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Original Article

The influence of a market-oriented primary care reform on family physicians' working conditions: A qualitative study in Turkey

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KEY MESSAGE:

- The Turkish health transition programme caused a shift from the physicians' role as healers to that of businesspeople, and caused more patients to behave as demanding consumers.
- The Turkish health transition programme has generated work stress and exhaustion among physicians, caused by heavy workload, increased patient demands and performance-based contracts, leading to uncertainty about the future.

ABSTRACT

Background: Turkey has undergone a 'Health transformation programme' putting emphasis on the reorganization of primary care (PC) services towards a more market-oriented system.

Objectives: To obtain a deep understanding of how family physicians (FPs) experienced the process of the reforms by focusing on working conditions.

Methods: This phenomenological and qualitative research used maximum variation sampling and 51 FPs were interviewed in 36 in-depth and four focus-group interviews.

Results: Thematic analysis of interviews provided seven themes: (1) change in the professional identity of PC physicians (physician as businessperson); (2) transformation of the physician–patient relationship in PC (into a provider–customer relationship); (3) job description and workload; (4) interpersonal relationships; (5) remuneration of FPs, (6) uncertainty about the future and (7) exhaustion. Most FPs felt that the Family medicine model (FMM) placed more emphasis on the business function of family practice and this conflicted with their professional characteristics as physicians. FPs complained that some of their patients behaved as extremely demanding consumers. Continuously increasing responsibilities and extremely high workload were commonly reported problems. Most participants described the negative incentives in the performance scheme as a degrading method of punishment. The main factor was job insecurity caused by contract-based employment. FPs described the point at which they are with terms such as exhaustion.

Conclusion: By increasing workload and creating uncertainty about the future and about income, the PC reforms have led to working conditions, which has led to changes in the professional attitudes of physicians and their practice of medicine.

Keywords: Family physician, family medicine, primary care, health care reform, working conditions

INTRODUCTION

Since 1980, the organization and financial structure of health care in many countries have undergone a market-oriented transformation (1,2). These transformations, structured by financial organizations such as the World Bank, have had serious impacts on the working conditions of primary care (PC) workers (3,4) and stress and decreasing job satisfaction are often-voiced problems (5,6).

Turkey has undergone a similar reform process beginning in 2003 under the name of the Health transition programme (HTP), and the Family medicine model (FMM) was introduced in 2005. In the FMM, family physicians (FPs) work alongside a midwife/nurse to provide individually oriented PC services to the people on their list (7,8). Patients can use the outpatient services of hospitals without any referral system and change their FP every six months (7,9). With the HTP, primary care

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physicians, who used to be salaried government officers, have become contracted family physicians. The remuneration of FPs was changed to a combination of capitation, and performance-based payment, where failure to meet performance targets can result in payment cuts (up to 20% of their basic salary) and also contract termination (7,9).

Despite these radical changes, there is little data related to the psychosocial work climate and the role of structural changes in the job-related experiences of FPs. The purpose of this study was to obtain a deep understanding of how FPs experienced the process of the reforms by focusing on working conditions related to organizational stress.

METHODS

The study presented in this article is part of a comprehensive project on the FMM, which involved the participation of all categories of PC personnel and evaluated the main features of PC (10). The scope of this article is reflecting the views of FPs about their working conditions and professional identities. Ethics committee approval was obtained from the Ege University Faculty of Medicine Research Ethics Committee (No. 12-5.1/17).

Study design and participants

For purposeful sampling of information-rich FPs, the 'maximum variation' (11) technique was applied in this phenomenological and qualitative study (12). The aim was to ensure variety among the FPs who participated in the study regarding attributes such as sex, age, professional and PC experience, the presence of any specialty, and geographical location. To ensure the participation of FPs from a variety of provinces, the Nomenclature of Territorial Units for Statistics of Turkey was taken into consideration and participants from 22 provinces were interviewed, including at least one province from each of the 12 sub-regions, which constitute level one.

Participants were initially telephoned or visited to explain the aim of the research and structure of the interview, to obtain their consent for tape-recording, and to set an appointment for an interview. Two FPs refused to join the study. Recruitment of new participants continued until saturation was reached, and it was clear that no new information was emerging (13); 51 FPs were interviewed.

Data collection

In order for participants to be able to express their views more comfortably, in-depth interviews were chosen to gather data (36 interviews). Focus groups (four interviews) were conducted with participants who knew each other and were judged to be able to express their views comfortably in an interactive setting. Each focus group involved the participation of three to five physicians. The gathering of data was completed between February and July 2013.

During a workshop, the project team developed a semi-structured form containing the main topics of the in-depth and focus group. The final version of the form was produced after it was piloted with two FPs who had not been involved in the study and necessary adjustments had been made to improve comprehensibility and content validity (Box 1).

The authors conducted the interviews in environments suitable to ensure confidentiality and tape recording, such as the offices of medical chambers and associations of family physicians in addition to physicians' surgeries out of working hours.

Explicitation of the data

Explicitation process recommended for phenomenological studies has been followed (13). First, each interview was transcribed verbatim, and two authors read all transcripts together to check similarities and differences of answers and to perform a phenomenological reduction. Hereafter, units were clustered to form themes. Finally, all themes and theme categories were checked with the participation of the other authors to see whether new themes or theme categories were needed and to relate themes through the general structure of the study. Each theme was illustrated with direct quotes from participants.

RESULTS

The study population according to regions, demographic features and professional qualities is presented in Table 1. Thematic analysis of interviews enabled a deeper exploration and understanding of the major themes grouped under the following seven themes. Box 1 gives examples of representative quotes.

The change in the professional identity of PC physicians: Physician as businessperson

Most FPs stated that the FMM has placed more emphasis on the business function of general practice and noted that factors such as customer satisfaction, profit–loss ratios, competition, purchasing services and employing workers had become part of their lives. FPs added that because of this process they felt like businesspeople, which conflicted with their professional characteristics as physicians.

Box 1. Themes and examples of typical quotes.

Themes	Examples of typical quotes
1. The change in the professional identity of the primary care physician: physican as businessperson	We have to behave like a businessperson or entrepreneur, we have to compete. I see myself as half merchant, half subcontractor. Because we employ workers, something which we did not do before. (Female, 43 years old)
	At the family health centre, we pay for most things out of our own pockets, but when there are repairs or something, we go for the cheapest option. It's human nature, the less you spend, the happier you are. When FPs pay, they think less like doctors and more like merchants and they may behave unjustly towards their patients. The Ministry of Health should not involve physicians in commercial matters. (Male, 47 years old)
2. The transformation of the physician–patient relationship in primary care: physician–patient relationship as provider–client relationship	Constantly asking for medicine, asking for a sick note without telling you their complaint, asking for sick notes for everything you could imagine. This also happened in the health centres, but it was easier to refuse, we could struggle and get results, we did not experience the various psychological pressures so much. Now it is constant arguing and harassment. They can even argue with me about the subject of taking medicine. (Female, 46 years old)
	A patient comes and throws a prescription in front of you, saying 'prescribe this'. We say 'Look, things don't work like this, in family medicine, we will take care of you, we will examine you.' There are many people who scream and shout 'I'm going to complain about you, I'm going to change doctors', slam the door and leave. (Male, 31 years old)
3. Job description and workload	The working day, which starts at 8 o'clock in the morning, may not finish by 5 o'clock in the evening. I look and see that I have examined 100 patients. I see that in a day, I can only devote four minutes to each patient. (Male, 40 years old)
	A major problem is the fact that we have to deal with the generator, fuel, arranging cleaning and supplies of consumables. I want to do my job as a doctor, and not deal with anything else. I am also uncomfortable about the fact that we are being given financial problems to deal with. (Male, 57 years old)
	We have a legal right to 30 days annual leave. However, I cannot take even 20 days. You cannot leave without finding someone to fill your place. (Male, 28 years old)
4. Interpersonal relationships	When we encounter a problem, there is nobody to back us up. Suppose I have made a medical error, or a patient has unjustly complained about me; in the past, there was a certain state system to back me up, but now you will be taken to court and we also have to deal with the insurance companies. (Female, 45 years old)
	You feel very lonely. The midwife and I work separately. You do not see anybody apart from your patients. The health centre was a more social environment. (Male, 42 years old)
	In this system, rather than cooperation and solidarity, there is competition and performance. It is expected that you will compete rather than cooperate. (Female, 43 years old)
	Now, you go and pay your social security contributions, you find the best cleaning staff and if you do not like them, you change them, and this has made us like bosses. (Male, 32 years old)
5. The remuneration of family physicians	Compared to those who have chosen not to become family physicians, our financial situation is good. However, is this sustainable? With health policies changing day by day, will they keep this up? (Male, 58 years old)
	If only they had given us a basic salary, which was enough to be reflected in a decent pension, rather than giving us a poor basic salary topped up by performance related pay. (Female, 43 years old)
6. Uncertainty about the future	I cannot predict the future. What will my salary be in a month's time, where will I work, will I be on call at my age? I feel trapped. Because we are contract workers. (Female, 33 years old)
	There is the fear of unemployment. We are always under threat because we are contracted. No matter how devotedly doctors work, they may not be able to avoid penalty points or cancellation of their contracts. Because that is what the system is based on. (Male, 48 years old)
7. Exhaustion	I have given up on all my original plans. As everything gets a bit worse every year, we have become unhappy, hopeless, apathetic doctors. What I mean is, I do not care about my patients any more. (Male, 45 years old)
	Am I this worthless, has all this effort been for nothing? Every evening you find yourself in this quandary. I am a new graduate, but I'm like an old doctor. (Female, 27 years old)

Table 1. Overview of demographic characteristics and experiences of the FPs[a].

Characteristics	Number of family physicians ($n = 51$)
Sex	
Female	18
Male	33
Age	
≤29 years	4
30–39 years	12
40–49 years	28
≥50 years	7
Years in profession	
<5 years	3
5–14 years	8
≥15 years	39
Experience in family medicine model	
≤3 years	38
>3 years	13
Experience in health centre model	
Yes	41
No	10

[a]Statistical Region (Level 1): Istanbul 7, West Marmara 1, Aegean 16, East Marmara 3, West Anatolia 6, Mediterranean 3, Central Anatolia 1, West Black Sea 1, East Black Sea 2, Northeast Anatolia 2, Central Anatolia 4, Southeast Anatolia 5.

The transformation of physician–patient relationship in PC: Physician–patient relationship as provider–client relationship

Half of FPs reported close and continuous relationship with their patients and that this increased patient satisfaction. However, some of these FPs stated that this situation was also due to the fact that the concept of customer satisfaction had been embraced. It was pointed out that the anxiety felt by physicians about a decrease in the number of patients had played a significant role in the increasing importance of customer satisfaction. In addition, a large number of participants complained vigorously that some of their patients were behaving as extremely demanding consumers. It was explained that the statements made by the Ministry of Health when introducing family medicine, represented the health workers as being responsible for all problems in the health system and mechanisms, which made it very easy to make complaints about physicians, all had a strong influence on patients adopting this behaviour.

Job description and workload

FPs complained of the ambiguity of their job descriptions, continually increasing responsibilities, and an extremely high workload as a result. Polyclinic workload (50–120 patients daily) resulting from the high numbers of patients on their lists was indicated as the main reason for the increase in workload. In addition, FPs complained of being unable to offer a higher quality service because of the amount of time they devoted to duties, which they had not undertaken before the HTP, such as maintenance of infrastructure and accounting. Participants explained that the difference in their job descriptions, which came with FMM, was related to the businessperson identity, which was being given to family physicians.

Interpersonal relationships

FPs described the transition that they experienced as one of 'becoming isolated.' Negative relationships with superiors and audits based on punishments played an important role in this process. Many FPs reported various problems with interpersonal relationships because they could not find time anymore to communicate with each other. Most participants stated that due to an increase in individualism and competition, practices of cooperation and feelings of mutual trust had decreased.

FPs reported they had become employers of other staff that gave them the advantage of being able to work with people they wanted to.

The remuneration of family physicians

Most FPs were happy with the level of their income, although serious concerns were raised about whether or not the present levels would continue. Almost all participants described the negative incentives in the performance scheme with statements such as 'they cause physicians stress' and 'degrading.'

Uncertainty about the future

Most FPs were seriously worried about their future. Main reasons given for this were contractual working, changes in levels of income, and that only a small proportion of their income was reflected in their pensions.

Exhaustion

Many participants described the point at which they had come to in their experience as FPs in terms of tiredness, exhaustion, depression, unhappiness, apathy and unwillingness. Ten FPs stated that although they would still be able to work for many more years, they planned to retire as soon as they could.

DISCUSSION

Main findings

This study showed fundamental changes occurred in the organizational environment of FPs with the transition to FMM. The changed environment after the HTP, has increased the workload of FPs, affected interpersonal

relationships and caused uncertainty about income and future. After the reforms, the importation of commercial principles and market mechanisms to the management of primary health services has led the FPs to a business focus while causing the pervasion of demanding consumer behaviour among patients.

Strengths and limitations

Although the generalizability of its findings can be considered a limitation, the qualitative approach used in the study has provided comprehensive and in-depth understanding of the experiences of FPs. In addition, the study population may not have covered the full range of perceptions and experiences of all FPs in Turkey, although we aimed for maximal diversity in the sampling approach and had a relatively high number of participants for a qualitative design.

As the health reforms in many European countries are made up of similar components to the HTP, it may be conceived that the reforms will affect primary care physicians in similar ways (3,14–16). For this reason, findings are relevant to policy and service development in primary care in many regions of Europe.

Changes in roles of family physicians and patients

Providing health care in a businesslike manner has become more acceptable among primary care physicians over the last two decades since health reforms in many countries have promoted privatization (17,18). Many FPs complained they now felt like businesspeople and this new role conflicted with their identity as physicians. This identity change affected their relationships with both patients and other health workers. As in the process of commercialization of medicine, patients are defined as clients, and physicians as service providers (19). FPs participating in this study reported that patients have gained the identity of demanding customers, and because of worrying about losing patients or being complained about, they have started to put customer satisfaction before the well-being of patients. Some family physicians reported that whereas before the HTP, communication difficulties stemming from patients were dealt with by the whole health centre team, now they had to deal with these problems by themselves. This process of isolation reported by physicians has been brought about by the disappearance of the practice of working together and the fact that family physicians have become rivals. These interlinked effects of the contractual FMM have also been experienced in transition periods in European countries (2).

Working conditions and workload

The atmosphere of uncertainty caused by the constantly changing regulations and responsibilities from the beginning of the transition to the FMM has also been reported in another Turkish study (8). General practitioners in England also complained during PC reforms that the range of services included in the contracts was too broad (3), and reported important changes regarding both workload and working conditions (20). Boerma also pointed out that when trying to solve workload and time pressure problems, it is necessary to take into account financial and managerial duties and responsibilities such as professional development (21). In this study, FPs also reported the workload increase created by duties such as personnel management, the maintenance of infrastructure, the supply of consumables, accounting, and keeping of records.

According to FPs, the increase in daily polyclinic numbers (50–120 patients) is the main reason for a heavy workload. In European countries, the average daily patient numbers in German, Hungary and the Czech Republic of 50 was considered too high (21). The Turkish Medical Association's study reported that FPs work on average 59 hours per week (22). A large proportion of FPs emphasized long working hours resulted in a limit on the time they could devote to professional development and their private lives, as in studies from Lithuania and Poland (5,20).

Payment and performance

FPs were happy with their level of payment, which is reported as an important factor of job satisfaction (6,23). Complaints were made about the negative incentives performance system, which is seen as a degrading method of punishment. Studies show that performance related pay schemes lead to FPs choosing their priorities according to performance criteria, threatening professionalism (24), and force FPs to choose between professional values and profit (25).

Mental effects

Almost all FPs reported serious concerns due to uncertainty about the future. Most important reasons were the job insecurity caused by working on a contract, the expectation of a fall in payment and constantly increasing duties. Furthermore, participants described their experiences with terms such as tiredness, depression, apathy and unwillingness. The Ministry of Health has also confirmed these signs of exhaustion, which shows that the problem is not limited to participants in this study (26). The rapid changes to PC in the world have meant that PC physicians have become an exhausted group of health care workers (20,27,28).

Conclusion

In conclusion, the seven themes that emerged in this study have revealed the many interrelated results of the

transition to the FMM. Accordingly, concepts such as business administration, flexible working, isolation, competition, exhaustion and insecurity are becoming more embedded into the lives of physicians. This transformation in working conditions has led to changes in the professional attitudes of physicians and their practice of medicine.

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