International Journal of Application or Innovation in Engineering & Management (IJAIEM)
Web Site: www.ijaiem.org Email: editor@ijaiem.org
Volume 7, Issue 5, May 2018 **ISSN 2319 - 4847**

Do the Satisfaction Levels of People Benefiting from the Service Differ in the Model of Family Practice?

Aykut Ekiyor[1], Hasan Hüseyin Uyanık[2]

[1]Asociate Professor Doctor, Gazi University Faculty of Economics and Administrative Sciences, Department of Health care Management, Ankara-Turkey

[2]MedicalSecretary, Kars ProvincialDirectorate of Health, Kars-Turkey

ABSTRACT

Satisfaction levels of patients receiving healthcare service in addition to considering the delivery of high quality healthcare service as necessity has now started to gain importance as the determiner of high quality service in healthcare. Measuring the levels of patient satisfaction and determining the lacking sides in the delivery of healthcare service are important in making policies for increasing the quality of service. Healthcare centres, which lost their functions in Turkey, have been replaced by family practice centres. The model first started as a pilot application in 15 October 2005 in Düzce, and the application was started in all provinces in Turkey beginning in the year 2010.

This study makes efforts to determine the extent to which patients benefitting the healthcare service are satisfied with the service setting out from the model of family practice implemented in Kars province, and it aims to demonstrate the differences between participants' levels of satisfaction according to demographic properties.

Patient Satisfaction Survey containing two sections and 25 questions was administered to 250 patients using family practice service in Kars. The data coming from the questionnaire were analysed on SPSS 22.0 programme, and the results were evaluated. Accordingly, it was found that 14% of the participants had not been satisfied with the service whereas 86% had been satisfied.

Keywords: Healthcare, Family practice, Patients' Satisfaction, Kars, Turkey

1.INTRODUCTION

Family practice is the primary care service which is preferably used and offered in almost all of the developed countries. An original model was created so as to regulate this primary care service in a contemporary approach and to be able to offer it in a way that is preferred by all individuals in the society, and the model was thus implemented.

Family doctors have responsibilities in issues from the health of babies mothers are to give birth to to the health of the oldest family members in the application of family practice. They consider any type of health problems individuals have, and they also take on the role of a coordinator by acting as a medical consultant and directing patients into specialised doctors or dentists when they cannot cope with the problems. Thus, family doctors are the people who function as the medical consultant to people registered in their area of responsibility, who function as the guide to them and who also defend their rights. The major goals of programme for transformation in health include using resources efficiently, reaching individuals easily according to their needs for healthcare. Having a family doctor whom one can reach easily and can consult without encountering any obstacles is the result of a people-oriented approach[1].

Healthcare services in many countries was understood only as the treatment of diseases, but it was seen later with such factors as advances in struggling with diseases, environmental health and hygiene or increase in knowledge about the contagion process of diseases that healthcare services centred around various areas. Thus, it was understood that individuals' health was closely associated with community health and preventive health services beside treatment services became important.

The first person to argue for the concept of family practice was Francis Peabody. Peabody argued in 1923 that patients had problems and were neglected as a result of increase in specialisation in the area of medicine, and therefore a field of expertise which would consider human health as a whole was needed. In accordance with this view about family practice, Family Doctors Royalty College was founded in England in 1952. "Family practice" was recognised as a new

branch of expertise in primary care in the USA in 1969, and the Board of Competency in Family Practice was formed [2][3]. In parallel to all these developments, specialisation in family practice gained wide acceptance all over the world, and it was accepted as a branch of expertise different from other branches of expertise of primary care in the Netherlands in 1974 [3].

Various institutions are defined in different ways in the literature of family practice. World organisation of family doctors (Wonca)refers to practitioners or family doctors as doctors who have the responsibility to give detailed care to people seeking medical care and who activate other medical staff when necessary (World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians [4]. The European region of world organisation of family doctors defined family practice in more details according to changing conditions of the world in 2002 [5]. According to the definition, family practice is an academic and scientific discipline about primary care which has its own content and investigation, which is based on evidence and which had clinical activities. Family physicians are specialised doctors who have been trained in accordance with the principles of family practice. They are the doctors who are responsible for giving comprehensive and continuous care to people who demand medical care regardless of their age, gender and diseases. They always have respect for patients' autonomy in the context of families, societies and cultures for their care. Besides, they also know that they have professional responsibility for the society. They use the management plans of diseases, patients' physical, psychological, social, cultural and existential factors by establishing trust by means of negotiations with patients and by integrating repetitive connections. Family doctors and general practitioners play their occupational roles by encouraging health, preventing diseases and by offering services such as curing, caring and diminishingillnesses. They ensure that patients reach those services when necessary either directly or by means of other medical staff according to medical needs and existing resources of society. Family doctors have the obligation to develop and preserve their skills, personal balance and values for effective and secure patient care. Olesen et al [6], in their study recommending that the job description of family doctors should be revised, define family doctors as general practitioners and as specialists trained to work on the front line of health system and to take the first step towards giving care to the health problems that patients might have.

Family practice is an area of expertise which provide individuals and families with continuous and versatile medical service, which is mingled with biological clinic and behavioural sciences and which includes all age groups, both genders and all diseases in its area of activity. World Health Organisation (WHO) describes family doctors as medical doctors who give primary care to the community attached to him regardless of age, gender or diseases and who have received at least two year training after completing medical training. According to WHO, the application of family practice means offering both families and individuals uninterrupted and versatile healthcare service [7].

The law of family practice no 5258 promulgated in the official gazette defines a family doctor as a family physician having the obligation to offer individuals preventive health care and primary diagnostic, remedial, rehabilitative healthcare service in a specified place, continuously and comprehensively regardless of age, gender or diseases offering mobile healthcare service when necessary and working full time, and as a specialised doctor who has received the training required by Ministry of Health or as a doctor [8].

Family doctors monitor the patients they have sent to an upper medical stage and have the responsibility for them. They take the effects of a disease on families and the effects of families on diseases into consideration while resolving patients' problems. Besides, they also obtain the views of patients and families at the stage of planning a treatment and thus they prepare a treatment plan jointly to ensure patients' adaptation into the treatment, to increase the efficiency of the treatment and to resolve the problem. Family doctors also function as a consultant in vaccination, in baby and pregnancy monitoring and in family planning. They also inform people of epidemics and contagious diseases, they make sure preventive measures are taken and they perform preventive medicine by cooperating with local governments [9].

Family practice is used in many places in the world. Primary healthcare is offered by family doctors in Germany. Patients have to be attached to family doctors to whom they submit their patient files at least for 3 months [10]. Family doctors play important roles in the USA. Research has shown that the branch of expertise looking after the biggest number of patients per day is family doctors. It is obligatory for patients in England to go to their family doctor first when they have a health problem. Those who are not sent by family doctors cannot go to the secondary care units unless the case has emergency. Family doctors are paid for per patient they have, but they can also be paid per service they offer so as to increase the efficiency of preventive services [11]. Primary healthcare is given by family doctors in Canada, and the system of sending patients to upper stages is also available there [10]. All medical services are given for free in the scope of general health insurance in Cuba. The health level of the country is high and the number of doctors per patient is sufficient due to the fact that preventive health services are considered important. Family doctors offer preventive health services, vaccination; they encourage healthy life and give rehabilitation. In addition to receiving patients in their offices, family doctors also visit homes and monitor pregnant women and children [12][13].

1.1.The Development of Family Practice in Turkey and Patients' Satisfaction

Discussions about the concept of family practice started in the mid-1970s in Turkey and it was considered as one of the functions of the doctors of health centres in that period, and there were no ideas about having a separate branch of expertise. Family physician was included in regulation for the art of medicine as a profession and was accepted as a branch of expertise in Turkey in 1983.The branch of family practice was opened in Turkey for the first time in Gazi University School of Medicine in 1984. Family physicians training programme was started in teaching hospitals of the Ministry of Health in 1985. The Board of Higher Education (YÖK) approved the establishment of family practice departments in schools of medicine in 1993[14].

Family medicine appeared in many official documents concerning the 6^{th}, 7^{th} and 8^{th} five-year development plans in the period following 1990. It was also included in the Urgent Action Plan of the 58^{th} government and in the programme for health transformation.With "health transformation programme containing family practice, preventive and therapeutic healthcare services, general health insurance, health information system, diagnostic and therapeutical institutions and with general policies in relation to the renewal of organisational structure of the institutions a new approach to healthcare services entered the agenda [15]. Family practice model was first used as a pilot application in Düzce on 15 October 2005, and then the model was implemented in all provinces in Turkey beginning with the year 2010.

This study investigates the satisfaction of patients benefitting from the application of family practice. The concept of patient satisfaction is defined in healthcare services as the difference between the level of service patients expect and the level of service they perceive [16]. The concept of customer in health facilities contains not only patients as was the case in the past but also all the individuals and institutions involved in the process of healthcare service. The first factor determining patient satisfaction is patients' expectations. Scientific, managerial and behavioural expectations of patients in relation to the services they are to receive from health institutions differ according to patients' age, gender, level of education, social-cultural properties and according to their prior experiences with healthcare services or health institutions [17]. Patients evaluate the services offered while benefitting from healthcare services, they are satisfied or not satisfied with the services and they make decisions on whether to go or not to go to the same health institution again [18]. Thus, those benefitting the services are to assess their doctor and make their choice as a result of the comparison.

It was found in relevant literature that some of the factors influencing patient satisfaction were related to patients, medical staff and physical and environmental properties. Patients' socio-demographic properties such as age, educational status, income, occupation, gender, native language, religion, race and family order play differing roles in the degree of patients' satisfaction. Those criteria, which differ from person to person, are closely related to the degree of satisfaction with healthcare services. In the same way, staff offering the services and the physical conditions are also influential in satisfaction [19].

There are also other studies concerning satisfaction with the application of family practice. The study entitled as patients' satisfaction with primary healthcare services which was conducted by the ministry of Health in RefikSaydam Hygiene centre presidency fills a gap in the area. The research for the study was conducted with 34.472 participants. The study was conducted so as to reveal the way healthcare delivery was perceived by patients in cities where the model of family practice wasused and in cities where it was not used, to find whether or not there were any differences between these two groups of cities and to find patients' satisfaction and dissatisfaction with primary healthcare services [20]. In an MA thesis prepared by Cengiz[21], the satisfaction levels of patients benefitting from family practice system applied in Edirne were researched. Gürfidan[22], on the other hand, highlights individuals' expectations of and satisfaction with family practice.

Revealing the satisfaction and dissatisfaction of people benefitting from the model of family practice- which was implemented in 2010 in the whole country but in which there are problems with the integration into the health system of the country due to various reasons- is likely to be beneficial to health policy makers, medical trainers and practitioners.

2.RESEARCH METHODOLOGY

This section includes the purpose, population and sample of the research, the research method and the hypotheses of the research.

2.1.Aim of Research

It is an undeniable fact that customer satisfaction has great importance in the field of medicine as in all other fields of service sector. Health business attains success and sustainability as long as it can meet the expectations and demands of its clients.It may be said that it is obligatory to meet individuals' expectations and demands in family practice due to the fact that patients have the freedom to change their family doctors.

This study aims to find the degree to which patients benefitting from the service family doctors offer within the scope of family practice model are satisfied with the service. For our purposes, efforts were made to determine the extent which people in Kars were satisfied with the service and thus to determine the differences between participants levels of satisfaction according to demographic properties.

2.2.Research Method

The study was conducted with the participation of individuals receiving healthcare service from family doctors in Kars. A 25-item patient satisfaction questionnaire was prepared for data collection. The questionnaire contained two sections: Section one included 8 questions about demographic properties while section two contained 17 questions of Likert type. Reliability of the questionnaire was tested with Cronbach's Alpha test. In consequence, Cronbach's Alpha coefficient was found to be .942. Accordingly, the questionnaire was considered to be very reliable. The questionnaire was given face to face to 250 patients receiving healthcare service from family doctors. Limits were imposed on the research due to the fact that it would be difficult to conduct the study in terms of time and cost with patients going to all family health centres. There are 8 community health centres, 28 family health centres and 81 centres of family practice in Kars. The sample was composed of 18 family practice centres from 7 family health centres in the central district, 2 family practice centres from1 family health centre in Digor district, 5 family practice centres from 2 family health centres in Sarıkamış district, 5 family practice centres from 1 family health centre in Selim district and3 family practice centres from 1 family health centre in Susuz district. The participants were asked to mark the options which were the most appropriate for them. Face-to-face survey technique was preferred so as to prevent lower level of responds due to incomprehensibility of the questions. In addition to that, the technique was preferred because it enabled the researcher to obtain the recommendations and suggestions made by the patients in relation to the services provided. The data, which were thought to have been collected through the questionnaire given to the sample were put to T-test, ANOVA test, TUKEY test and Tamhane's T2 test on SPSS 22 statistical package programme.

2.3. Research Hypotheses

The following hypotheses were made in accordance with the purpose and sub-purposes of the study:

H1: There are significant differences between satisfaction with family practice and gender.

H2:There are significant differences between satisfaction with family practice and marital status.

H3: There are significant differences between satisfaction with family practice and educational status.

H4: There are significant differences between satisfaction with family practice and age.

H5: There are significant differences between satisfaction with family practice and occupation.

H6: There are significant differences between satisfaction with family practice and income.

H7: There are significant differences between satisfaction with family practice and reasons for consulting family practice centre.

3.RESULT AND DISCUSSION

Table 1: Patients' Demographic Properties

Demographic properties		f	%
Gender	Female	161	64.4
	Male	89	35.6
Age	20 and below	23	9.2
	21-30	93	37.2
	31-40	59	23.6
	41-50	42	16.8
	51-60	30	12.0
	61 and above	3	1.2
Marital status	Married	166	66.4

	Single	84	33.6
Educational status	Illiterate	6	2.4
	Literate	10	4.0
	Primary school	29	11.6
	Secondary school	24	9.6
	High school	65	26.0
	University and post-graduate education	116	46.4
Occupation	Civil servant	115	46.0
	Worker	21	8.4
	tradesman / self-employed	5	2.0
	Farmer	5	2.0
	Retired	5	2.0
	Student	39	15.6
	Unemployed	16	6.4
	Other	44	17.6
Monthly income	1000 TL and less	41	16.4
	1001-1500 TL	35	14.0
	1501-2000 TL	35	14.0
	2001-2500 TL	52	20.8
	2501-3000 TL	41	16.4
	3001 TL and more	46	18.4
Reasons for consulting family doctor	For treatment	124	49.6
	For check-up	16	6.4
	For prescription	62	24.8
	For family planning	7	2.8
	For injection- for wound dressing	17	6.8
	For vaccination	12	4.8
	For medical report	12	4.8

According to Table 1, 64.4% of the participants are female while 35.6% are male. Of them 9.2% are aged 20 and below, 60.8% are aged 21-40, 28.8% are aged 41-60 and 1.2% are aged 61 and above. 66.4% of the sample is married whereas 33.6% is single. Of the patients 26.6% are high school graduates whereas 46.4% are university graduates or hold a post-graduate degree. 46.0% are civil servants. 49.6% of the participants stated that they consulted family doctors for treatment while 24.8% said that they went to family doctors to get them to write a prescription.

TABLE 2: AVERAGES FOR THE SCALE OF PATIENTS' SATISFACTION WITH THE SERVICE

	X
Evaluate the degree of accessibility to your family doctor (can you reach your family doctor easily?)	4.320

What do you think of the physical conditions of your family doctor? (warmth cleanliness, seats, etc.)	4.192
What do you think of the signs leading you to the place you want to go in the family practice centre (doctor's office, laboratories, wound dressing room, etc.) ?	3.972
What is your evaluation of your family doctor's adequacy in terms of medical stuff and equipment?	3.908
What do you think of the staff guiding you in terms of registration and procedures to follow?	4.148
What do you think of the length of time in registration transactions?	4.232
What do you think of the length of time you wait before the doctor examines you?	4.104
What do you think of your family doctor's behaviours and politeness in his room when he/she welcomes you?	4.332
What do you think of your family doctor's examination, hi/her listening to you and his/her permitting you to ask questions?	4.320
What do you think of your family doctor's informing you of how to use the prescribed medicine and of its side effects?	4.168
What do you think of your family doctor's informing you of analyses and therapy he/she suggests?	4.172
What do you think of your family doctor's competence in monitoring your medical information and records (vaccination, baby monitoring, pregnant monitoring, disease monitoring, etc.)?	4.220
What do you think of the behaviours of medical staff (midwife/nurse/ medical assistant) serving you in family practice centre?	4.244
What do you think of the medical service the medical staff (midwife/nurse/ medical assistant) in the family practice centre offers you?	4.156
What do you think of the service (medical examination, lab, wound dressing, vaccination, etc.) offered to you in the family practice centre?	4.136
What is your overall evaluation of family practice?	4.184
What do you think of the system of family practice when compared to former system of health centres?	4.136

According to the figures, in the scale, the averages for satisfaction are generally high. The highest values are in family doctors' welcoming patients in doctors' office, their politeness, their listening to the patients during examination and permitting patients to ask questions and accessibility to family doctors. The lowest averages, on the other hand, are in family doctor's adequacy in medical stuff and equipment and in direction signs showing patients the directions to doctors' office, laboratories, wound dressing rooms, etc.

3.1.Testing the Hypotheses

The t-test, ANOVA test, TUKEY test and Tamhane's T2 were used in analysing the data collected from the large and inclusive sample through the questionnaire.

Table 3:Group Statistics for Patients Receiving the Service according to Gender

Gender		**N**	**Mean**	**Standard deviation**	**Standard error average**
Average satisfaction	**Female**	161	4.1794	.61754	.04867
	Male	89	4.1619	.66358	.07034

As is clear from Table 3, gender averages are very close. The t-test was administered so as to test the hypothesis (see Table 4).

Table 4: T-test Analysis of Patients Receiving the Service according to Gender

Receivers of service-gender	Levene's test for the equivalence of variances		T-test for the Equivalence of Averages					
	F	Sig	t	p	Average difference	Standard error difference	95% confidence interval of the difference	
							Bottom	Top
When variances are equal	.131	.738	.208	.835	.01746	.08378	-.14754	.18247
When variances are not equal			.204	.838	.01746	.08553	-.15138	.18630

p >.005

According to Table 4,hypothesis H1 was refused because p=0.835 and p is bigger than .005 at the significance level of 95%. Accordingly, it was concluded that there were no significant differences between the satisfaction levels of patients benefiting from the service of family practice according to gender. Besides, on examining the male-female satisfaction averages (see Table 3), the values are very close (Female: 4.1794; Male: 4.1619)- which is supportive of this conclusion.

Table 5: Group Statistics for Patients Receiving the Service according to Marital Status

Marital Status		N	Mean	Standard deviation	Standard error average
Average satisfaction	married	166	4.2119	.63556	.04933
	single	84	4.0966	.62471	.06816

Table 5 showsthe averages for participants' marital status. It is clear that averages for participants' satisfaction with the service of family practice are close. The t-test was administered so as to test the hypothesis we have made in relation to marital status (see Table 6).

Table 6: T-test Analysis of Patients Receiving the Service according to Marital Status

Receivers of service-Marital status	Levene's test for the equivalence of variances		T-test for the Equivalence of Averages					
	F	Sig	t	p	Average difference	Standard error difference	95% confidence interval of the difference	
							Bottom	Top

When variances are equal	.064	.801	1.362	.174	.11527	.08462	-.05139	.28193
When variances are not equal			1.370	.173	.01527	.08414	-.05083	.28136

p >.005

According to Table 6, hypothesis H2 was refused because p=0.174 and α is bigger than .005 at the significance level of 95% when variances are equal. It was concluded that there were no significant differences between patients' levels of satisfaction with the service according to marital status. An examination of Table 5 shows that averages for marital status are close (Married: 4.2119; Single: 4.0966) - which is supportive of the findings.

Table 7: One-way Variance Analysis of Patients Receiving the Service according to Educational Status

Satisfaction average-Educational status	**Descriptive statistics**							
	N	**Mean**	**Standard deviation**	**Standard error**	**95% confidence interval of the difference**		**F**	**p**
					Lower limit	**Upper limit**		
Illiterate	6	4.9020	.10952	.04471	4.7870	5.0169	5.176	.000
Literate	10	4.5471	.43936	.13894	4.2328	4.8614		
Primary school	29	4.4767	.38871	.07218	4.3288	4.6245		
Secondary school	24	4.2574	.60434	.12336	4.0022	4.5125		
High school	65	4.1086	.70414	.08734	3.9341	4.2831		
University or post-graduate	116	4.0461	.61893	.05747	3.9323	4.1600		
Total	250	4.1732	.63304	.04004	4.0943	4.2520		

p<.005

Variance analysis (ANOVA) was performed so as to determine the differences between participants' levels of satisfaction with the service of family practice according to educational status. According to the results, hypothesis H3 was accepted because p< α. Thus, statistically significant differences were found between satisfaction levels according to educational status. In which groups the difference is influential can be found with Tamhane's T2 test since variances are not homogenous (p< α; p=0.018; α=.005). According to the results of Tamhane's T2 test, patients' levels of satisfaction with the service decrease as their levels of education increase. While illiterate patients have very high levels of satisfaction with the service, patients with higher levels of education have lower levels of satisfaction.

Table 8: One-way Variance Analysis of Patients Receiving Service according to Age

Satisfaction average-Age	**Descriptive statistics**						
	N	**Mean**	**Standard deviation**	**Standard error**	**95% confidence interval of the**	**F**	**p**

					difference			
					Lower limit	Upper limit		
20 and below	23	4.2225	.61259	.12773	3.9576	4.4874	1.068	.379
21-30	93	4.1278	.64073	.06644	3.9958	4.2597		
31-40	59	4.1595	.50756	.06608	4.0273	4.2918		
41-50	42	4.0938	.76939	.11872	3.8541	4.3336		
51-60	30	4.3824	.64600	.11794	4.1411	4.6236		
61 and above	3	4.4902	.39167	.22613	3.5172	5.4631		

p >.005

As clear from Table 8, there are no statistically significant differences between participants levels of satisfaction with the service according to age (p>α; p=0.379; α=.005). Thus, hypothesis H4 was refused.

Table 9: One-way Variance Analysis of Patients Receiving the Service according to Occupations

Satisfaction average-Occupation	**Descriptive statistics**							
	N	**Mean**	**Standard deviation**	**Standard error**	**95% confidence interval of the difference**		**F**	**p**
					Lower limit	**Upper limit**		
Civil servant	115	3.8900	.65999	.06154	3.7681	4.0119	7.771	.000
Worker	21	4.3109	.70445	.15372	3.9903	4.6316		
Self-employed	5	4.4824	.43506	.19456	3.9422	5.0225		
Farmer	5	4.6588	.47498	.21242	4.0691	5.2486		
Retired	5	4.5294	.28516	.12753	4.1753	4.8835		
Student	39	4.3167	.54092	.08662	4.1414	4.4921		
Unemployed	16	4.4596	.39209	.09802	4.2506	4.6685		
Other	44	4.4853	.38815	.05852	4.3673	4.6033		

p< .005

One-way variance analysis (ANOVA) was performed so as to determine the differences between participants' levels of satisfaction with the service of family practice according to their occupation. Based on the results, hypothesis H5 was accepted since p>α. statistically significant differences were found between participants' levels of satisfaction according to their occupation. The source of variance can be found through Tukey test since variances are homogenous (p<α; p=0.057; α=.005). Following the TUKEY test, it was found that civil servants, students', unemployed people and occupations distinguished as others having similar levels of satisfaction had lower levels of satisfaction than workers, self-employed people, farmers and retired people.

Table 10: One-way Variance Analysis of Patients Receiving the Service according to their Monthly Income

Satisfaction Average-income	Descriptive statistics							
	N	Mean	Standard deviation	Standard error	95% confidence interval of the difference		F	p
					Lower limit	Upper limit		
1000 TL and less	41	4.3859	.62738	.09798	4.1879	4.5840	4.201	.001
1001-1500 TL	35	4.4773	.49540	.08374	4.3071	4.6475		
1501-2000 TL	35	4.1731	.55548	.09389	3.9823	4.3639		
2001-2500 TL	52	4.0633	.73488	.10191	3.8588	4.2679		
2501-3000 TL	41	4.0402	.57926	.09047	3.8573	4.2230		
3001TL and more	46	3.9949	.60242	.08882	3.8160	4.1738		

p< .005

One-way variance analysis (ANOVA) was performed so as to determine the differences between participants' levels of satisfaction with the service of family practice according to their monthly income. Hypothesis H6 was accepted because p<α. It was found that there were statistically significant differences between participants' levels of satisfaction according to their monthly income. Variances were found to be homogenous in the correlations between satisfaction with family practice and income groups (p>α; p=0.158; α=.005). The source of variance can be found through TUKEY test since variances are homogenous. TUKEY test results showed that participants' levels of satisfaction were inversely proportional to their levels of income. Thus, participants' levels of satisfaction with the service fell as their levels of income rose.While the participants with 1500 TL and less income were generally satisfied with the service, those with 1501 TL or more income had less satisfaction with the service.

Table 11: One-way Variance Analysis of Patients Receiving the Service according to their Reasons for Consulting Family Doctors

Satisfaction average-Reasons for going to family practice centres	Descriptive statistics							
	N	Mean	Standard deviation	Standard error	95% confidence interval of the difference		F	p
					Lower limit	Upper limit		
Examination	124	4.2306	.60267	.05412	4.1234	4.3377		

Check up	16	4.4853	.41344	.10336	4.2650	4.7056	3.791	.001
Prescribing medicine	62	3.9412	.69528	.08830	3.7646	4.1177		
Family planning	7	4.1765	.83535	.31573	3.4039	4.9490		
Injection-wound dressing	17	4.5260	.50665	.12288	4.2655	4.7864		
Vaccination	12	4.1667	.41126	.11872	3.9054	4.4280		
Getting a medical report	12	3.8676	.62963	.18176	3.4676	4.2677		

$p < .005$

According to Table 11, there are statistically significant differences between participants' levels of satisfaction with the service according to their reasons for going to family practice centres. Hypothesis H7 was accepted because $p<\alpha$ according to the results obtained. The variance was found to be homogenous in the correlations between participants' satisfaction and their reasons for consulting their family doctor ($p>\alpha$; $p=0.192$; $\alpha=.005$). The source of variance can be found through TUKEY test since variances are homogenous. As a result of the TUKEY test, it was found that patients had consulted their family doctors most to have medical examination (49.6%) while they consulted the least for family planning (2.8%). While the satisfaction levels of those who consulted their family doctors to get a medical report and for medicine prescription were low, the satisfaction levels of those who had consulted their family doctors for other reasons were high.

4.CONCLUSION AND RECOMMENDATIONS

This study aiming to determine the levels of people's satisfaction with family practice centres was conducted with patients benefitting from service offered by family practice centres.

Healthcare service, which is complex and variable, is a model of presentation which needs sustainability so as to be able to have healthy individuals and healthy environment. While the purpose was the treatment of and protection from diseases in the past, the purpose today is to increase the areas in which receivers of service are satisfied. The fact that family practice model implemented in our country is person-oriented, that it considers individuals along with the environment, that the relations are one to one and that individuals' medical information is recorded in the database are the factors which are to make the system successful.

The aim in assessing patient satisfaction is to improve the performance of health institutions and thus to search for the best ways to meet patients' expectations.Patients' expectations and the behaviours of medical staff are at the foundation of patients' satisfaction.

The findings of this study have shown that 14% of patients are not satisfied with the model of family practice whereas 86% are satisfied with the model. It was found that 35 out of 250 participants were not satisfied with the model but that 215 were satisfied with it. The biggest problem was the lack of medical equipment (3.9080) and the inadequate number of direction signs (3.9720). The research conducted by the administration of hygiene school of RefikSaydam hygiene centre of the Ministry of Health also found that patients' level of satisfaction with primary healthcare services in all provinces was 82.8%- a finding supportive of the findings of this current study.

The findings also showed that patients' levels of satisfaction with the model of family practice fell as their level of education rose. Thus, while illiterate patients' levels of satisfaction were very high, the levels of satisfaction dropped gradually as the level of education rose. Patients' expectations and standards in relation to services increase as the level of people's consciousness increases. In a similar vein, in a study concerning satisfaction with family practice, Cengiz[21] found that the rate of satisfaction fell as the level of education rose. On comparing participants according to occupations, it was found that civil servants, students, unemployed people and others- who had similar levels of satisfaction - had lower levels of satisfaction than workers, self-employed individuals, farmers and retired people. Cengiz[21] found that 97% of the group of civil servants were satisfied with family practice while 10% of the group of workers, tradesmen, housewives, unemployed people and retired people were satisfied and 67% of the group of farmers were satisfied.

It was found in this study that patients' levels of satisfaction with family practice were inversely proportional to their monthly income. Thus, their levels of satisfaction fall as their levels of income rise. Accordingly, reductions were observed in the satisfaction levels of patients with 1500TL or less income. As is clear from this, satisfaction levels decrease as the levels of prosperity increase, and their expectations of better quality service increase.

Patients go to family practice centres mostly for examination (49.6%) and they go to those centres the least frequently for family planning (2.8%). While satisfaction levels of patients who go to family doctors for medical report and for medicine prescription are low, the satisfaction levels of patients going to the centres for other reasons are high.

It is clear that the system of family practice – which focuses on individuals and which aims to deliver effective and high quality healthcare service- is more functional and more effective than former health centres- which had lost their functions and which had become slower. The responses given by the participants to the survey questions indicate this.

According to the results obtained, the areas where patients have lower satisfaction levels need improving. Regulations should be made according to the source of difference in groups where differences arise according to demographic properties. It will be possible to raise the levels of satisfaction by eliminating the differences. Generalisations cannot be made for this research since it was conducted with the participation of 250 patients receiving service from family practice model in the city of Kars. It is recommended that the research should be done with larger masses and in differing regions so that the results can be generalised.

REFERENCE

[1]AileHekimliği,http://ailehekimligi.gov.tr /images /stories /Mevzuat /saglikcalisanlariacisindanailehekimligi.pdf, (Erişim Tarihi:05.05.2015).

[2]H.Çağlayaner, Temel Kavramlar ve Tarihsel Perspektif. Aile Hekimliği. 1. Baskı. İstanbul: İletişim Yayınları, 1995.

[3]RE. Rakel, TheFamilyPhysician, 6th ed, Philadelphia: WB Saunders, 2002.

[4]Wonca,The Rol Of The General Practitioner/ FamilyPhysician in HealthCareSystems: a statementfromWonca, 1991.

[5]Wonca, The European Definition of General Practice/Family Medicine. Wonca Europe. Barcelona: Wonca Europe Office Publication, 2002.

[6]F.Olesen, J.Dickinson, P.Hjortdahl, General Practice- Time for a New Definition, BMJ, 320: 354- 357, 2000.

[7]R.Akdağ, AileHekimliğiTürkiyeModeli, Editör: Sabahattin Aydın, Ankara: MaviOfsetYayıncılık, 2004.

[8]ResmiGazete, 5258 SayılıAileHekimliğiKanunu 25665, Madde: 1, 2013.

[9]Z. Öztek, SağlıktaDönüşümveAileHekimliği, Tıp Dergisi, 25 (2): 1-6, 2006.

[10]E. Saatçi,H.Sezer,DünyadaAileHekimliğiUygulamaları. Aile Hekimliği II? Editör.ÇağlayanerHaluk. İletişimYayıncılık,49-70, 1996.

[11]İ.Ünlüoğlu, DünyadaveTürkiye'deAileHekimliğininGelişimi, Aktüel Tıp DergisiAileHekimliğiÖzelEki, 9 (6): 18, 2004.

[12]Z.Amato, Küba'nınSağlığı Ne Durumda? Tıp Dünyası TTB, Aralık 17: 4-6, 1993.

[13]GJ.Ebrahim, JP.Ranken, Primary Health Care Reorienting Organisational Support, USA: Mac Millan Publishers, 1988.

[14]K.Algın, İ.Şahin,M.Top,Türkiye'deAileHekimlerininMeslekiSorunlarıveÇözümÖnerileri, HacettepeSağlıkİdaresiDergisi, 7 (3): 249-273, 2004.

[15]Sağlık Bakanlığı, http://sbu.saglik.gov.tr/Ekutuphane/kitaplar/sagliktadonusum.pdf, (Erişim Tarihi:05.05.2015).

[16]A. Özer, E. Çakıl, Sağlık Hizmetlerinde Hasta Memnuniyetini Etkileyen Faktörler, Tıp Araştırmaları Dergisi, 5 (3): 141, 2017.

[17]Ş.Kavuncubaşı, Hastane ve Sağlık Kurumları Yönetimi, Ankara: Siyasal Kitapevi, 2000.

[18]A. Yanık, Sağlık Bakım Hizmetlerinde Hasta Bakım Tatmini ve Haydarpaşa Numune Eğitim ve Araştırma Hastanesinde Hasta Tatmini Üzerine Bir Araştırma, İstanbul Üniversitesi, Sosyal Bilimler Enstitüsü, Doktora Tezi, İstanbul, 2000.

[19]S.Yıldız, SE.Yıldız, Hizmet Kalitesinin Müşteri Memnuniyetine Etkisi: Kars'taki Devlet ve Üniversite Hastaneleri'nde Bir Araştırma, Bilgi Ekonomisi ve Yönetimi Dergisi, VI(II): 127, 2011.

[20]Türkiye Cumhuriyeti Sağlık Bakanlığı Refik Saydam Hıfzıssıhha Merkezi Başkanlığı Hıfzıssıhha Mektebi Müdürlüğü, Birinci Basamak Sağlık Hizmetlerinde Hasta Memnuniyeti, Sağlık Bakanlığı Yayın No: 806, Ankara: Opus Basın Yayın Ltd. Şti, 2010.

[21]R. Cengiz, AileHekimliğiUygulamasıve Hasta Memnuniyeti: Edirne İli MerkeziÖrneği, BeykentÜniversitesiSosyalBilimlerEnstitüsü, YayınlanmamışYüksekLisansTezi, İstanbul, 2014.

[22]C.Gürfidan, AileHekimliğineİlişkinBilgiBeklentiveMemnuniyet (Kırklaraeli İl MerkeziÖrneği), BeykentÜniversitesi, SosyalBilimlerEnstitüsü, YüksekLisansTezi, İstanbul, 2014.

CORRESPONDING AUTHOR

AykutEkiyor has completed his Bachelor Degree on Management, Master's Degree on Hospital Management and Doctorate Degree on Management at Gazi University. He has published a lot of articles in academic journals in the field of Health Marketing and attended a lot of scientific meetings. He is working at the Department of Health Administration, Faculty of Economics and Administration Sciences, Gazi University as Associate Professor.