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THE NATURE OF THE CONCEPT OF PRIMARY MEDICAL AID AND ITS PSYCHOLOGICAL ASPECTS

Abstract

Healthcare reform is perhaps one of the most discussed topics in social policy today. In the 1990s, the health care reforms carried out in many countries of the world mainly separated the provision and financing of health care services, leaving the provision of services to the responsibility of the State Insurance Organization (SHI), which was created from the collected insurance premiums. Healthcare reforms in the field of primary care destroy the structures that ensure the provision of integrated health services (Health Centers) and give priority to preventive health services created by the community in the past under the unique conditions of each country. Although the goal is to direct people to therapeutic services, concepts such as efficiency and freedom to choose a doctor are used as the main arguments.

Keywords: *social efficiency, health protection, demand for health, accessibility*

Introduction

Inequality and poverty are the main challenges in healthcare systems today. There are serious disparities in access to health care for low-income individuals both globally and within countries. These inequalities are the reflection of social inequalities. Their elimination is possible only by eliminating social inequalities. However, even in regions with the deepest social inequalities, comprehensive and equitable primary health care has been shown to be highly effective in improving health and reducing health inequalities (Starfield, 2018:36).

Today, the process of fundamental changes in the primary health care service is being implemented in Azerbaijan. There is a serious conflict between the goal and the work done. The proposed new model excludes the most basic features of primary health care, defined by many years of scientific knowledge. The reason for this contradiction is that justifications are being sought for healthcare reforms that are not really about primary care, or even public health. In this environment where concepts are misused and attacks on the health system and the right to health are masked by common phrases, the characteristics of egalitarian and effective primary care have become an issue that needs to be reelucidated.

In the simplest terms, the first healthcare institution that a citizen turns to for various reasons and the healthcare service provided in this institution can be defined as "primary healthcare". This service is offered in different ways in different countries around the world. However, one common feature can be noted. Primary healthcare services are an indispensable part of the healthcare systems of countries (Macinko, Starfield, 2013: 24).

The characteristics of primary health care are grouped under two headings. The first heading is system characteristics, or in other words, structural characteristics, which are linked to national-level policy priorities and support a country's primary care orientation. Characteristics under this heading are the distribution of primary care infrastructure and workforce capacity, the type of funding, the location of services, and the type of health worker responsible for primary health care. The second title defines the functions of primary care based on these system characteristics: initial referral, inclusion, continuity and coordination. The fact that primary medical care is the first stage of individuals entering the health care system, being the first appeal, providing preventive and curative health services to all, except for rare and unusual cases, explains the comprehensiveness and long-term relationship with the patient (Macinko, Starfield, 2013: 26).

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There are two main models for providing primary care services. In the first model, the service is provided by doctors who work independently in their private practices and employ the number and qualifications of staff they want. This model, typical of public and private health insurance systems, is also applied in Italy and England, which are National Health System countries. In the second model, the service is provided by doctors and health workers who work as public employees in public health centers in exchange for wages (Boerma, 2013:47).

In a group of countries, including England, Italy, the Netherlands, Finland, Sweden, Norway, Iceland and Greece, primary care is provided only by general practitioners. On the other hand, in most countries with public or private insurance systems, such as Germany and the United States, specialists can provide primary care services by opening private medical facilities. Portugal and Spain are a special group. Because general practitioners and specialists work in public health centers in these countries. However, this is because these two countries, which have recently transitioned to the National Health System, do not have enough general practitioners for a system based on primary care and fill these gaps with internists and paediatricians (Carlsen, Norheim, 2015:70).

The success of primary care is determined by the education of the primary care physician. Because primary care services are a whole and healthy type of service that has a special responsibility for the health of the people, provides services to meet the needs of society, makes clinical decisions using information about the society and environment where the patient lives. For this reason, the education of primary care physicians should be planned with content relevant to primary care. Students in pre- and post-medical education, mainly in tertiary care institutions, are generally exposed to very rare and highly differentiated diseases in the community and tend to overestimate the likelihood of encountering serious disease upon discharge from tertiary care hospitals (Guy, 2011:16). This trend, combined with the inability to assess people in their social and physical environment and the economic incentives of expensive technologies, the promotional activities of pharmaceutical companies and the influence of the competitive system, results in the introduction of many unnecessary diagnostic tests. For this reason, it is not suitable for physicians who have completed any specialty training other than primary care or have undergone a process that is not specifically designed for primary care and consists only of rotations in other stages of the health care system (Guy, 2011:16).

In public health centers, the physician is only one of many members of the multidisciplinary primary care team. This team also includes other health professionals such as midwives, nurses, environmental technicians, medical secretaries, social workers, psychologists, dentists, pharmacists, and physiotherapists. The participation of various health professionals in the primary care team allows for the common use of social, psychological, and medical knowledge and skills, resulting in the expansion of the patient service framework, comprehensive assessment of problems, reduction of hospital visits, and continuity of medical care. While teamwork allows physicians to spend more time on patient care, preventing excessive workload, it also allows patients who can more easily communicate with non-physician healthcare providers to benefit from healthcare services. In addition, non-physician healthcare workers working in a team have higher job satisfaction and lower levels of disengagement (Baegelhole, Bonita, 2019:15).

The fact that specialists have higher incomes than primary care physicians means that the health care system encourages medical students to specialize, thereby undermining primary care. Strong primary care requires a type of physician whose income level and status in the community is at least as high as that of other specialists. In countries where the National Health System is implemented, the status and income level of primary care physicians play an important role in the success of primary care (Jarman at. el, 2019:318).

Today, there is a strong trend towards multidisciplinary teamwork in Europe, and teamwork is promoted through national policies in Spain, Great Britain, Finland, Spain and Portugal. However, at this point it is useful to explain what teamwork is, or rather, what it is not. Healthcare workers working together does not mean they work as a team. Teamwork requires shared goals, with

everyone understanding and appreciating their role and the roles and skills of others on the team. For teamwork to occur, the professional training of primary medical workers should be organized according to the principles of teamwork. Additionally, teamwork can be difficult when team members have different types of employment, for example, some are contracted, some are permanent, or some are affiliated with a separate organization as a subcontractor (Gulliford at. el, 2014:12).

The implementation of primary medical aid takes place in several stages. Those stages are given according to the scheme below.

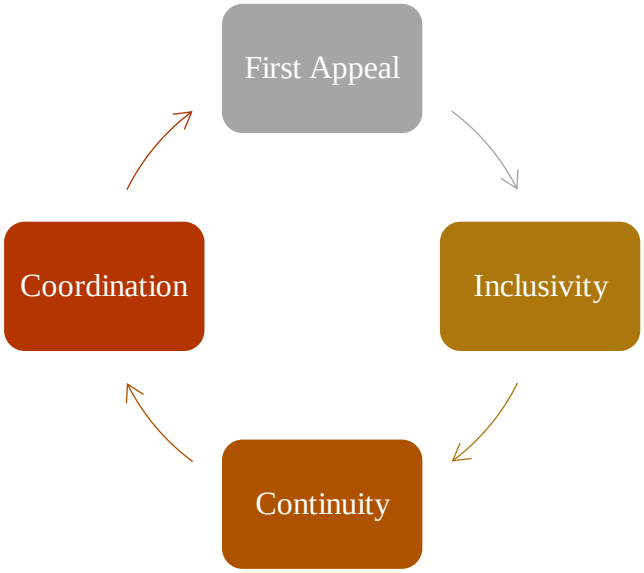

Figure 1. Stages of implementation of first aid

First Appeal. The characteristic of first referral defines primary care as the first stage at which individuals encounter the health care system for each new care need that arises due to a health problem. In a significant number of countries with health systems focused on primary care, specialist services can only be accessed through a referral from a primary care physician. General practitioners' control over patients' use of other stages of the health care system is called "gatekeeping" (Starfield, 2018). Gatekeeping is basically implemented in two different ways. The first model is for general practitioners working in public health centers to serve a geographically defined population, while the second model is for privately employed doctors to serve a patient list of patients registered with them over a period of time (Boerma, 2013). The practice in which patients are not prevented from consulting a specialist at the initial stage of application and access to specialist services is not controlled is called "open system" (Gulliford, at. et, 2014:12). But what this experience brings is not freedom, as the name suggests, but complete chaos in the health care system. In open systems, it is more appropriate to classify health care as ambulatory and inpatient rather than primary, secondary, and tertiary care, and ambulatory care includes all primary care-related services as well as office-based specialist services and outpatient hospital care.

One thing we find particularly useful to note here is that the concepts used involve a certain point of view and therefore care should be taken when using these concepts. Although the term "open" has positive connotations, it describes an unregulated system where anyone can go wherever they want. The concept of "closed" is used instead of a systematic and rational organization, although it gives rise to a negative experience that limits the health rights of individuals. Likewise, gatekeeping emphasizes the blocking function, but is used as a core concept of the system in the sense of filtering out what is not needed.

In private doctor's offices, the service is physician-centered, and other health professionals are only support staff. There are significant differences between doctors and other workers in terms of

type of employment and income level. Today, more and more private doctors come together and share work and opportunities in the private clinics they create, a practice called group practice. A group practice gives physicians significant flexibility and increases the number of tools needed to meet patients' needs under one roof. However, group practice should not be confused with multidisciplinary teamwork and it should not be forgotten that it does not make any difference within the service (Guy, 2011:16).

Gatekeeping brings many advantages, such as ensuring coordinated delivery of services, reducing unnecessary interventions, overuse of specialist services, hospital length of stay and medication use, and preventing inequalities by preventing overuse of services by one segment of the community. Today, there is a trend towards gatekeeping practice, where private general practitioners control the referrals of patients on their lists across Europe, particularly in Eastern Europe. However, this type of gatekeeping, which is part of the process of privatization in health care, only reinforces the physician's responsibility to the patients on his list and distances physicians from providing continuous care to individuals, families, and society at the primary level. Competing with each other to get more patients on their lists, general practitioners are under pressure from patient demands and unable to fulfill their role as gatekeepers to healthcare systems based on patient satisfaction. Gatekeeping can only be applied in countries where primary health services are strong enough and the health system is focused on primary care. The Swedish example is very surprising. The reason for this preference can be attributed to the wide range of services in primary care and the status of general practitioners in society (Guy, 2011:16). When these two conditions are not met, patients prefer to go to emergency rooms or pay to see a specialist directly. In non-community-based, non-community-based primary health care systems based on a market economy, and in countries where the importance of general practitioners is not sufficiently understood by society, the practice of gatekeeping leads to the deterioration of patient-physician relationships, the crushing of doctors under consumer pressure, and the increase of health inequalities.

Inclusivity. The main principle regarding service coverage is that regardless of the type of primary care, it should be able to identify and intervene in all health problems that are common in the community. Therefore, when assessing inclusion, the adequacy of staff training and numbers, institutional capacity, equipment and support services to identify and intervene in these problems is questioned. The level of implementation of activities such as immunization, health education and screening also reflects inclusion. A high application rate, another criterion used to assess inclusion, indicates insufficient inclusion (Starfield, 2018:49).

The World Health Organization, which in the past established the concepts of Primary Health Care and comprehensive primary health care with the Alma-Ata Conference, has now abandoned the principle of "comprehensive care for all" on the grounds that it is expensive. The organization states that governments now have an obligation to provide cost-effective services aimed at protecting the health of their people and treating only the most common health problems, thus improving health statistics and helping economic development, but the goal should not be to provide everything possible. The organization advocates an approach of "inclusiveness but not all-inclusiveness". According to the World Health Organization, governments can prioritize and allocate resources to such areas as immunization, safe motherhood and tobacco control. This depoliticized approach to Primary Health Care is called Selective Primary Health Care. While primary health care (PHC) is based on a broad definition, the concept of selective primary health care (PSHC) offers more technical and limited approaches to health problems - with a focus on child health; While tsh emphasizes equality, tsh considers health as the absence of disease, IHS advocates a multifaceted approach to health, while SIS deals with the management, treatment, and prevention of diseases and major health problems, SIS refers to community participation as full participation, and in SIS, community participation means giving consent. In this context, SISX reduced its work to "immunization, supplementary feeding support, breastfeeding, and distribution of antimalarial drugs" (Kocaturk, 2017).

Continuity. Continuity is the long-term relationship between the patient and the primary care facility regardless of the presence of any health problems. A community definition of continuity includes the availability and use of a regular source of primary care. For a service provider, sustainability reflects the level of knowing the community it serves, knowing the needs of this community, and monitoring whether the needs are met or not (Kutlu, Kapıcıoghlu, 2017:44).

Primary care facilities serving a geographically defined population and having records containing information about these people are key to ensuring sustainability. These records are essential for general practitioners to carry out their public health duties and obtain information that guides the planning of health services. Primary care, which is not organized based on geographically defined regions, is called a practice list system, in which doctors serve only registered patients (Badır, 2015). The roster system does not allow the primary care team to get to know the community. Moreover, in this system, which works with the logic of consumer relations, patients can leave one doctor's list, switch to another, and change doctors again in the next period. In this situation, even if doctors make an effort to get to know their patients, due to the variability of patient lists, it is difficult to obtain results to ensure the continuity of their efforts (Akdemir, Birol, 2015:45).

Coordination. Coordination determines the transfer of information between the first stage and other stages of the system. Three main conditions must be present to ensure coordination. The first condition is the application of "gatekeeping". Other conditions are that, in addition to primary care, all information about patients should be recorded in secondary and tertiary care and that this information be transferred to primary care according to official guidelines. A study evaluating health services in OECD countries reported that coordination remains inadequate even in countries that are quite successful in terms of other primary care characteristics. For this reason, it would not be wrong to define coordination as a feature that is relatively more difficult to achieve.

Conclusion

From the point of view of structural characteristics, it appears that the distribution of the labor force is theoretically predicted. If there is not one family doctor per 3,000 people and there are no volunteers, the appointment approach is based on the principle of equality. In terms of infrastructure, equality is theoretically out of the question. In terms of the financing principle, the choice of family medicine is based on a less egalitarian insurance model and is also evaluated in conjunction with the General Health Insurance model, where user contributions are a form of financing.

The health workers who will provide the service are family doctors who are only trained in treatment services and do not have any responsibility to the community. Obstetricians and gynecologists, nurses and health workers have been defined and de-identified as ancillary health workers and the team concept has been completely eliminated. In terms of practice principles, the choice of family medicine theoretically puts first practice first.

The first step in evaluating the health of a community or the health services provided in that community is to bring together all the relevant variables. However, it is very difficult to interpret these crowded variable lists containing a large number of data and to summarize and analyze the current situation through these lists.

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