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Examination of Reasons Why Individuals Choose Hospitals over Family Medicine

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SUMMARY: The aim of this study is to determine the reasons why individuals prefer hospitals over family medicine and to investigate whether there is a difference in the preferences of them according to their sociodemographic characteristics.
The working community consists of individuals who receive service from family medicine centers in the center of Istanbul. Among these individuals, 93 patients selected by voluntary sampling method have been included in the sample group of the study.
A personal information form questioning the sociodemographic characteristics of the participants and the "Reasons of Individuals Not Preferring Family Physicians" scale developed by Baş (2017) in order to determine the preferences of family medicine centers were used as data collection tools in the study. The scale is in the 5-point Likert type and it shows that the hospital preferences increase as the scores approach 5. By percentage distribution and arithmetic average, descriptive statistical data;by KolmogorovSmirnov test, whether the data was normally distributed or not; by independentsamples t and One-Way ANOVA tests, the gap analyses were analyzed. The SPSS 26.0 program was used in the analyses.
The participants stated that the seriousness of their illnesses ($\bar{x}$=3,59), the insufficiency of family health centers ($\bar{x}$=3,47) and the limited analysis and examination facilities in family medicine ($\bar{x}$=3,14) were more effective in their decision to prefer the hospital over family medicine. The three statements that the participants least supported were; "I go to the hospital because my financial situation is good" ($\bar{x}$=1,88), "I go to the hospital because I do not know the family physician" ($\bar{x}$=1,88) and "I go to the hospital because the family physician behaves worse". With the help of the sociodemographic characteristics of the participants, it was seen that only the income level made a difference in their preferences and it has been determined that those with an income higher than 3000TL prefer hospitals more often than those with lower income.
It is important to raise awareness in the society on the subject of primarily preferring family medicine which has an extensive service network in Turkey and also is expected to have a part in the increase of society's health status. Therefore, it is recommended to strengthen family health services, to introduce existing opportunities and to take the necessary steps for the referral system.
Key Words: Family Medicine, Hospital, Preference of Health Service

I. INTRODUCTION

The main purpose of health services is to help people about protecting their health and avoiding health risks instead of treatment. In this context, avoiding individuals at risk of disease, reducing the risks of individuals at risk, providing early diagnosis and treatment of existing diseases, and preventing permanent damage from chronic diseases are the priorities of health services. Therefore, preventive healthcare and the concept of health promotion become crucial (1).

Primary healthcare services play a leading role in achieving the goals of health services. In the declaration of Alma-Ata, the importance of bringing primary healthcare services as close as possible to the places where people live and work and the sufficiency of the first step that the individual, family and society will establish contact with the national health system are emphasized in raising the health level of countries (2). It is stated that countries with family medicine practice provide more efficient health services both economically and clinically (3).

The value given to family medicine is increasing in almost all countries of the world. Since the 2000s, it has been recognized that the

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family medicine discipline has played a leading role in the healthcare system. In all countries where healthcare services are at a high level, family physicians take on the main role in primary healthcare services (4).

Family medicine practice started in 2005 as a pioneer in Turkey has spread to all provinces in 2010; however, mandatory referral system could not be put into effect. Still, only 33% of all physician applications are made to family medicine units (5). It is observed that individuals often apply to the hospital first instead of family medicine centers. And, it is necessary to examine the reasons why individuals prefer the hospital in order to increase the efficiency and productivity in health services. The purpose of this study is to detect the reasons why individuals prefer the hospital over family medicine centers and to determine whether their preferences differ according to gender, marital status, age, educational status, social security of the family, number of individuals and income of the family.

II. PRIMARY HEALTHCARE AND FAMILY PRACTICE

The purpose of health services is to increase the health level of the society, to take the necessary precautions to prevent individuals from getting sick, to rehabilitate the sick and disabled people as soon as possible and then to adapt them to their social environment (6). Health services are classified as preventive health services, curative health services, rehabilitation services and health promotion services (7). The main goal of preventive health services is to protect the health of the society and to eliminate the factors of the diseases. All of these services are provided with a holistic approach within the scope of primary healthcare (PHC) services (8).

The main pillar of primary healthcare services is that access to healthcare is a right for all people. Primary healthcare provides most of the healthcare services a person needs throughout his/her life. The basic components of the primary health approach are meeting the health needs of individuals throughout their lives, organizing health services by taking into account multi-faceted policies and determinants of health, and self-responsibility of individuals, families and communities about their own health (9).

As a milestone in global health; the principles of the PHC were first determined in 1978 in Alma-Ata, and the Astana Declaration was signed at the Global Primary Health Care Conference by world leaders in Astana in 2018. However, at least half of the world population still cannot get this comprehensive health service. One of the main reasons for this is the lack of quality and number of medical staff to present PHC. The world's healthcare professional deficit is estimated at 18 million. Primary Healthcare is considered a good value investment as it reduces total healthcare costs and increases efficiency by reducing hospital admissions. The role of the PHC is important in achieving the Health-related Sustainable Development Goals (10).

Family physicians are one of the keystones in providing primary healthcare services. They are obliged to provide preventive health services and primary healthcare services to individuals without discrimination. Also, they are considered as a bridge between primary care and upper levels of health services. They usually offer these services at a fixed location or when required, on a full-time mobile basis (11).

III. DEVELOPMENT OF FAMILY MEDICINE IN THE WORLD

Family medicine was first defined in 1923 by the English physician Francis Peabody. He emphasized that a holistic approach to patients is a necessity due to excessive specialization in medical sciences and stated that a comprehensive individual health expertise is required to do that. Despite this opinion, the development and expansion of family medicine which provides comprehensive and individual services dates back to the 1950s. In 1952, Royal College of General Practitioners was established to train specialist physicians to work in primary healthcare services in England. General practice/family medicine was accepted as a specialty in England, 1965 and in the USA, 1969. Following these developments, World Organization of National Colleges, Academies and Academic Associations of General Practitioners/ Family Physicians, WONCA, was established in 1972 (12).

At the Leeuwenhorst meeting held in 1974 in the city of Leeuwenhorst in the Netherlands, the understanding of family medicine was defined in the most general sense; it was emphasized that it was not enough to graduate from a medical school to become a family doctor and family medicine was a specialty; and the duties, authorities and responsibilities of family physicians were defined. In this meeting, it was explained that the family doctor is a licensed medical specialist who provides personal, primary and continuous care services to individuals, families and a specific population as a whole, regardless of age, gender and disease (13).
Olesen and his colleagues reconsidered the definition of family medicine/general practitioner and identified it as a specialist trained to work at

the forefront of a healthcare system and take the first steps towards caring for the health problems the patients may have. According to this definition, the general practitioner provides care to individuals in a community, regardless of the type of disease or other personal and social characteristics, and organizes resources in the health system for the best advantage of patients. It is recommended for a general practitioner to deal with individuals in the fields of prevention, diagnosis, treatment, care and rehabilitation using and integrating biomedical, medical psychology and medical sociology (14).

The general practitioners or family physicians provide a family with care in the context of individual and society regardless of race, religion, culture and social class. They are responsible for providing most of their care clinically, taking into account the cultural, socioeconomic and psychological background of their patients. Additionally, they take care of their patients with comprehensive and continuous care. The main purpose of the family doctors is to make an early diagnosis. They make the first decisions about every problem presented to them as doctors and take responsibility for the continuous management of patients with chronic, recurrent or fatal diseases (15). Family physicians working in collaboration with medical and non-medical professions are specialist physicians who have responsibility for the society and know when to intervene in order to improve the health of individuals and families (13).

The WONCA European Region has defined family medicine as "an academic and scientific discipline with its own educational content, research, evidence-based and clinical applications and a clinical specialty focused on primary care". General practice and family medicine are generally used in the same sense, but unlike basic practitioners, family physicians complete their pre-graduate medical education and receive at least three years of primary care specialty training as a general practitioner. The duration of this specialty training in Europe is three years in thirteen countries, four years in seven countries and five years in six countries. And in Turkey, the duration of the same training is three years, as well. With the decisions of the European Council in 1986, 1993 and 2001, the duration of specialty training, which was at least 2 years from 1995, must be at least 3 years from 2001 (16).

Family physicians who have received the specified trainings provide services within the scope of the five basic components below;

- **Team Approach:** The ability of family physicians to meet the health needs of the population they have to provide health services is directly proportional to the team approach. In a team approach, doctors take responsibility for patient care and share risk (17).
- **Electronic Medical Records:** Regular and continuous patient records increase the quality of healthcare services (18). One of the ways healthcare providers improve the quality of patient care is to keep patient records continuous and organized (18, 19). Family physicians keep track of basic information of patients with electronic medical records to ensure patient safety (20).
- **Referral and Consultation:** Guidance and consultation are important among primary care physicians and hospital physicians in order to evaluate the diagnosis and findings of patients and to meet the emergency health needs of the patient (16).
- **Family Health Unit Management:** Being a good family doctor requires clinical skills as well as managerial skills. Poor management of the family medicine unit decreases the quality of patient care, patient satisfaction and the motivation of employees (20).
- **Chronic Disease Management:** Chronic diseases constitute the biggest part of the disease burden in societies. These diseases cause other illnesses and death. Therefore, the importance of chronic disease management is increasing day by day (21).

IV. FAMILY MEDICINE IN TURKEY

In Turkey, family medicine specialist training began in a total of nine Ministry of Health, Training and Research Hospitals located in Istanbul, Ankara and Izmir in 1985. The first department of Family Medicine was established in Trakya University, Faculty of Medicine in 1993. The family medicine system, which started its pilot scheme in Düzce in 2005 with the Health Transformation policy, spread throughout the country in 2010. According to annual health statistics data (2018), a total of 200 family medicine units and 14 family health centers are available in Turkey. While the population per family medicine unit is 3124, the population per family doctor is 3405 and the number of applications to the units has increased by 20% between the years of 2014 and 2018. However, the number of applications to family medicine has a share of only 33% among all physician applications. Referral rate from family medicine is between 0.2% and 0.3% (5). In Turkey, there are 79 Department of Family Medicine and 35 Training and Research Hospitals, Family Practice

Clinic. In Turkey, the Academic Staff consists of 56 professors, 56 associate professors, 71 PhDs, 20 chief residents, 10 lecturers and 50 specialists (16).

In the Family Medicine Implementation Regulation published in the Official Gazette in 2013 in Turkey, family physicians are defined as experts who receive the training stipulated by the institution or family medicine specialists who are obliged to provide personal protective health services and primary care diagnosis, treatment and rehabilitative health services to each person comprehensively and continuously in a specific place regardless of age, gender and disease; provide mobile health services to the extent necessary; work on a full time basis. In the same regulation, the structure consisting of a family physician and at least one family health personnel is defined as a family medicine unit, whereas, a health institution where family medicine service is provided by one or more family physicians and family health personnel is defined as a family health center. According to the regulation, family physicians are expected to provide a wide range of integrated and holistic health services, including home visits, periodic examinations, follow-up of chronic patients, reproductive health and immunization services (22).

Determining the frequency and reasons of use of family medicine services, as in other departments of health services, enables the evaluation of the performance of the health system and encouragement of access to health services. Individuals' demographic characteristics (age, gender and marital status), socio-cultural characteristics (education, ethnicity and occupational status), health levels, belief, attitudes and behaviors regarding health and health services affect their level of health service use.

V. MATERIAL AND METHOD

5.1. Aim of the Study

The aim of this study is to determine the reasons why individuals prefer the hospital over family medicine centers and to investigate whether their preferences differ according to gender, marital status, age, educational status, social security of the family, number of family members and income.

5.2. Type of Research

This is a descriptive, deductive and cross-sectional study.

5.3. Population and Sample

The population of the study consists of individuals benefiting from family medicine centers in the city center of Istanbul. Among these, 93 individuals selected by the convenience method have been included in the sample group of the study.

5.4. Data Collection Tool

In the study, the personal information form developed by the researcher in order to determine the sociodemographic characteristics of the participants and the 5-point Likert-type scale entitled "The Reasons Why Individuals Do Not Prefer Family Physicians" developed by Baş in 2017 to determine the reasons why individuals prefer the hospital over family medicine centers were used (23). The scale consists of 37 statements except for open-ended questions, and 10 subjects were removed from the scale as a result of the factor analysis performed by Baş. It was answered by the participants as "1- I totally disagree" and "5- I strongly agree". The reliability coefficient of the Reasons Why Individuals Do Not Prefer Family Physicians questionnaire was calculated by Baş and found to be 0.905, and it was concluded that it was highly reliable. Propositional statements within the scope of the scale are interpreted as "Not Effective at All" for 1.00-1.80, "Less Effective" for 1.81-2.60, "Moderately Effective" for 2.61-3.40, "Mostly Effective" for 3.41-4.20 and "Absolutely Effective" for 4.21-5.00. The closer the scores given to the propositions in the scale to 5, it is understood that the proposition is more effective in choosing the hospital. Permission for the use of the scale was obtained from Baş via e-mail.

5.5. Research Questions

The research questions below were tested in the study;

1. What are the reasons for individuals to choose the hospital instead of family medicine?
2. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to gender factor?
3. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the marital status factor?
4. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the educational status factor?
5. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the age factor?
6. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the income factor?

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7. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the family's social security factor?
8. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the occupational group factor?
9. Is there any kind of differences among individuals' tendencies to prefer hospitals over family medicine according to the number of family member factor?

5.6. Analysis of Data

By percentage distribution and arithmetic average, descriptive statistical data; by KolmogorovSmirnov test, whether the data was normally distributed or not; by independentsamples t and One-Way Anova tests, the gap analyses were analyzed. The SPSS 26.0 program was used in the analyses.

VI. FINDINGS

6.1. Reliability Findings of the Scale

Internal consistency reliability analyzes related to the scale used in the study were made; and the Cronbach'salpha value of the 27 propositional family medicine scale was calculated as 0.920. This shows that the scale reliability is high.

6.2.Demographic Characteristics of Participants

Distribution of the participants according to their sociodemographic characteristics is shown in Table 1.

Table 1: Sociodemographic characteristics of participants (n=93)

	n	%		n	%
Educational Status			**Marital Status**		
Primary School	17	18,3	Married	45	48,4
Secondary School	12	12,9	Single	48	51,6
HighSchool	19	20,4	**Gender**		
Bachelor's Degree	29	31,2	Female	43	46,2
Master's Degree	16	17,2	Male	50	53,8
Age			**Income Status**		
18 - 22	25	26,9	≤ 1000 TL	26	28,0
23-35	27	29,0	1000 TL – 1999 TL	19	20,4
36-49	22	23,7	2000 TL – 2999 TL	19	20,4
50 or above	19	20,4	≥ 3000 TL	29	31,2
Number of People in Household			**Social Security**		
1	2	2,2	Retirement Fund	8	8,6
2	8	8,6	Social Insurance Institution	52	55,9
3	14	15,1	BAGKUR	19	20,4
4	25	26,9	Legal Dependent	14	15,0
5	23	24,7	**Occupation**		
6 and above	21	22,6	Official	15	16,1
			Private Sector	31	33,3
			Housewife	11	11,8
			Student	36	38,7

29% of the participants in the study are between the ages of 23-35, 53.8% are male, 31.2% are university graduates and 51.6% are single. 31.2% of the participants have an income of 3000 TL or more. The proportion of those living with 4 people in the household is 26.9%, and 2% of them live alone. When their distribution was examined according to their professions, it was seen that 38.7% were students and 11.8% were housewives. While 85% of the participants have SGK guarantee, 15% of them are legal dependents.

6.3. Reasons for Patients to Prefer the Hospital to Family Practice

The standard deviation and average values of the answers given by the participants to the 27

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statements included in the family medicine scale are presented in Table 2.

Table 2: Scores and Standard Deviation Values on the "Reasons of Individuals for Not Preferring Family Physicians Scale"

	Reasons for Patients to Prefer Hospital to Family Medicine	**Average**	**Standard Deviation**
37	I go to the hospital when I think my illness is serious.	3,59	1,28
5	I go to the hospital because analysis and examination opportunities are limited in family medicine.	3,47	1,30
30	I go to the hospital because the family doctor cannot prescribe some medications.	3,14	1,32
2	I go to the hospital because I think the specialist is generally more informed than the family doctor.	3,05	1,36
6	I go to the hospital because the analyzes done in the family medicine take a long time to result.	2,89	1,23
7	I go to the hospitals because they offer more comprehensive diagnosis and treatment than family medicine.	2,88	1,23
33	If I have any illnesses, I go to the hospital (to a specialist physician) with the advice of the people around me.	2,84	1,24
29	I go to the hospital because I think my concern will be resolved sooner than family medicine.	2,83	1,33
16	I do not prefer family doctors just because they usually direct me to the hospital.	2,78	1,21
3	I go to the hospital because I do not think the family doctor is experienced.	2,75	1,27
4	I go to the hospital because I cannot reach the family doctor after working hours.	2,69	1,37
28	I go to the hospital because I consider going to the family doctor as a waste of time.	2,51	1,29
34	I go to the hospital because it is a habit for me.	2,49	1,24
27	I do not go to the family doctor because of the lack of information and publicity about family medicine.	2,48	1,08
1	I go to the hospital because I do not trust the family doctor's knowledge.	2,47	1,29
8	I go to the hospital because the external appearance of family medicine does not give me the confidence that my problem will be solved.	2,44	1,31
19	I do not go to my family doctor because it is easy to reach a specialist physician.	2,43	1,17
26	I go to the hospital because I do not think the family medicine practice is different from the health center practice.	2,43	1,17
36	I go to the hospital because I have a chronic illness (diabetes, high blood pressure, asthma, etc.)	2,39	1,29
17	I do not go to the family doctor because there is no obligation for me to go to family medicine.	2,33	1,19
18	Since there is no appointment system in family medicine, I go to the hospital.	2,33	1,22
21	I go to the hospital due to the negative behaviors of non-physician personnel working in family medicine.	2,32	1,22
13	I go to the hospital because the family doctor does not pay enough attention to my complaints.	2,30	1,27
10	I do not go to the family doctor because it is far from my home.	2,13	1,11
9	I go to the hospital because the family doctor treats worse.	1,99	1,22

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11	I go to the hospital because I am not familiar with the family doctor.	1,88	1,07
12	I go to the hospital because my financial situation is good.	1,88	1,07

When the scores given to the statements in the "Reasons of Individuals for Not Preferring Family Physicians Scale" were examined, it was seen that the participants gave the highest three points among the statements regarding the reasons of the hospital preferences to "I go to the hospital when I think my illness is serious ." ($\bar{x}$=3,59), "I go to the hospital because analysis and examination opportunities are limited in family medicine." ($\bar{x}$=3,47) and "I go to the hospital because the family doctor cannot prescribe some medications." ($\bar{x}$=3,14). The statements that the participants least supported are "I go to the hospital because my financial situation is good ." ($\bar{x}$=1,88), "I go to the hospital because I am not familiar with family doctor." ($\bar{x}$=1,88) and "I go to the hospital because the family doctor treats worse ." ($\bar{x}$=1,99). None of the 27 statements in the scale were found to be "absolutely effective" in hospital preference, 2 of them were "mostly effective", 9 of them were "moderately effective" and 16 of them were "less effective." Also, none of the statements were marked as "not effective at all."

6.4. Comparison of Individuals' Preference Tendencies According to their Sociodemo graphic Characteristics

The test results showing that there is no significant difference among the scores of the patients who participated in the study for choosing the hospital according to their sociodemographic characteristics appear in Table 3.

Table 3: Scores in preferring the hospital to family medicine according to sociodemographic characteristics

Family Medicine Preference Status	**Variable**	**n**	**Average**	**F**	**t**	**p**
Gender	Female	43	46,2		3,529	,064
	Male	50	53,8			
Marital Status	Married	45	48,4		,897	,347
	Single	48	51,6			
Educational Status	Primary School	17	18,3	,306		,873
	Secondary School	12	12,9			
	High School	19	20,4			
	Bachelor's Degree	29	31,2			
	Master's Degree	16	17,2			
Age	18-22	25	26,9	,477		,699
	23-35	27	29,0			
	36-49	22	23,7			
	≥ 50	19	20,4			
Income Status	≤ 1000 TL	26	28,0	4,299		**,008**
	1000 TL -1999 TL	19	20,4			
	2000 TL -2999 TL	19	20,4			
	≥ 3000 TL	29	31,2			
Social Security	Retirement Fund	8	8,6	,531		,663
	Social Insurance Institution	52	55,9			
	BAGKUR	19	20,4			
	Legal Dependent	13	14,0			
Number of People in Household	1	2	2,2	,149		,980
	2	8	8,6			
	3	14	15,1			
	4	25	26,9			
	5	23	24,7			
	6 and above	21	22,6			
Occupational Group	Official	15	16,1	,783		,507
	Private Sector	31	33,3			

	Housewife	11	11,8			
	Student	36	38,7			

As a result of the IndependentSample t-test, it was determined that there was no statistically significant difference among the scores of preferring the hospital to family medicine according to gender and marital status (p 0,05).

The scores of individuals participating in the study to prefer the hospital to family medicine according to the variables of education, number of people in the household, social security, occupation, age and income were compared with one-way analysis of variance (ANOVA); it was determined that there is only a significant difference in terms of income ($p<0,05$). It also has been observed that those with an income of 3000 TL and above are more likely to prefer the hospital.

VII. DISCUSSION AND CONCLUSION

In this study, the reasons why individuals prefer hospitals over family medicine and whether there is a difference in their preferences according to sociodemographic characteristics were analyzed. As stated in the Alma Ata Declaration, providing preventive health services, care and treatment services, rehabilitation services and health promotion services together and to the individual in the closest area is effective in increasing the health level of the society. For this reason, it is thought that determining the reasons for not choosing family physicians, who play a leading role in primary health care services, will be a guide for planning health services (2).

When the answers given to the "Reasons Why Individuals Prefer Family Physicians" scale developed by Baş (Baş; 2017) were examined, it was seen that the most supported statements were "I go to the hospital when I think my illness is serious.", "I go to the hospital because analysis and examination opportunities are limited in family medicine." and "I go to the hospital because the family doctor cannot prescribe some medications." These results might be interpreted as individuals find the diagnosis and treatment opportunities in family medicine units insufficient; and the family physicians' authority to prescribe medication is limited. In Baş's study, it is seen that these propositions constitute three of the first four propositions with the highest score (23). In the 27th article of the Family Medicine Implementation Regulation, it is stated that simple examinations and analysis procedures can be performed in family health centers; and also, the laboratory test samples will first be sent to public health laboratories or to the ones approved by the Provincial Health Directorates. In the 4th paragraph of the 28th article, it was approved for the family physicians to write official prescriptions, and furthermore, it was stated that they were authorized to issue a medical report. In the study of Bulut and Uğurluoğlu examining the views of family physicians about the referral system, they stated that 20.61% of the individuals do not know about the family medicine services and 14.55% of those do not prefer them because they do not trust the family physician (24). It can be said that the individuals not knowing the authority of the family physician to prescribe medication and the examination and analysis possibilities of the family medicine directs them to the hospital.

In the study, the reasons for individuals to prefer the hospital to family medicine centers were examined according to sociodemographic characteristics, and it was found that only the income received created a preference difference; it was determined that those with an income of 3000 TL and above preferred the hospital more than the others. However, the statement "I go to the hospital because my financial situation is good" became the least supported statement. This contradiction may be due to the fact that 3000 TL is not considered as a good level of income. In subsequent studies, it is suggested to classify the distribution of the level of income differently.

In their study, Güven and Aycan examined the opinions of individuals who applied to a university hospital about family medicine and found out 41.3% of the participants did not know that they had to pay a contribution when they directly applied to the hospital without applying to the family medicine. 60% of those who do not have this information states that they will apply to the family doctor first (25). In this study, determining the preference difference according to the income level supported the research result. The low cost of the health services provided and individuals' having financial access power increase the preferableness.

In the same study of Güven and Aycan, 54.1% of the individuals stated that they were satisfied with the family medicine system, but 78.4% of them found the conditions inadequate, and 39.3% of them stated that a better quality service was provided in hospitals (25). It can be said that the thought of providing higher quality services in hospitals causes those with suitable income to prefer the hospital. Similarly, in this study, the statements that the specialist physician is

more knowledgeable, the analysis results are obtained late in the family medicine centers, and the hospitals provide more comprehensive services are the most frequently supported propositions as 3rd, 4th and 5th.

Based on the results of the study, in order to eliminate inequalities in public access to health, it is recommended to strengthen family health centers to encourage primary healthcare services, to introduce the facilities available in family medicine, and to take the necessary steps to establish a referral system by decision-makers.

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