişehir (N=810)	
Visit frequency past 12 months	Abs.	(%)	Abs.	(%)
Family doctor				
• no visits	7	1	8	1
• 1-3 visits	227	33	176	23
• 4-6 visits	180	26	187	25
• 7-9 visit	66	9	57	8
• 10-12 visits	124	18	193	26
• 13 or more visits	92	13	129	17
Total FD	696	100	750	100
Average annual visit frequency FD *)				
• urban practice	7.1 (7.2)		9.2 (9.3)	
• rural practice	7.8 (7.8)		6.3 (6.3)	
Nurse				
• no visits	171	28	162	26
• 1-3 visits	184	30	159	25
• 4-6 visits	101	16	88	14
• 7-9 visit	50	8	39	6
• 10-12 visits	70	11	120	19
• 13 or more visits	45	7	65	10
Total Nurse	621	100	633	100
Average annual visit frequency nurse *)				
• urban practice	4.4 (6.2)		6.2 (8.3)	
• rural practice	5.1 (6.6)		4.7 (6.4)	

* In brackets: averages of those who answered as having made one or more visits

- **Interpersonal continuity**

This section deals with the patients' perception of their doctor's social and technical competence. Important aspects are perceived medical competence, communication and information skills and the ability to build up mutual trust. How well doctor and patient know each other is influenced by how long they have known each other, how exclusive their relationship is and how much time they spend together in consultations. Therefore, Table 33 also contains indications of these 'enabling' conditions for a patient-doctor relationship that can detect non-medical reasons for ill-health.

The length of time that patients have been registered with a FD is an indicator of continuity of care. It also serves as a background for the evaluation of the FD. The longer a patient is with the FD, the more experience he or she has with the FD. As the family medicine model was introduced only relatively recently in the two pilot provinces, the patients had been with their current FD for a relatively short time. Almost nobody said they had been with the current FD for longer than three years. In Bolu 44% and in Eskişehir 36% of respondents had been with their FD for less than one year. Despite the fact that most FDs in Turkey usually work in group practices, practically all patients saw their own FD for each visit.

The duration of consultations was relatively short. One fifth of the patients in Bolu and one out of eight in Eskişehir answered that a consultation usually took no more than 5 minutes. One third in both provinces said it was between 6 and 10 minutes and one quarter reported consultation times of between 11 and 15 minutes.

Table 33:   Patients' experiences with their family doctor

Statements	Bolu (N=738)		Eskişehir (N=810)	
	Abs.	% *)	Abs.	% *)
Length fo time as a patient with this FD • less than 1 year • 1-3 years • more than 3 years	322 387 18	44 53 3	288 484 29	36 60 4
If I visit a family doctor I see the same doctor each visit	679	93	731	92
Estimated duration of the consultation • up to 5 minutes • 6-10 minutes • 11-15 minutes • more than 15 minutes	149 249 168 129	21 36 24 19	89 265 215 169	12 36 29 23
During the consultation no other persons are in the room except the FD and myself	520	72	571	73
My family doctor has my medical record(s) available during my visit (don't know 24%)	456	63	548	70
My family doctor knows my personal situation (e.g. work or home situation) (don't know 14%)	349	48	408	52
My family doctor knows the medical problems and illnesses I have had in the past (don't know 12%)	372	52	471	60
My family doctor takes sufficient time to talk to me	619	85	681	87
My family doctor listens well to me	682	94	741	94
My family doctor gives clear explanations about prescribed medicines	642	89	700	90
My family doctor gives clear explanations about my illness and health problems	644	89	686	88
My family doctor keeps to promises and appointments (don't know 13%)	592	82	653	85
My family doctor is not just available for medical problems but also for personal problems and worries (don't know 22%)	408	58	462	61
I am satisfied with how my family doctor treats me	688	96	737	94
My family doctor would refer me to a medical specialist if I were to ask (don't know 10%)	644	90	657	85
My family doctor has sufficient medical equipment (don't know 28%)	356	51	469	63
My family doctor would visit me at home if I were to ask (don't know 45%)	265	37	225	29
After a visit to my family doctor I feel able to cope better with my health problem/illness (don't know 13%)	572	80	633	82
My family doctor is a good doctor	662	93	703	90

* If 10% or more indicated that they did not know, the percentage has been added in brackets in the first column.

For reasons of confidentiality, patients may prefer to be alone with their FD during a consultation. According to almost three quarters of the patients, this was normally the case. However, one quarter of the patients had the experience that another person, probably a nurse, was present during the consultation. We have no information on whether this was in line with the patients' preference.

A majority of about two thirds answered that their FD had their medical records at hand during the consultation, but a quarter did not know. Although patients and FDs had not known other very long, half of the respondents thought that their FD was familiar with their personal circumstances, such as things related to the work and home situation, and a slightly higher proportion found that their FD was aware of their previous medical problems and illnesses.

Findings also indicate that most patients were satisfied with the way they were treated by their FD. This is probably best summarized in their response to the statements 'my family doctor is a good doctor' and 'I am satisfied with the way my doctor treats me', which were endorsed by over 90%. But also specific items concerning the time FDs take to talk and to listen, explanations they give on health matters and medicines, and keeping to promises and appointments, met with agreement from 80% to 90% of the patients.

There seemed to be some hesitation as to whether FDs were available not just for medical problems but also for personal problems. About 60% agreed, while 22% did not know whether their FD was the right person to ask help with personal worries.

A large majority, of between 855 and 90%, said that they expected their FD to agree to a request for a referral to a medical specialist. Half of the respondents in Bolu and two thirds in Eskişehir thought their FD had sufficient medical equipment, whereas one quarter had no idea about it.

There was quite strong reservation as to whether the FD would make a home visit at the request of the patient. Only one third thought this would happen; almost half did not know whether they would get a home visit.

Patients could summarize their experiences of a visit to the family health centre by responding to the statement 'after a visit to my FD, I feel able to cope better with my health problem or illness'. This was endorsed by 80% of the respondents in both Bolu and Eskişehir.

2.4.4 Coordination of care

- **Cohesion within primary care/ coordination with other care levels**

The patient-centeredness of primary care can benefit from the patients' freedom to choose their own health providers and to be allowed to change to different providers if desired. Table 34 shows to what extent this situation was true in the two provinces. Being assigned to a FD seemed to be the rule, especially in Bolu. In Bolu, 80% of the patients indicated that they had not chosen their FD. In Eskişehir, two thirds answered that there had been no choice.

Furthermore, one third of the patients in both provinces responded that they could not go to another FD if they wanted to. About equal proportions (35% in Bolu and 30% in Eskişehir) answered that they did not know. Overall, this indicates that the policy on choice and gatekeeping principles is either not very well defined, or not well communicated to the patients. Choice and gatekeeping do not exclude each other: other countries, for example, give patients the right to change their family doctor once every 3 or 6 months.

Table 34: Patients' freedom to choose and change their FD

	Bolu (N=738)		Eskişehir (N=810)	
Option	Abs.	(%)	Abs.	(%)
Patients reporting they were assigned to their FD	586	80	535	66
N =	731		807	
Patients reporting they cannot change to another FD	241	33	265	33
N =	730		801	

A similar picture emerges with regard to the policy on referral rules (see Table 35). In Bolu, the number of people who thought they would need a referral from their FD to see a specialist is almost equal to the number of respondents who thought that such referral was not needed. Fourteen percent admitted that they did not know. In Eskişehir, half of the respondents thought no referral was needed to visit a specialist, almost one third had the opposite opinion and 22 percent had no idea. In summary, it seems that there was a lot of confusion about the formalities concerning referrals to secondary care and the gatekeeping role of the FD.

Despite this lack of clarity, most people (around three quarters) go first to their FD with new health problems. Only 15% to 20% said they did not go to their FD first with a new healt problem before turning to a medical specialist.

Table 35: **Patients' perception of referral rules and the gatekeeping role of family doctors**

Statements	Bolu (N=738)		Eskişehir (N=810)	
	Abs.	(%)	Abs.	(%)
'To see a specialist, I need a referral from my family doctor'				
• Yes	303	43	235	31
• No	302	43	356	47
• Don't know	102	14	169	22
Total	707	100	760	100
'With a new health problem, I go to my FD before going to a medical specialist'				
• Yes	548	76	608	79
• No	134	19	119	15
• Don't know	35	5	42	6
Total	717	100	769	100
'It is possible to buy antibiotics without prescription of a doctor'				
• Yes	131	18	166	21
• No	543	74	539	68
• Don't know	57	8	88	11
Total	731	100	793	100

Improper use of antibiotics is a threat to public health and therefore the free availability of antibiotics is not desirable. Physicians should control the 'gate' to this improper use. Two thirds of the respondents in Eskişehir, and three quarters in Bolu answered that it was not possible to buy antibiotics without a physician's prescription. However, around 20% responded that antibiotics were freely available.

And finally, Table 36 looks at the experiences of patients of how health staff handle and communicate information on their health: overall, communication of laboratory test results to the patients seemed to be good. In Bolu 80% and in Eskişehir 89% of respondents reported that they were well informed about test results.

Between 40% and 50% of the patients answered they were allowed to see their medical records on request. However, an almost equal proportion had no idea whether this was possible.

Patients' perceptions of the communication between their FD and other health personnel such as specialists were mixed. Although visits to a doctor other than one's own FD wer infrequent, less than half of the patients answered that this doctor had the necessary information at his or her disposal. Similarly, after treatment by a specialist, just half of the respondents thought that the FD would know the results. And only one third said they thought that the FD would inform the medical specialist when the patient was referred. This clearly points to the need for improvement in communication between the levels of care, at least from the point of view of the patients.

On the other hand, patients almost unanimously thought that FDs and nurses work well together. It seems, however, that the role of the nurse was mainly to support the FD, and they have few independent tasks. Only a few patients (12%) answered that nurses sometimes carry out independent consultations, making it unnecessary to visit to the FD.

Table 36:   Patients' experiences with of health staff handle information on their health

	Bolu (N=738)		Eskişehir (N=810)	
Statements	Abs.	%	Abs.	%
If a laboratory test has been done, I get the results of my tests (don't know 12%)	578	80	690	89
I can look at my medical records if I want to (don't know 43%)	347	48	308	41
If I visit a family doctor other than my own, he/she has all the information needed to correctly treat me (don't know 31%)	335	47	324	43
If I have been treated by a medical specialist, my family doctor knows the results of it (don't know 30%)	332	47	365	48
When I am referred, my family doctor informs the medical specialist about my illness (don't know 35%)	272	38	273	36
Sometimes a nurse does the consultation, making it unnecessary to see my family doctor	94	13	93	12
My family doctor and the practice nurse work well together (don't know 10%)	625	87	660	86

*) If 10% or more indicated they did not know, the percentage has been added in brackets in the first column.

2.5.   Lessons learned from the pilot project

The following observations and lessons learned are based on the experiences of the team members involved in the pilot implementation in Turkey and the Russian Federation - as well as of the international experts who reflected on the Primary Care Evaluation Tool and the draft report during the review meeting in April 2008 in Copenhagen.

Lessons learned
• Three questionnaires (national level, primary care physicians and patients level), which together form the draft Primary Care Evaluation Tool, were discussed by national experts in Turkey and the Russian Federation, and subsequently successfully tested in surveys in those countries.

• Based on the experiences from the pilot implementation and the extensive feedback given during the international review meeting in Copenhagen, the following major changes have been made to the Tool for its future use:

- » in general, questions have been made more factual; questions asking for opinions have been removed or rephrased;
- » the sequence of topics and questions has been reordered;
- » the character of the national level questionnaire has been changed from a questionnaire for stakeholders to a questionnaire/template for a background document to be prepared by a small team of experts;
- » the questionnaires for patients and primary care physicians have been reduced in size, for instance, by removing questions considered to be outside the scope of FDs or patients;
- » the consistency of terminology and wording throughout the questionnaires has been improved.

- The sensitivity of the instrument could be improved if the quantitative elements (questionnaires) were supplemented with qualitative methods. New sources of information might include group interviews with primary care workers, additional inspection of documents, direct observations and site visits. These additional approaches would help to clarify questions remaining after the quantitative analyses, compensate for possible low rates of response and thus improve the validity of the Tool.

- In an early stage of the Tool's application in a Member State, a check is needed to determine whether terms and answer categories in the questionnaires are adequate. Possible adaptations need to be made before the translation.

- The applicability of the Tool could be further improved by extending the generic core with a variable section that would take the local primary care policy priorities in Member States into account.

- Correct translation of the Tool, using a check and double-check procedure, is essential. Both linguistic and health care expertise are required.

- In general, the following data collection methods can be identified for the surveys:

  - » postal survey (with or without postal or telephone follow-up);
  - » survey via the Internet;
  - » distribution and collection of questionnaires via instructed local health care officials (for instance, chief physicians in districts);
  - » transfer and collection of questionnaires via the appropriate organization in the health administration;
  - » distribution and collection of questionnaires via trained fieldworkers;
  - » distribution and collection of questionnaires via the network of professional associations;
  - » involvement of nongovernmental organizations.

- The choice of data collection method is related to available resources and local circumstances. In Turkey, where health care is hierarchically structured and lines of communication are clear, it was obvious that the health administration structures should be used to implement the surveys.

- It has an added value if, within a country, the Tool is implemented in contrasting regions or areas. These regions may differ, for instance, in terms of the stage of primary care reform or the model of service provision. The choice of regions or areas should be explicitly discussed. The selection of regions for comparison should be driven by relevant questions related to health policy, reform processes, different models of service provision, etc. The formulation (at the beginning of the project) of expected differences between regions may serve as a reference for the interpretation of results and offer a starting point for follow-up activities.

- Successful implementation of the Tool, including the dissemination of results and follow-up activities, depends on the involvement and commitment of stakeholders. Although the ministry of health will usually play a leading role, organizations representing health care professionals, health insurers, patient organizations, donors and others should be involved. The more stakeholders are able to contribute, the richer and more useful the information generated by the Tool will be.

- The pilot studies in Turkey and the Russian Federation showed clearly that the surveys had a wider impact than simply in terms of data collection. Introduction of the activities at central, regional and local levels involved information transfer and awareness-raising on issues of quality in primary care. The more intensive the approach and the more personal the way in which the surveys were introduced, the stronger the action effect achieved.

Limitations of the Tool
- The Tool relies strongly on self-reported behaviour, rather than on direct observations or registrations. The resulting information may be biased and may not correctly reflect the real situation. Attempts have been made to reduce this bias. Revisions of the Tool have been made with the explicit aim of reducing a positive answering tendency. However, this still cannot be excluded. As a counterbalance, additional observations, checks and interviews have been included in the revised Tool. Quantitative results from the surveys can be validated by these additional measures.

- The focus of the Tool is those aspects of primary care that were defined as essential: coordination, comprehensiveness, accessibility and continuity, embedded in the structure of the WHO health systems framework. The aim of this report is therefore not to give a full chronological overview of the reform process in primary care that has taken place in a given country but to point to possible improvement areas for policy-makers and other interested stakeholders. The set of proxy indicators developed is therefore to be seen as a helpful indication for improvements – especially when compared to primary care practices in other countries – but not as cast in stone. Because the Tool and the corresponding report are based on a defined structure and framework, findings might, however, be selective. Since health reforms are much more comprehensive than the topics covered by the PCET, the results produced should not be considered as a way of fully monitoring those reforms. Such monitoring would require the collection of much more varied data.

The fundamental revision of the Tool and the many suggestions and lessons for future application are valuable outcomes of the project.

3 MAIN CONCLUSIONS AND RECOMMENDED ACTIONS

The table below provides an overview of the results and conclusions, structured according to the health system functions, selected dimensions and proxy indicators, as outlined in the Primary Care Evaluation Scheme in Table 2 of this report.

Table 37:   Findings from the surveys and system checklist in Bolu and Eskişehir, Turkey.

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
Stewardship				
Policy development	Primary care as priority area	• Specific legislation developed concerning Primary Care (PC): yes • Department at the MoH specifically dealing with PC: PC is organized from a special Directorate General in the MoH	Primary care was acknowledged as important long ago in Turkey but its implementation has only recently become effective. The concept of integrated primary health care was introduced in 1961. Plans in the early 1990s, including for decentralization, partial gatekeeping by GPs and better training programmes were not successful. It took until 1996 before family medicine was adopted as a more comprehensive model for primary care. Since 2003, this model has been implemented in 13 provinces (by early 2008) out of 81 overall in Turkey.	National level quest.
	Regional variation		Despite decentralization, the role of the Ministry of Health in primary care is still strong. To a large extent, the management and provision of primary care services in Turkish provinces is uniform (although Istanbul seems to be an exception). The Ministry has a strong influence on appointments at provincial health directorates. Directorates take technical decisions in line with central guidelines and hold major responsibilities for the management of estate and human resources in their province.	National level quest.
	Subjects of debate		The current shortages of physicians and nurses, as well as the (unequal) geographical distribution of physicians in the country; the improvement of coordination of care through gatekeeping; and, as a third topic: physical improvement of health care premises and equipment.	National level quest.
Conditions for the care process	Laws and regulation		The government's vision of primary care has been published in various laws and documents. These cover the specification of primary care disciplines and their tasks and responsibilities, education and accreditation requirements, availability of norms, medical record requirements and requirements related to performance monitoring.	National level quest.

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
Conditions for responsiveness	Involvement of professionals and patients in policy process		Organizations of professionals and patients are not involved in the policy process but rather in the implementation of policies. It is expected that the roles (in the policy-making process) of these organizations will become more formalized in the future.	National level quest.
	Patient rights	% PC centres or practices with patient *complaint procedure* reported to be in place: 78%	The position of patients has been formally acknowledged but this position has not yet been fully translated into practice. For instance, patient complaint procedures are not applied yet in every health centre.	National level quest.
Financing				
Incentives for providers		• *Employment status* of PC physicians: 100% state employed (n.b. performance related payment elements being introduced)	All physicians are state employed and are paid on the basis of a capitation scheme. The recent introduction of a more performance-related payment scheme (mixed scheme) seems to be a major step towards implementing a more comprehensive, efficient and responsive primary care system. Incentives need to be fine-tuned in order to avoid overproduction and to stimulate quality of care.	National level quest.
Financial access for patients		• % patients reporting *co-payments* for drugs prescribed in PC: 57%	Although primary care is officially free of charge, this was not true for prescribed medicines or injections. Many patients reported co-payments for these services. Some patients also reported co-payments for home visits and for visits to a specialist after referral from the FD. Co-payments seem to be an obstacle to the utilization of health care services. Patients answered they had abstained from a visit to their FD or a medical specialist for financial reasons.	Patient survey
Resource generation				
Professional development	Workforce	• % of all active physicians in Turkey *working in PC* (mostly as family doctors (FDs) but also as general physician): 13.8% • % *provinces* in Turkey where family medicine is being introduced: 16% • % of primary care doctors who are FDs in provinces where FM is being introduced: 72% • Average age of FDs: 39 years	The implementation of family medicine in the 13 provinces (as of early 2008) is well underway. About 27 500 physicians are working in primary care. In these provinces, a majority of primary care doctors are now family doctors. Nationwide (81 provinces), however, the proportion of family doctors is only 10%. Most medical universities have departments for family medicine where family doctors are trained. However, the capacity in the residential programmes (about 500 places per year in 40 medical universities) is not fully used. Only 80% of places are filled. In the light of the current severe shortages, everything should done to ensure full use of capacity. Expansion of the current capacity may be also considered.	National level quest.
	Shortages	• % of FD positions currently *vacant* in Turkey: not available	There are severe shortages of physicians and nurses in primary care.	FD survey

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
	Quality improvement mechanisms	• Number of hours FDs report to spend on *professional reading*/information per month: 9.5 hours • % of FDs reporting that they frequently *use clinical guidelines:* 16%	Quality improvement mechanisms such as obligatory re-certification schemes or periodic knowledge and skills tests are not yet in use and formalized. There are few requirements concerning the quality and confidentiality of medical records. Formal and informal mechanisms of performance assessment, such as practice inspections and medical audits, are infrequently applied. A positive change may be the introduction of the performance-related payment scheme. However, its focus seems to be more on the quantitative side of performance than on quality. Clinical guidelines in primary care are developed and implemented under the exclusive responsibility of the Ministry and drawn up by medical specialists with minor inputs from family doctors. Use of the guidelines is not evaluated.	National level quest.
	Human resources planning		Registers of primary care professionals are in place, but it is not clear if they are up-to-date and how they are used for workforce planning.	National level quest.
	Organization of professionals	• % of medical universities in Turkey with a *department of family medicine* and FM training facility: 74%	Three quarters of all medical universities in Turkey have a department of family medicine. There is also a national organization of GPs and FDs (TAHUD) with a broad range of activities; however, its role in the policy-making process is not formalized. In addition, GP and FD organizations are developing in eight provinces.	National level quest.
Medical equipment		• Number of items of medical equipment reported to be available to FDs (from a list of 29 items): 21 items (= 72%) • % of FDs reporting no or insufficient access to a laboratory: 3.8% • % of FDs reporting no or insufficient access to X-ray equipment: 45%	Family health centres were reasonably well equipped; the situation in Eskişehir was slightly better than in Bolu. Typically absent were peakflow meters, tuning forks and ultrasound equipment. Many FDs also said they did not have a blood pressure meter. FDs in Eskişehir were better equipped for gynaecological services than their colleagues in Bolu. A general problem was insufficient access to external X-ray facilities; access to laboratory facilities was very good.	FD survey
Delivery of care				
Accessibility				
Geographical access		• % of patients reporting *up to 20 minutes travel* to family health centre: 79%	Primary care physicians are geographically very unevenly distributed in Turkey. This suggests regional differences in the availability of primary care services. In Bolu and Eskişehir, however, patients had no difficulty to reach family health centres, pharmacies and hospitals.	Patient survey

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
Organizational access	Practice population	• Reported *number of patients per FD:* 3715 patients	Related to the former point is the large variation in the number of population per primary care physicians in Turkey. The average is 2484 per physician. In provinces with the lowest physician density the average population is threefold the average in provinces with the highest density. Compared to the European situation, practices in Bolu and Eskişehir were very large (around 3700 patients) and there was little variation in the size of practices.	FD survey
	Workload	• Reported number of *patient consultations* per day per FD: 47 consultations • Reported number of *home visits* per day per FD: 1.7 • Reported number of *working hours* per week per FD: 46	As a consequence of the large practice sizes, the number of consultations in Bolu and Eskişehir per day was high, although modest in relation to the size of the practices. There were large variations between rural and urban areas. Home visits were rarely made.	FD survey
	Patients' access and availability of services	• Reported *visiting frequency* of patients (utilization rate): 7.6 visits per year • Reported average *length of a patient consultation per patient:* 11 minutes • % FDs reporting to use an *appointment system* for most consultations: 1%	Most patients were satisfied with the current opening hours of the health centres (which varied significantly between centres), the availability of medical staff during these hours or getting a doctor on the telephone. Usually it was possible to visit a FD the same day and waiting times were acceptable, even if making an appointment was unusual. Visiting a FD outside the normal office hours, in the evening or on weekend, was only rarely possible. Centres hardly ever used the Internet for their communication with and information to the patients. Consultation time per patient was relatively short.	Patient survey FD survey
Coordination				
Cohesion within primary care	Practice management		Lack of coordination of care seems to be a major problem. For instance, multidisciplinary teamwork, for the benefit of patients with chronic diseases (such as diabetes) hardly exists.	FD survey
	Collaboration	• % FDs reporting *working with other PC physician(s)* on the same premises: 90% • % of FDs reporting having regular face-to-face *meetings* with: • Practice nurse: 77% • Social worker: 19%	Most FDs worked in teams of three or more FDs. Beside FDs, family health centres consisted of practice nurses and, in most cases, midwives as well. Other primary care disciplines, like physiotherapists, dentists and pharmacists were not usually part of the centre. Cooperation was not strongly formalized between team members. Regular meetings were not usual between FDs and nurses and even less so between FDs and midwives.	FD survey

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
Coordination with other care levels	Referral system	• Number of *referrals* by FDs to medical specialists per 100 patient contacts: not available • Number of *hospital admissions* ordered by FDs per 100 patient contacts • Number of pharmaceutical: *prescriptions* by FDs per 100 patient contacts: not available	There are no mechanisms to promote coordination between the primary and the secondary levels. The policy on the gatekeeping role for FDs was not clear to patients and, in daily practice, gatekeeping was not well maintained. Despite this lack of clarity, most people first visit their FD with new health problems. It is not usual to refer patients back to primary care after hospitalization.	FD survey Patient survey
	Collaboration with secondary level		Working relations between FDs and medical specialists and hospitals left much to be desired. Consultation or asking advice from medical specialists is rare. Referral letters are poorly used and medical specialists do not inform FDs properly about their treatment. Discharge reporting is not formalized.	FD survey
Continuity				
Informational continuity		• % FDs reporting that they keep medical records of all patient contacts on a routine basis: 43%	Conditions for clinical and other information were good in the family health centres. 97% of respondent FDs had a computer at their disposal, which was used for keeping patients' medical record. However, these possibilities were not optimally used, because records were not kept routinely. Furthermore, it was difficult to use computer records to produce lists of patients on the basis of common diagnosis or elevated health risks. Most patients were not sure whether they could see their own medical files if they would like. Many patients felt the exchange of information between physicians could be better. Patients' expectations of the communication between their own FD and other physicians were also modest.	FD survey Patient survey
Longitudinal continuity		• % of patients reporting that they were assigned to their FD (did not have a choice): 71% • % of patients reporting having been with their FD for at least 1 year: 59% (n.b. FM was introduced only recently)	Patients had visited the health centres about seven times during the previous year. In Eskişehir, the visiting rate with FDs was much higher in the urban centres than in the rural ones. Patients thought that it was not possibile to choose their doctor. They had usually been assigned to their current FD. Patients saw restrictions in changing from one doctor to another. Since family medicine had been introduced rather recently, patients had been with their doctors for a rather short period.	Patient survey

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
Inter-personal continuity			Despite the fact that FDs worked in groups, patients would generally see their own FD on each visit. Consultations were relatively short and FDs did not always have the patient's medical file at hand. Patients were satisfied about the way they were treated by their FD, although they were not generally convinced that the FD was aware of their personal situation and the details of their medical history. Patients found that FDs took sufficient time, listened and communicated well and kept to promises and appointments. Patients were reserved about their FD's preparedness to make a home visit. They were also not sure if their FD would be the right person for discussing non-medical problems that impacted on health.	Patient survey
Comprehensiveness				
Practice conditions	Conven-ience		Wheelchair access to the family health centres was reported to be problematic, but patients were satisfied with the convenience of the waiting rooms and the prompt and friendly treatment at the reception desk.	Patient survey
	Information material		Overall, practices provided sufficient in-formation leaflets for patients in the wait-ing room. Least available was information on social services, on sexually transmitted diseases, on obesity and on self-treatment for colds.	FD survey
Medical equipment		• Number of items of medical equipment reported to be avail-able to FDs (from a list of 29 items): 21 items (= 72%) • % of FDs with a computer available in the FMC: 97%	Family health centres were reasonably well equipped, especially with computers. With regard to medical equipment, the situation in Eskişehir was slightly more favourable than in Bolu. Typically absent were peakflow meters, tuning forks and ultrasound equipment. Many FDs said they did not have a blood pressure meter. FDs in Eskişehir were better equipped for gynaecological services than their colleagues in Bolu. A general problem was insufficient access to external X-ray facilities.	FD survey
Services delivery	Population groups served	• Consolidated score for the FD as doc-tor of *first contact* (based on 17 items; range of score 1-4): 2,47	FDs had a strong position as the doctor of first contact for health problems of children (except concerning hearing), and women (such as family planning, fertility problems, pregnancy). For problems with strong social and psychological compo-nents, the first contact role was less devel-oped. For sexual problems, psychiatric or relationship problems, FDs were not the first choice to contact.	FD survey

Selected dimension	Selected information items	Selected proxies and findings	Background to findings	Source
	Involvement of primary care physicians in the treatment of diseases	• Consolidated score for the provision of *treatment of diseases* by FDs (based on 18 items; range of score 1- 4): 2.59	The involvement of FDs in the treatment of diseases could be improved, if compared to that of colleagues in Europe. However, in comparison with the results of a European study conducted 15 years ago, the current situation is far improved.	FD survey
	Provision of preventive and medical technical procedures	• Consolidated score for the provision of *medical procedures and prevention* by FDs (based on 16 items; range of score 1-4): 2.41 • Coverage of public health activities (based on 14 items = 100%) by FDs on a routine basis: 55.3%	FDs were moderately involved in the provision of preventive care and medical technical procedures. Expansion of these tasks could include insertion of intrauterine devices and minor surgical procedures. Activities of FDs aimed at specific patient groups or other public-health related tasks mainly covered the areas of mother and child health and family planning. FDs did not conduct much screening for sexually transmitted infections, HIV/AIDS, tuberculosis or cervical cancer.	FD survey Patient survey
Quality of care and evaluation of services		• Number of hours per month reported by FDs to be spent on *professional reading*/information: 9.5 hours per month • % of FDs reporting frequent *use of clinical guidelines*: 16%	Professional development turned out to be a point of concern. Many FDs reported having difficulty in keeping up with the latest professional developments. Furthermore, clinical guidelines were not well used by the FDs. FDs in Eskişehir reported spending much more time on professional reading than their colleagues in Bolu.	FD survey
Community orientation		• % of FDs reporting regular *meetings with local authorities:* 26%	Links with the community turned out to be weak. FDs in Bolu mentioned community connections more frequently than FDs in Eskişehir.	FD survey

Evaluation of the organizational model of primary care in Turkey

Turkey: recommended policy actions

- Involve associations of health professionals and nongovernmental organizations (NGOs) more formally into the process of health policy development and in aspects of its implementation.

  » The evaluation has shown that organizations of professionals and patients are already involved in the policy making process but rather on an ad-hoc basis. The inclusion of stakeholders on a more formal basis for example in the form of a standing committee or by officially delegating health policy and implementation responsibilities to them might be considered.

- Further develop and formalize the role of patients in primary care, for instance by improving complaint procedures in health centres, better communication about referral rules and the right to choose a family doctor, by promoting patients' responsibilities in prevention or by monitoring patients' needs on a regular basis.

  » The evaluation has shown that the important role and position of patients has been formally acknowledged, but patients were not always aware of their rights and the new functioning of the system, nor do patients and FDs realize fully the potential of informed and active patients for better health outcomes. A public information campaign targeting the population as well as physicians with differentiated messages and using mass media such as radio or TV might be beneficial.

- Take measures to reduce the shortages among FDs and nurses and to realize a more equal distribution of primary care providers over the whole country. This may also reduce the current high workload of FDs.

  » The evaluation has shown that much has been done since the start of the reforms – however, nation-wide the proportion of family doctors to other specialities is still only 10%. Consider fully using existing capacities in the residential programmes (about 500 places per year in 40 medical universities; but only 80% occupation) - and even whether this capacity can be expanded. Continue with the new payment scheme that keeps family medicine attractive for new students and consider adding other incentives such as free internet connections and e-learning programs for doctors in rural areas. Enhance the reputation of FDs by subsidizing and supporting research for FDs (for example in drawing up clinical guidelines) or extending the task profile of FDs. Keep the register of primary care professionals' up-to date and use it for active human resources planning.

- Improve the coordinating role of FDs by removing obstacles to collaboration and working relations between FDs and medical specialists from the secondary level (strengthening of the gatekeeping role of FDs), as well as further support cooperation and teamwork within primary care.

  » The evaluation has shown that formalized multidisciplinary team work within primary care or between levels of care for the benefit of for example patients with chronic diseases or multi-morbidities hardly exist. Referral letters are poorly used and secondary specialists are not informing FDs routinely about their treatment. Discharge reporting from the hospital is not formalized. Consider introducing clear reporting rules and link it to the new IT software and by that, enhance the coordinating role of the FD. Introduce team working schemes for the core primary care team and provide training on it. Consider introducing new disciplines in primary care such as nurse practitioners and others that can support the network of an extended general practice model, or include existing ones more closely, for example pharmacists, physiotherapists and dentists. Stimulate stronger links between primary health care facilities and the community to enhance coordination between health and social services.

- Continue to introduce incentives for good performance, focusing in particular on improving the quality of services.

  » The evaluation has shown that the introduction of performance elements into the payment scheme for FDs has been a successful first step, however with too much impact on quantity and little on quality. Consider a national strategy to systematically establishing quality improvement mechanisms that build on each other: certification and re-certification schemes, continuous medical education programs based on the need of doctors, practice inspections and medical audits, peer review circles, routine electronic patient records, participation in the development of clinical guidelines etc.

ANNEX 1 GLOSSARY OF TERMS ON PRIMARY CARE

Accessibility: the patients' ability to receive care where and when it is needed, given possible physical, financial or psychological barriers *(10)*.

Comprehensiveness: the extent to which services provided comprise curative, rehabilitative and supportive care, as well as health promotion and disease prevention *(16)*.

Confidentiality: the right to determine who has access to one's personal health information *(1)*.

Continuity: the ability of relevant services to offer interventions that are either coherent over the short term both within and among teams (cross-sectional continuity), or are an uninterrupted series of contacts over the long term (longitudinal continuity) *(10)*.

Coordination: a service characteristic resulting in coherent treatment plans for individual patients. Each plan should have clear goals and necessary and effective interventions, no more and no less. Cross-sectional coordination means the coordination of information and services within an episode of care. Longitudinal coordination means the interlinkages among staff members and agencies over a longer period of treatment" *(10)*.

Financing: function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system *(8)*.

Family medicine teams: Family medicine teams can vary from country to country and in size: the core team usually encompasses the family doctor and a nurse, but can cosist of a multidisciplinary team of up to 30 professionals, including community nurses, midwifes, feldshers (medical attendants), dentists, physiotherapists, social workers, psychiatrists, speech therapists, dieticians, pharmacists, administrative staff and managers, etc. *(21)*. In 2003, WHO used the description that a primary care team is a group of "fellow professionals with complementary contributions to make in patient care. This would be part of a broader social trend away from deference and hierarchy and towards mutual respect and shared responsibility and cooperation" *(22)*. By definition, family medicine teams are patient-centred and therefore their composition and organizational model cannot but change over time: it is a flexible construct.

General practice: General practice is a term now often used loosely to cover the general practitioner and other personnel as well, and is therefore synonymous with primary care and family medicine. Originally, it was meant to describe the concept and model around the most significant single player in primary care: the general practitioner or primary care physician, while family medicine originally encompassed more the notion of a team approach. Whenever the notion of solo practitioner (general practice)

versus team-based approach (family medicine) is relevant, the distinction should be made. According to Atun, the specificity of the general practitioner is that he/she is "the only clinician who operates in the nine levels of care: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of disease complications, rehabilitation, palliative care and counselling" *(23)*

Primary health care: This term should be used when it is intended to refer to the broad concept elaborated in the Declaration of Alma Ata (1978) with its principles of equity, participation, intersectoral action and appropriate technology and its central place of the health system *(24)*.

Primary care: is more than just the level of care or the gate-keeping – it is a key process in the health system. It is the first contact, accessible, continued, comprehensive and co-ordinated care: first contact care is accessible at the time of need; ongoing care focuses on the long-term health of a person, rather the short duration of the disease; comprehensive care is a range of services appropriate to the common problems in the respective population and coordination is the role by which primary care acts to co-ordinate other specialists that the patient may need *(23)*. Primary care is a subset of primary health care.

Performance: (or composite goal performance) is defined as a relative concept: the extent to which the health system involves relating goal attainment to what could be achieved in the given context of the country *(1)*.

Resource generation: the provision of essential inputs to the health system, including human capital, physical capital and consumables *(1)*.

Responsiveness: is measure of how the system performs relative to non-health aspects, meeting or not meeting a population's expectations of how it should be treated by providers of prevention, care or non-personal services (not a measure of how the system responds to health needs, which shows up in health outcomes). Enhancing responsiveness to the expectations of the population, includes: (a) respect for persons (including dignity, confidentiality [of information] and autonomy of individuals and families to decide about their own health); and (b) client orientation (including prompt attention, access to social support networks during care, providing quality of basic amenities and choice of provider) *(1)*.

Stewardship: a function of a government responsible for the welfare of the population, and concerned with the trust and legitimacy with which its activities are viewed by the citizenry. It includes the overseeing and guiding of the working and the development of the nation's health actions on the government's behalf. The components of stewardship are: Health policy formulation (defining the vision and direction for the health system); Regulation (setting fair rules of the game with a level playing field) and Intelligence (assessing performance and sharing information) *(1,8)*.

ANNEX 2 PRIMARY CARE PHYSICIANS IN TURKEY

Table 38: Number of active primary care physicians per province in Turkey[3]

Name of province	Active physicians (FDs)	Name of province	Active physicians (FDs)
Adana	797	Kahramanmaraş	390
Adıyaman	194 (163)	Karabük	110
Afyonkarahisar	279	Karaman	93
Ağrı	142	Kars	102
Aksaray	152	Kastamonu	158
Amasya	150	Kayseri	527
Ankara	1604	Kilis	49
Antalya	976	Kırıkkale	133
Ardahan	39	Kırklareli	138
Artvin	73	Kırşehir	103
Aydın	635	Kocaeli	562
Balıkesir	506	Konya	908
Bartın	68 (57)	Kütahya	225
Batman	166	Malatya	327
Bayburt	25	Manisa	588
Bilecik	83	Mardin	229
Bingöl	99	Mersin	699
Bitlis	102	Muğla	514
Bolu	106 (69)	Muş	127
Burdur	124	Nevşehir	128
Bursa	946	Niğde	150
Çanakkale	230	Ordu	278
Çankırı	70	Osmaniye	198
Çorum	240	Rize	132
Denizli	369 (260)	Sakarya	361
Diyarbakır	538	Samsun	436 (342)
Düzce	143 (104)	Şanlıurfa	450
Edirne	141 (110)	Siirt	103
Elazığ	220 (168)	Sinop	72 (55)
Erzincan	76	Şırnak	119
Erzurum	356	Sivas	259
Eskişehir	275 (208)	Tekirdağ	302
Gaziantep	566	Tokat	238
Giresun	169	Trabzon	355
Gümüşhane	52 (35)	Tunceli	30
Hakkâri	71	Uşak	172
Hatay	505	Van	317
Iğdır	60	Yalova	90

3   This table refers to health centres under the responsibility of the Ministry of Health, which is 75% of all health centres in Turkey. The numbers in brackets signify the number of newly trained family doctors. Source: Ministry of Health, Turkey, 2008.

Evaluation of the organizational model of primary care in Turkey

Name of province	Active physicians (FDs)	Name of province	Active physicians (FDs)
Isparta	151 (117)	Yozgat	193
Istanbul	3745	Zonguldak	227
İzmir	1650 (1087)		
		TOTAL (81 provinces)	**27485**

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SUMMARY

Although the strengthening of primary care services is a priority of health reforms in many countries, both in Central/Eastern and in Western Europe, backgrounds and reasons for reforms are not similar. In Western Europe emphasis on primary care is expected to be an answer to questions of rising costs and changing demand as a result of demographic and epidemiological trends. Central and Eastern European countries, as well as former Soviet Union countries, are struggling to fundamentally improve the performance of their entire health systems. Primary care is now being reorganized in many countries to bring adequate and responsive health services closer to the population.

In many countries in transition health reforms are part of profound and comprehensive changes of essential societal functions and values. Reforms of (primary) care are not always based on evidence, and progress is often driven by political arguments or interests from specific professional groups rather than on the basis of sound evaluations. However, policy makers and managers nowadays increasingly demand for evidence about progress of reforms and responsiveness of services.

This report evaluates developments in primary care in Turkey, using a methodology that characterizes a good primary care system as one that is comprehensive, accessible, coordinated and integrated; that ensures continuity; and that recognizes that all health-system functions outlined in the WHO framework are equally considered in work to improve the overall health system. This means that the financing arrangements, service delivery, human and other resources (such as appropriate facilities, equipment and drugs) and finally all necessary legal frameworks and regulations are in place, and the system is steered by the right leader. The report thus offers a structured overview of the strengths and weaknesses of a country's organizational model for primary care services – including the voices of the professionals and patients concerned – to interested policy-makers and stakeholders.