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Follow-up Status of Patients Referring to Secondary and Tertiary Hospitals in Family Health Centers

Sonay Gökçeoğlu,[1] Mehmet Reşat Ceylan,[1] Emine Beyaz[2]

[1]Şanlıurfa Provience Health Directorate, Public Health, Şanlıurfa, Türkiye
[2]Department of Midwifery Muş Alparslan University, Health Sciences Faculty, Muş, Türkiye

ABSTRACT

Objectives: This study aimed to evaluate the frequency of patients' preference for other health care services instead of receiving health care services from Family Health Center (FHC) and the factors affecting this preference.

Methods: The cross-sectional study involving 1217 patients was conducted between 12 and 22, December 2023. Among the patients who applied to the outpatient clinic, all patients who agreed to participate in the study were included in the study without skipping a line. Thus, the sample group was randomly selected. Data were collected using a structured information form. Face-to-face interviews were conducted with the patients in the study.

Results: The study included 1217 patients who were admitted to the hospital for outpatient treatment, and 729 (59.9%) of the patients were treated in hospitals despite being eligible for diagnosis and treatment at the FHC. When the factors determining the tendency to seek care in FHC were evaluated, being 18 years of age or older 2.133 times (CI: 1.518–2.997; p<0.001), being literate or more educated 2.410 times (CI: 1.713–3.391; p<0.001), having income equal to or more than expenses 2.418 times (CI: 1.712–3.415; p<0.001), having a large family type 418 times (CI: 1. 712–3.415; p<0.001), having a large family type 1.954 times (CI: 1.309–2.917; p=0.001), being satisfied with the FHC 1.515 times (CI: 1.058–2.170; p=0.023), having a complaint duration of 8–90 days 2.368 times (CI: 1.465–3.828; p<0.001) have an effect.

Conclusion: In this study, 59.9% of hospital admissions were found to be unnecessary admissions, suggesting that primary health care services are not used effectively.

Keywords: Health care system, outpatient health services, primary healthcare, public hospitals, referral

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Address for correspondence: Dr. Sonay Gökçeoğlu. Şanlıurfa Provience Health Directorate, Public Health, Şanlıurfa, Türkiye

Phone: +90 537 595 19 46

E-mail: sonay.gokceoglu@gmail.com

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INTRODUCTION

Healthy societies and nations are built upon healthcare systems that prioritize preventive healthcare services as much as curative ones.[1] Following the Alma Ata Declaration, the significance of primary healthcare services has been widely acknowledged, leading to global efforts to enhance such services.[1,2] In Türkiye, the Health Transformation Policy implemented in 2003 introduced substantial reforms in healthcare service delivery. With this transformation, the goal was to elevate primary healthcare practices and service providers. In the new era of healthcare, the Family Medicine model was developed to ensure more accessible and effective primary care.[1,3] According to this model, healthcare services should initiate at the primary care level and progress, as needed, with patients being referred by their family physicians to secondary and tertiary healthcare facilities. Disruption in this healthcare delivery system results in chaos, where the family medicine system fails, and hospitals become overwhelmed. Delivering healthcare services that should be provided in Family Health Centers (FHC) in secondary and tertiary healthcare facilities is a situation that rapidly depletes the country's financial resources

and negatively affects the continuity of service. The absence of an active referral system in Türkiye undermines the integrity of the healthcare system, leading to the misuse of hospitals and the provision of substandard healthcare services.[4-6]

In fact, in 2022, 39.9% of all physician visits in Türkiye were made to primary care and 60.1% to secondary and tertiary healthcare institutions.[7] While the number of physician visits per person was 3.1 in 2002, it increased to 10 in 2022. In the Southeastern Anatolia region, the average number of physician visits per person was 2.3 in 2002 and reached 9 in 2022; only 3.5 of these were made to primary care institutions. Although the Health Transformation Policy increased access to healthcare services and usage levels, it could not provide the expected improvement in the level of preference for primary care institutions.

This study aimed to evaluate the frequency of patients' preference for secondary and tertiary health care services instead of receiving health care services from FHC and the factors affecting this preference.

METHOD

The cross-sectional study was conducted in three public hospitals (Health Science University Mehmet Akif İnan Training and Research Hospital, Şanlıurfa Training and Research Hospital and Balıklıgöl State Hospital) located in the provincial center of Şanlıurfa between 12 and 22, December 2023. This research was conducted in a Şanlıurfa city where the fertility rate and child population are highest and the socioeconomic level is quite low. Centers with the potential to represent the average health service use of the city were chosen for the study.[8]

The population of the study consisted of patients who were examined in pediatrics, internal medicine, child and adolescent mental health, physical therapy and rehabilitation, neurology, cardiology, chest, infectious diseases, ear nose and throat, gynecology, and obstetrics outpatient clinics. Departments where polyclinic applications are intense, where patients followed up in FHCs apply, and where there have been problems in finding an appointment for examination in the recent period, were selected. Patients referred to subspecialty clinics for preoperative evaluation and consultation were excluded in the study.

No sample selection was made, and every patient who agreed to participate in the study among the patients applying to the outpatient clinics was included in the study without skipping a turn. Thus, the sample was randomly selected. It was aimed to reach the entire universe and 1217 patients were studied.

A polyclinic was selected from each department so as not to disrupt the hospital's operations. All patients who accepted to participate in the study from among the patients who applied to the selected polyclinics were included in the study without skipping a turn. During data collection, help was received from the parent/patient's relative for patients under the age of 18 and for patients who could not be contacted one-to-one. A structured information form consisting of 19 questions was used in the study. Data was collected using the face-to-face interview technique. The information form questioned the patients' socio-demographic characteristics, health service usage preferences, and the physician's opinion on the current application. The form consists of two parts, the sections to be answered by the patients and the physician. The patient-related section of the survey was filled out by the hospital's Information Technology (IT) personnel during face-to-face interviews with the patients; the physician-related section was filled out by the physician at the end of the patient's examination. The average data collection time for each patient was six minutes. Interpreter support was provided for patients who did not speak Turkish. The IT personnel and physicians who worked in data collection were informed about the survey before the research. In the information form, the physician was asked which health institution the patient should apply to with his/her current complaint and preliminary diagnosis. In line with the answer, unnecessary outpatient clinic application status was determined.

The dependent variable of the study is the situation of thinking that FHCs should be preferred with current complaints. Independent variables are age, gender, education level, income level, employment status, family type, presence of chronic diseases, number of days of complaints, and satisfaction level with FHCs.

Analysis was conducted using SPSS 25.0 statistical software. Descriptive statistics (frequency, percentage), Continuity Correction Chi-square (gender, employment status, chronic illness status), and Pearson Chi-square (age groups, educational status, income level, family type, satisfaction with FHCs, complaint duration) tests were used for data analysis. Multiple Logistic Regression analysis was performed for variables found to be significant in univariate analysis. Statistical significance was accepted as $p<0.05$.

RESULTS

The study was conducted with 1217 patients who applied to the hospital for outpatient treatment. The sociodemographic characteristics of the patients are summarized in Table 1.

Table 1. The sociodemographic characteristics of the patients

	n (%)
Age groups	
0–17 years	457 (37.6)
18–24 years	169 (13.9)
25–64 years	554 (45.5)
65 years and above	37 (3.0)
Gender	
Female	730 (60.0)
Male	487 (40.0)
Educational status	
Does not speak Turkish	41 (3.4)
Illiterate	257 (21.1)
Literate	105 (8.6)
Primary school	174 (14.3)
Middle school	212 (17.4)
High school	237 (19.5)
University and above	191 (15.7)
Employment status	
Yes	329 (27.0)
No	888 (73.0)
Occupations of workers	
Civil servant	122 (37.1)
Worker	106 (32.2)
Tradesmen	50 (15.2)
Farmer	51 (15.5)
Income level	
Less than expenses	621 (51.0)
Equal to expenses	524 (43.1)
More than expenses	72 (5.9)
Family type	
Nuclear	862 (70.8)
Extended	355 (29.2)
Chronic illness	
Yes	170 (14.0)
No	1047 (86.0)
Comorbidities*	
Diabetes/HT/Cholesterol	74 (43.5)
Asthma/COPD/Chronic bronchitis	48 (28.2)
Chronic hepatitis	20 (11.8)
Cardiac disease	7 (4.1)
MS/Epilepsy/Migraine	7 (4.1)
OCD/SCH/Bipolar/ADHD	6 (3.5)
Allergy	3 (1.8)
Rheumatic disease	3 (1.8)
Chronic intestinal disease	2 (1.2)

*Among those with chronic illnesses.

ADHD: Attention deficit hyperactivity disorder; COPD: Chronic obstructive pulmonary disease; HT: Hypertension; MS: Multiple sclerosis; OCD: Obsessive-compulsive disorder; SCH: Schizophrenia.

Of the patients, 895 (73.5%) preferred hospital care without first consulting their family physician regarding their current complaints. The complaints and health service utilization characteristics during the hospitalization of the patients are summarized in Table 2.

Although they were suitable for diagnosis and treatment at the FHC, 729 (59.9%) of the patients applied to the hospital. Follow-up status in the FHC for the applications made are summarized in Table 3.

When the patients were evaluated according to the characteristics of health service seeking, significant differences were found in terms of age groups, education status, income level, satisfaction with the services in FHC, and duration of complaint ($p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$, $p<0.001$, respectively). Significant differences in these variables were observed in the 0–17 age group for age groups, in the uneducated group for education status, in the less than expenses group for income level, in the satisfied group for satisfaction with diagnosis and treatment at the FHC, and in the 8–90 days group for duration of complaint. The seeking for health services according to sociodemographic characteristics of the patients are summarized in Table 4.

When the factors determining the tendency to seek care in FHC were evaluated, age groups, educational status, income level, family type, satisfaction with diagnosis and treatment at the FHC, and duration of complaint were found to be significant (Coefficients of the logistic regression model=132.543, $p<0.001$). The factors determining the tendency to seek care in FHC are summarized in Table 5.

DISCUSSION

In this research, the reasons why institutions are preferred for health care and unnecessary applications to polyclinics are examined. It has been determined that patients first prefer public hospitals for their complaints, primary care institutions are often overlooked, and more than half of hospital applications are unnecessary. The health service structure in Türkiye has been shaped through FHC, 2nd and 3rd level hospitals.[2,9] For the health system to function properly, especially primary health services should be used effectively; all applications should be made to FHCs in all cases except for emergencies. However, it has become common for patients to directly visit hospitals without consulting a family physician first.[10,11] The study revealed that a significant number of patients visited hospitals for reasons such as pain, upper respiratory tract infection, gastrointestinal system, pregnancy monitoring, and general check-ups. Interestingly, patients even sought hospi-

Table 2. The complaints and health service utilisation characteristics during hospitalisation of the patients

	n (%)
Complaint duration	
0–7 days	672 (55.9)
8–90 days	288 (25.7)
91–180 days	33 (2.9)
181 days and above	129 (11.5)
Reason for admission	
Pain	268 (22.0)
General examination, follow-up	135 (11.1)
Pregnancy monitoring and conditions accompanying pregnancy	156 (12.9)
Gastrointestinal system complaints (diarrhea, constipation, bloating, nausea, vomiting)	102 (8.3)
Cough, shortness of breath	94 (7.8)
Weakness, fatigue, loss of appetite	51 (4.2)
Upper respiratory tract infection complaints (including sore throat)	51 (4.2)
Fever	39 (3.2)
Skin complaints	43 (3.4)
Urinary system complaints	31 (2.5)
Menstrual irregularity	27 (2.2)
Medication or medical report request	24 (2.0)
Contraceptive need/counseling	23 (1.9)
Neurological complaints (numbness, tremors, forgetfulness, fainting, dizziness, hand tremors)	23 (1.9)
Psychiatric complaints (distress, obsession, continuous monitoring, fear of surveillance, gaming addiction, inability to communicate)	23 (1.9)
Irregular blood sugar levels	22 (1.8)
Growth retardation	20 (1.6)
Cardiac complaints (palpitations, leg edema, chest pain)	18 (1.5)
Genital complaints	16 (1.3)
Anal area complaints (itching, pain, bleeding, hemorrhoids)	10 (0.8)
Uncontrolled hypertension	10 (0.8)
Academic failure, inattention, speech impairment	13 (1.1)
Obesity-related complaints	8 (0.7)
Nosebleeds, hearing loss, ringing in the ears	7 (0.6)
Cancer screening	2 (0.2)
Infertility	1 (0.1)
Reason for not consulting your family physician for the current complaint	
I do not find the healthcare services provided at the FHC sufficient.	219 (24.5)
I wanted to consult a specialist physician.	178 (19.9)
I do not find my family physician's knowledge sufficient.	149 (16.6)
I usually do not visit the FHC.	115 (12.8)
My family physician is very indifferent.	77 (8.6)
I am under follow-up at the hospital.	61 (6.8)
I could not get an appointment.	43 (4.8)
It was said that tests cannot be performed at the FHC.	16 (1.8)
The FHC is far from my home.	25 (2.8)
My family physician does not prescribe the medications I want/request.	12 (1.4)
Satisfaction with the diagnosis and treatment received from the FHC	
Not satisfied	264 (21.7)
Undecided	633 (52.0)
Satisfied	320 (26.3)

Table 2. The complaints and health service utilisation characteristics during hospitalisation of the patients (CONT.)

	n (%)
Health institutions to which another person with the same complaint can apply	
FHC	198 (16.3)
State hospital	758 (62.3)
University hospital	183 (15.0)
Private hospital	78 (6.4)
The first health institution usually consulted for any complaint, except in emergencies	
FHC	192 (15.8)
State hospital	911 (74.9)
University hospital	52 (4.3)
Private hospital	62 (5.0)
Reason why FHC is not the first choice for any complaint	
Limited diagnostic facilities at the FHC	282 (27.5)
I want to receive higher-quality service from specialist physicians at the hospital.	254 (24.8)
I do not consider my family physician knowledgeable enough to understand my health problem.	227 (22.1)
I only prefer my family physician to get prescriptions.	137 (13.4)
My family physician does not issue prescriptions or reports.	48 (4.7)
I had issues with my family physician.	40 (3.9)
I only go for vaccinations and follow-ups.	25 (2.4)
The hospital is closer to my home.	12 (1.2)
Requesting a laboratory test*	453 (39.2)
Requesting an imaging*	303 (26.2)

*The physician declined to participate in the study for 61 patients who presented to the relevant outpatient clinics.
FHC: Family health center.

Table 3. Follow-up status in the FHC for the applications made

Specialties	Applications at the polyclinic level (n=1217)	Eligibility for treatment at FHC for each outpatient clinic* (n=729)
Pediatrics	361 (29.7)	266 (73.6)
Internal Medicine	242 (19.9)	153 (63.1)
Obstetrics and Gynecology	215 (17.7)	138 (63.8)
Ear, Nose and Throat	118 (9.7)	49 (40.7)
Child and Adolescent Mental Health	87 (7.1)	9 (9.2)
Pulmonology	70 (5.8)	53 (74.3)
Cardiology	39 (3.2)	23 (59.0)
Infectious Diseases	37 (3.0)	10 (27.0)
Physical Therapy and Rehabilitation	25 (2.1)	18 (70.6)
Neurology	23 (1.9)	10 (45.5)

*The data in this column shows the percentage of patients eligible for treatment at the FHC for each outpatient clinic.
FHC: Family health center.
Data is presented as n (%).

tal care for contraception needs and cancer screening.[12] Despite the primary responsibility of FHCs for preventive healthcare, they are underutilized, indicating a potential lack of public awareness about the services they offer.[2,11,12] Of the patients, 73.5% visited the hospital without consulting a family physician first, and 74.9% generally preferred

Table 4. The seeking for health services according to sociodemographic characteristics of the patients

	Health Facilities where Health Services are Sought		Chi-square	p
	FHC (n=198)	Other (n=1019)		
Age groups			51.008	<0.001*
0–17 years	116 (58.6)	341 (33.5)		
18–24 years	10 (5.1)	159 (15.6)		
25–64 years	71 (35.9)	483 (47.4)		
65 years and above	1 (0.4)	36 (3.5)		
Gender			0.987	0.320†
Female	112 (56.6)	618 (60.6)		
Male	86 (43.4)	401 (39.4)		
Educational status			60.151	<0.001*
Illiterate	88 (44.4)	210 (20.6)		
Literate	12 (6.1)	93 (9.1)		
Primary school	25 (12.6)	149 (14.6)		
Middle school	17 (8.6)	195 (19.1)		
High school	22 (11.1)	215 (21.1)		
University and above	34 (17.2)	157 (15.5)		
Employment status			0.280	0.597†
Yes	50 (25.3)	279 (27.4)		
No	148 (74.7)	740 (72.6)		
Income level			36.764	<0.001*
Less than expenses	140 (70.7)	481 (47.2)		
Equal to expenses	50 (25.3)	474 (46.5)		
More than expenses	8 (4.0)	64 (6.3)		
Family type			13.191	<0.001†
Nuclear	162 (81.8)	700 (68.7)		
Expended	36 (18.2)	319 (31.3)		
Chronic illness			3.341	0.068†
Yes	19 (9.6)	151 (14.8)		
No	179 (90.4)	868 (85.2)		
Satisfaction with diagnosis and treatment at the FHC			120.292	<0.001*
Not satisfied	95 (48.0)	169 (16.6)		
Undecided	42 (21.2)	591 (58.0)		
Satisfied	61 (30.8)	259 (25.4)		
Complaint duration			21.104	<0.001*
0–7 days	124 (76.1)	548 (57.1)		
8–90 days	23 (14.1)	265 (27.6)		
91–180 days	3 (1.8)	30 (3.1)		
181–365 days	13 (8.0)	116 (12.2)		

FHC: Family health center.

Data is presented as n (%).

*Pearson Chi-square, †Continutiy Correction Chi-square.

Table 5. The factors determining the tendency to seek care in FHC

	B	SE	p	OR	95% CI
Age group	0.758	0.173	<0.001	2.133	1.518–2.997
(Ref: 18 years and older group)					
Educational status	0.880	0.174	<0.001	2.410	1.713–3.391
(Ref: Being literate and having higher education)					
Income level	0.883	0.176	<0.001	2.418	1.712–3.415
(Ref: The situation where income is equal to and greater than expenses)					
Family type	0.670	0.204	0.001	1.954	1.309–2.917
(Ref: Extended family type)					
Satisfaction with diagnosis and treatment at the FHC	0.416	0.183	0.023	1.515	1.058–2.170
(Ref: Being satisfied with diagnosis and treatment at FHC)					
Complaint duration	0.862	0.245	<0.001	2.368	1.465–3.828
(Ref: 8 and 90 days)					

FHC: Family health center.
Multiple Logistic Regression.

public hospitals for any medical concern. This suggests that the primary care level is often overlooked by patients.[12,13] Healthcare services that should be provided at the primary care level are often sought at hospitals instead. Similarly, in many hospitals across Türkiye, patients seek care for complaints that do not necessarily require specialist expertise, bypassing the primary care level. Most of these referrals, made without consulting a family physician, end up in the wrong outpatient clinics.[11,13,14] According to data from the Ministry of Health, in 2022, 39.9% of physician visits were made to primary care facilities, while 60.1% were made to secondary and tertiary care facilities. The per capita physician visits were 3.9 at FHCs, whereas it was 6.0 at secondary and tertiary care hospitals. This situation indicates that benefiting from FHCs lags behind hospitals relatively both in the research region and across Türkiye.[2,13-15]

This study revealed that the majority of patients preferring state hospitals without consulting a family physician are dissatisfied with the healthcare services provided at FHCs, including laboratory testing facilities, and the competence of their family physicians. A significant frequency of patients also believe they should always consult a specialist, even if they do not trust their knowledge and experience, while some patients choose their family physician solely to obtain prescriptions. The aim of the family medicine system is for individuals to receive healthcare services from their local healthcare institution. However, with the introduction of the new family medicine practice, individuals were granted the right to choose their preferred physician, thus eliminating the concept of locality in family medicine.[16] This research highlights the significant number of patients who visit hospitals due to the distance from FHCs. Interestingly, while some patients find the testing facilities at FHCs inadequate, a considerable number of specialists still request laboratory tests and imaging studies for many patients. However, most of these laboratory requests consist of routine tests typically conducted at FHCs. The perception of inadequate testing facilities and family physicians' competence at FHCs across Türkiye has reduced patient satisfaction with primary healthcare institutions.[12-14,16,17] The frequency of satisfaction with FHCs in this study was found to be low. In a university hospital in Istanbul in 2017, the satisfaction level with healthcare services provided at FHCs was found to be 22.0%, while in a study conducted in Denizli in 2020, it was 27.5%.[18,19] Despite the passage of years, there has been no significant improvement in patient satisfaction with FHCs. This indicates that as satisfaction with FHCs decreases, patients are more likely to bypass primary healthcare institutions.

The majority of those seeking hospital cares with an expectation of quality health service are actually cases that could be managed at FHCs. For instance, 49.5% of visits to the internal medicine clinic of an educational and research hospital, and 70.7% of those to the ear, nose, and throat clinic of another hospital, could have been managed at FHCs.[11,20] In this study, the frequency of unnecessary visits to outpatient clinics while patients could have been managed at FHCs is 59.9%. Particularly, there have been more than 60.0% unnecessary visits to pediatrics, physical therapy and rehabilitation, internal medicine, obstetrics, and gynecology clinics. However, in more specialized clinics, such as

child psychiatry and infectious diseases, the frequency of unnecessary visits is relatively lower. The research reveals that visits to state hospitals, which patients prefer, often involve cases that could have been managed at FHCs.

In this study, a significant frequency of patients felt that consulting a family physician instead of a hospital was necessary for their current complaint, influenced by various factors. The likelihood of adults visiting primary healthcare centers was lower compared to pediatric patients. The prevalence of respiratory infections in children, often linked to school environments, tends to steer families towards the nearest healthcare center, typically a FHC.[21] The presence of mothers accompanying child patients and the easy accessibility of primary healthcare centers may also contribute to this preference.[21,22] Furthermore, factors beyond maternal influence play a role in healthcare decisions. Patients from extended families were more inclined to believe that hospital visits were necessary instead of consulting FHCs. The extensive familial influence often shapes healthcare decisions, possibly influenced by frequent hospital visits by elderly family members for chronic conditions.[18] Age, education, and socioeconomic status also affect healthcare preferences. Patients with higher education levels and better income tended to prefer primary healthcare centers less compared to illiterate and economically disadvantaged individuals. Surprisingly, an increase in education level reduced the preference for FHCs, contrary to expectations. Alongside education, rising income levels increased expectations for effective and quality healthcare services. Educated individuals with no financial constraints tended to seek care from hospitals and specialist physicians, while less educated and relatively poorer patients found basic healthcare services provided by FHCs sufficient.[23] The study suggested that it is necessary to visit FHCs for symptoms present for the first few days and those persisting for more than three months. Easily accessible family physicians are preferred during the first seven days of symptom onset, with conditions, such as fever accelerating this preference. Hospital visits were primarily for respiratory tract infections and fever complaints. Patients with complaints for 8–90 days were more inclined to consider hospitals as their preferred choice. Concerns arising from symptoms originating from known acute and chronic conditions often lead to referrals to specialist physicians for detailed examination.[24] Surprisingly, those satisfied with the services provided by FHCs were more likely to visit hospitals. Despite satisfaction with their family physician and the services received those who choose hospitals may be unaware of conditions requiring hospital visits and may prefer consultation with a specialist physician. The lack of an active referral system significantly contributes to this situation.[5,6]

The density of patients in outpatient clinics may have negatively affected the participation frequencies of both physicians and patients in the study. This is the main limitation of the study.

CONCLUSION

74.2% of the patients generally applied to the hospital first to receive health care and did not prefer a family physician. Patient satisfaction with FHC is at a low level of 26.3%. The main reason for skipping FHCs was the inadequacy of the health services provided. This situation caused the unnecessary outpatient clinic admission level in hospitals to be 59.9%. Barriers to the effective use of primary care; rapid general practitioner turnover, a newly graduated physician easily becoming a family physician, insufficient family physician specialists in the field, and some physicians not having sufficient field experience. Studies should be conducted to strengthen primary care for the solution, and a referral system that does not bring physicians and patient's face-to-face should be developed. This study highlights unnecessary congestion in hospitals due to the underutilization of primary healthcare services. The objective is to draw attention to the dysfunctional aspects of the system to mitigate further harm to the economy and healthcare workforce.

Disclosures

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