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PAGES: 949-959

ORIGINAL PDF URL: https://dergipark.org.tr/tr/download/article-file/1612113

Factors Affecting the Demand for Family Medicine: Evidence for Behavioral Model from Turkey Data

Mehmet Nurullah KURUTKAN[1], Hasan Hüseyin YILDIZ[2], Tuba ARSLAN[3], Melek TERZİ[4], Dilek ŞAHİN[5]

Özet

Bu çalışmanın amacı, kronik hastalıkların ve sosyo-ekonomik faktörlerin, aile hekimliğine yönelik talep üzerindeki etkilerini incelemektir. Kullanılan temel yaklaşım Andersen'in davranışsal sağlık modelidir. Değişkenler 2016 yılına ait "TÜİK Sağlık Araştırması" mikro veri setinden elde edilmiştir. Kronik hastalığa ait verilerin ve sosyo-ekonomik değişkenlerin sağlık talebini etkileme derecesini tespit etmek için üç model kurulmuştur. Modellerin analizinde Binary Logit Regresyon analizi kullanılmıştır. Değişkenlerden cinsiyet, yaş, çalışma durumu, öğrenme güçlüğü, konsantrasyon problemi, tedavi masraflarının Sosyal Güvenlik Kurumu (SGK) tarafından karşılanıyor olması, güvenilir yakınının bulunması, komşularından yardım alma, sağlık hizmeti randevularına gecikme yaşamaları, kronik hipertansiyon ve şeker hastalığına sahip olmaları aile hekimliğinden hizmet alma durumuna etki eden değişkenlerdir (p<0,05). Araştırma sonuçlarına göre, hipertansiyon, şeker ve zihin sağlığı parametreleri ile sosyo-ekonomik değişkenlerin, aile hekimliği hizmeti alma durumu üzerinde etkili olduğu belirlenmiştir. Politika yapıcılar, aile hekimliği sisteminin sürdürülebilir olması ve daha çok tercih edilmesi amacıyla, farklı kronik durumların, demografik ve ekonomik yapının karşılaştırmalı yüküne ilişkin ekonometrik modellere dayalı kanıtlardan faydalanabilir.

Anahtar kelimeler: *Aile Hekimliği, Davranışsal Model, Kronik Hastalıklar, Sağlık Talebi, Türkiye Sağlık Araştırması*
Jel Kodu: *I11, I12, I15*

Aile Hekimliğine Olan Talebi Etkileyen Faktörler: Davranışsal Model İçin Türkiye Verilerinden Kanıtlar

Abstract

This study aims to investigate the effects of chronic diseases and socio-economic factors on the demand for family medicine. The basic approach used is Andersen's behavioral health model. The variables used in the analysis were obtained from the "TurkStat Health Survey" micro data set for 2016. Three models were established to determine the degree of chronic disease data and socio-economic variables affecting health demand. Binary Logit regression analysis was used in the analysis of models. The variables such as gender, age, employment status, learning difficulties, concentration problems, treatment costs covered by the Social Security Institution (SGK), having a reliable relative, receiving help from neighbors, delaying health care appointments, having chronic hypertension and diabetes are the variables that influence the condition of receiving service from the family medicine (p<0,05). According to the results of the research, it was determined that hypertension, diabetes, and mental health parameters and socio-economic variables are effective on the status of receiving family medicine services. Policymakers would benefit from evidence-based econometric models of the comparative burden of different chronic conditions, demographic and economic structures in order to ensure that the family medicine system is sustainable and more preferable.

Keywords: *Family Medicine, Behavioral Model, Health Demand, Turkey Health Interview Survey*
Jel Codes: *I11, I12, I15*

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INTRODUCTION

Many countries with a national health system state that the most appropriate strategy for achieving effectiveness, efficiency and fairness is a comprehensive family medicine program (Family Physician Program; FPP) (Strasser, 2003; Rivo, 1997; Khedmati, 2019). Family physicians, the heart of this system, play an important role in providing health services effectively and equally and act as a communication bridge (Atun et al., 2007).

The behavioral model developed by Andersen (1968) is frequently used in researches on healthcare use (Andersen, 1965; Andersen, 1995; Holtzman et al., 2015; Imbus et al., 2018). According to this model, healthcare use is the result of trends in use (demographic characteristics, social structure, etc.), factors that facilitate use (income level, presence of health insurance, etc.) and need for health care (having a chronic disease, evaluating the general health status, etc.) (Babitsch, 2012). These three factors are considered as "predisposing or personal", "enabling" and "needs-related" factors in most studies (Andersen, 1965; Fortin et al., 2018; Dhingra et al., 2010; Heider et al., 2014).

The development process of the model has been revised four times (Kara and Kurutkan, 2018: 34). Constructive criticism of the model made the revisions mandatory. Social-level factors were included in the model in the first revision, current health system and consumer satisfaction in the second revision. Factors such as personal care, proper and balanced diet, and exercise, etc. were included in the third revision, and indirect effects of factors affecting the use of health services on the level of health were included in the model in the last revision (Andersen, 1995; Gökkaya, 2016; Kılıç and Çalışkan, 2013).

Recently, in the studies on the use of health care and family medicine practice and the factors affecting it; age (Hirshfield et al., 2018; Fortin et al., 2018; Graham et al., 2017), age group (Hirshfield et al., 2018; Fortin et al., 2018), gender (Dhingra et al., 2010; Fortin et al., 2018), marital status, (Dhingra et al., 2010; Heider et al., 2014; Fortin et al., 2018; Graham et al., 2017), employment status (Graham et al., 2017; Hong et al., 2019), number of persons in the household (Graham et al., 2017), ethnic race (Hirshfield et al., 2018), education level (Dhingra et al., 2010; Heider et al., 2014; Fortin et al., 2018; Conner, 2012), sexual orientation (Hirshfield et al., 2018), spoken language (Fortin et al., 2018; Jin et al., 2019), social environment (Heider et al., 2014; Graham et al., 2017; Bradley et al., 2002), religious factors (Conner, 2012), place of residence (Hirshfield et al., 2018; Fortin et al., 2018), household income (Heider et al., 2014; Hirshfield et al., 2018; Hong et al., 2019), source of income (Fortin et al., 2018), health insurance (Heider et al., 2014; Hirshfield et al., 2018), spiritual support (Dhingra et al., 2010), general health status (Dhingra et al., 2010; Chong and Ho, 2018), financial problems (Graham et al., 2017), HIV, diabetes, heart disease, obesity (Hirshfield et al., 2018), cancer (Jin et al., 2019), depression (Hirshfield et al., 2018; Chong and Ho, 2018), hypertension (Ogunsanya et al., 2016), adaptation disorder, suicidal ideation, schizophrenia, anxiety, personality disorder, attention deficit, mood disorder (Fortin et al., 2018), mental disorder (Fortin et al., 2018; Graham et al., 2017), day-to-day treatment service (Heider et al., 2014; Kaya et al., 2019), alcohol and substance use (Hirshfield et al., 2018; Fortin et al., 2018), status of psychiatrist consultation, psychologist consultation, social worker consultation and alcohol and drug consultation (Fortin et al., 2018) are among the variables used.

The purpose of this study is to examine the status of receiving services from the family medicine within the framework of the behavioral model developed by Andersen. Differential analysis for preparatory, facilitating and perceived health-related independent variables constitutes the sub-purpose of the study.

2. METHOD

In this study, 2016 "Turkey's Health Research" micro data sets were used. The Health Questionnaire is conducted every 2 years by TURKSTAT and the most recent survey belongs to 2016. Its scope is households located in all settlements within the borders of Turkey. The population defined as institutional (population living in dormitories, hospitals, jails, rest homes, and soldiers) are out of coverage and the residential places having less than 20 addresses are left out of coverage since it is thought that we would not be able to reach enough sample household number. The total number of observations in the data set is 23.606. In this study, since the information about individuals over 15 years old was used, the total number of observations first decreased to 17.242. Afterwards, the number of observations included in the econometric analysis fell to 9.278 including all variables (chronic diseases and socio-demographic factors). The data process is explained in detail in Figure 1.
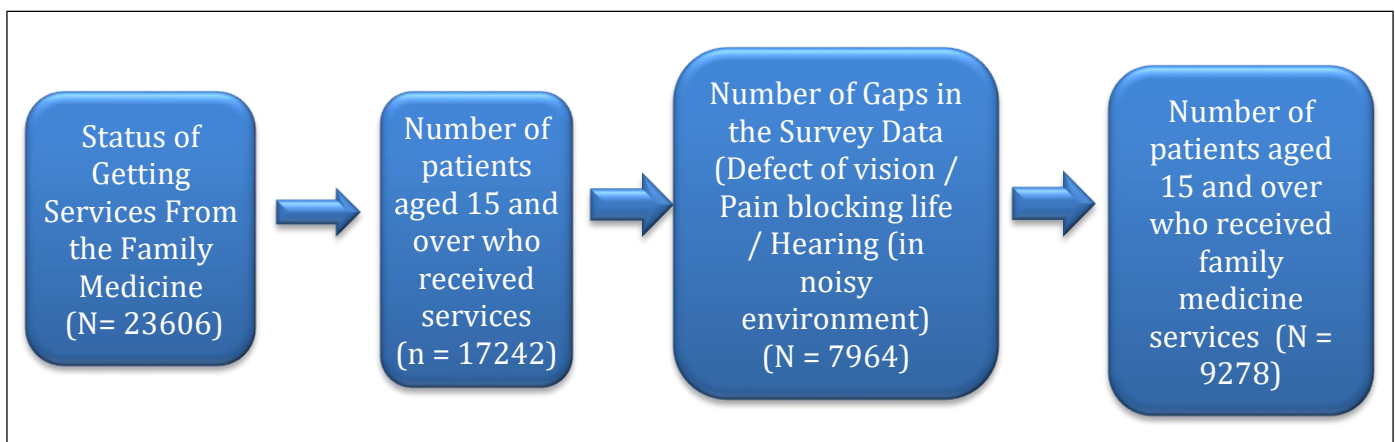

Figure 1: Data Process Diagram

The binary logit regression analysis method was used to determine the status of going to the family medicine. It is possible to summarize the working algorithm of logit model analysis as follows.

The logit method is used as an alternative to discriminant analysis and cross tables in case of various assumption distortions (normality, having common covariance). In case the dependent variable is binary such as 0/1 or polychotomous discrete variable involving more than two levels, it is used as an alternative to linear regression analysis due to the disruption of normality assumption (Kaşko, 2007).

3. FINDINGS

General descriptive statistics about demographic factors are given at the beginning of the findings section. The findings section consists of two main headings:

- Difference analysis table of variables (Table 1),
- Binary logit regression analysis for factors affecting the status of receiving services from a family medicine (Dependent variable) (Table 2)

The average age of the people in the study is 48,20 (SD ± 888). Most of the participants are women (63,50%), primary school graduates (43,50%), married (72,70%), their household incomes are 1265- 1814 TL (27,80%) and they did not work in any job (67.10%). While 89.1% (n = 8270) of the participants received service from the family medicine, the remaining 10.9% (n = 1008) received no service from the family medicine

Differential analyzes for preparatory factors: Among the preparatory factors, the analysis of the differences between only three variables (gender, employment status and difficulty in remembering) is statistically significant

(p<0,05). According to the analysis, it was determined that the rate of women using the family medicine is higher than that of men.

In terms of employment status, it was found that non-employed people have higher rates of using family medicine than employees. In terms of remembering, it was found that people who have difficulty remembering have higher rates of using the family medicine. No difference was found between the groups of variables evaluated within the other preparatory factor.

ifferential analyzes for facilitating factors: The analysis of differences between groups of seven variables (household income, being a member of the SGK, reliable relative, interest from the environment, help from neighbors, delay in treatment because of not making an appointment and delay in medical care caused by insufficient payment capacity) from facilitating factors is statistically significant (p<0.05). In terms of household income, it was found that families with incomes between 2541-3721 TL were more likely to use family medicine. In terms of treatment costs, it was determined that people who are assured by SSI-Social Security Institution (SGK) have a higher rate of using family medicine. In terms of reliable relative and neighbor help, it was found that people who have a reliable relative and who can get help from their neighbors have a higher rate of using the family medicine. From the point of view of the delay in the appointment, it was determined that people who experience a delay in appointment have a higher rate of using the family medicine. In terms of payment difficulties in medical care, people who do not have payment difficulties were found to have higher rates of using the family medicine. The reason for this is thought to be due to the fact that people who do not have payment difficulties have social security.

Difference analysis for Perceived Health: The variables under this factor consist of variables for both chronic diseases and mental health. In total, a difference was found between the groups of fifteen variables (p <0.05). People with moderate general health status were found to be more likely to use family medicine

In terms of difficulty in seeing and hearing in a noisy environment, it was found that people who have difficulty in seeing and hearing in a noisy environment have a higher rate of using the family medicine. In terms of disease-health status, it was found that people with any disease use family medicine more. From the point of view of physical pain, it was found that people with higher levels of physical pain use family medicine more. At the same time, from the point of view of the pain-blocking life, it is determined that people whose life is blocked due to pain use family medicine more. In terms of chronic diseases, it was determined that people who experience hypertension, asthm, arthritis, depression, diabetes, coronary heart disease, lower back and neck diseases use family medicine more.

There is no statistically significant difference between subgroups of variables such as age and marital status, place of birth, learning difficulties, concentration problem, alcohol use status, receiving inpatient service for the last 12 months, receiving psychologist consultation for the last 12 months, receiving psychotherapist consultation for the last 12 months, unofficial aid, delay in receiving health care due to transportation problems, depression, feeling the pleasure, feeling worthless, difficulty in hearing in a quiet environment, stroke-paralysis, chronic bronchitis, kidney disease and infarction (p>0,05).(Table 1).

According to the results of Model 1, individuals' age increases their likelihood of applying for family medicine service by 1,016 times and their educational status by 1,088 times. On the other hand, gender differences decrease the likelihood of individuals applying to family medicine service by 0.58 times, employment status by 0.814 times and learning difficulties by 0.8 times.

Table 1. Differential Analysis of Variables Affecting the Status Of Receiving Services From The Family Medicine

Preparative Factors

Factor	Level	N	%	Mean	Std	CI		Sig.
Gender	Female	5892	63.5	.91	.004	.90	.92	0.000
	Male	3386	36.5	.86	.006	.85	.87	
Age	15-120	9278		48.20	17.888			
Marital Status	Single	2531	27.3	.88	.006	.87	.89	0.054
	Married	6747	72.7	.90	.004	.89	.90	0.051
Education	Illiterate	1412	15.2	.88	.009	.87	.90	0.084
	Didn't finish any school	658	7.1	.90	.012	.88	.92	
	Primary School	4038	43.5	.90	.005	.89	.91	
	Middle School	735	7.9	.90	.012	.87	.91	
	High School	1381	14.9	.87	.009	.86	.89	
	College	346	3.7	.90	.016	.87	.94	
	University	615	6.6	.90	.012	.87	.92	
	Post graduate (Master/Ph.D.)	93	1.0	.83	.039	.75	.91	
Place of Birth	Turkey	9109	98.2	.89	.003	.89	.90	0.510
	Other	169	1.8	.87	.025	.83	.93	
Employment Status	Employee	3052	32.9	.88	.006	.85	.88	0.000
	Not employee	6226	67.1	.90	.004	.90	.91	0.000
Learning	Having difficulty	2260	24.4	.90	.006	.89	.91	0.259
	Not having difficulty	7018	75.6	.89	.004	.88	.90	
Recalling	Having difficulty	2863	30.9	.90	.006	.89	.91	0.021
	Not having difficulty	6415	69.1	.89	.004	.88	.89	
Concentration Problem	Yes	2494	26.9	.90	.006	.89	.91	0.060
	No	6784	73.1	.89	.004	.88	.90	
Alcohol use status	Yes	2138	23.0	.89	.007	.87	.90	0.314
	No	7140	77.0	.89	.004	.89	.90	
Receiving inpatient service for the last 12 months	Yes	1486	16.0	.90	.008	.88	.91	0.390
	No	7792	84.0	.89	.004	.88	.90	
Receiving psychologist consultation for the last 12 months	Yes	269	2.9	.91	.018	.87	.94	0.401
	No	9009	97.1	.89	.003	.89	.90	
Receiving psychotherapist consultation for the last 12 months	Yes	413	4.5	.90	.015	.87	.93	0.531
	No	8865	95.5	.89	.003	.88	.90	

Facilitating Factors

Factor	Level	N	%	Mean	Std	CI		Sig.
Household income	0-1264 TL	2333	25.1	.86	.007	.85	.87	0.000
	1265-1814 TL	2578	27.8	.89	.006	.88	.91	
	1815-2540 TL	1668	18.0	.91	.007	.90	.93	
	2541-3721 TL	1415	15.3	.92	.007	.91	.93	
	3722+ TL	1284	13.8	.89	.009	.87	.90	
Treatment cost SGK	Yes	7727	83.3	.91	.003	.90	.91	0.000
	No	1551	16.7	.82	.010	.80	.84	
Reliable Relative	I have	8734	94.1	.89	.003	.89	.90	0.000
	I don't have	544	5.9	.85	.016	.82	.88	
Interest From the Environment	Too much	1085	11.7	.88	.010	.86	.90	0.001
	Much	4635	50.0	.90	.004	.89	.90	
	Not sure	2308	24.9	.89	.006	.88	.91	
	Little	880	9.5	.91	.010	.89	.93	
	None	370	4.0	.84	.019	.80	.87	
Help From Neighbors	Very difficult	369	4.0	.80	.021	.76	.84	0.000
	Difficult	813	8.8	.87	.012	.84	.89	
	Moderate	1391	15.0	.90	.008	.89	.92	
	Easy	5159	55.6	.90	.004	.89	.90	
	Very Easy	1546	16.7	.90	.008	.88	.91	
Unofficial Aid	Yes	1013	10.9	.90	.009	.89	.92	0.197
	No	8265	89.1	.89	.003	.88	.90	
Delay due to long appointment time	Yes	1674	18.0	.87	.007	.86	.89	0.012
	No	7604	82.0	.89	.004	.88	.90	
Delay due to transportation or distance	Yes	1175	12.7	.88	.009	.87	.90	0.403
	No	8103	87.3	.89	.003	.88	.90	
Payment Difficulty in Medical Care	Yes	1142	12.3	.87	.010	.85	.89	0.034
	No	8136	87.7	.89	.003	.89	.90	

Factors Affecting Perceived Need

Factor	Level	N	%	Mean	Std	CI		Sig.
General Health Status	Very Bad	407	4.4	.87	.016	.84	.91	0.000
	Bad	3466	37.4	.87	.006	.85	.88	
	Moderate	3600	38.8	.92	.005	.91	.93	
	Good	1610	17.4	.90	.008	.88	.91	
	Very Good	195	2.1	.85	.026	.80	.90	
Distress	Disturbed	5125	55.2	.89	.004	.89	.90	0.355
	Didn't disturb	4153	44.8	.89	.005	.88	.90	0.885
Feeling the Pleasure	Disturbed	4659	50.2	.89	.005	.88	.90	
	Didn't disturb	4619	49.8	.89	.005	.88	.90	0.467
Feeling worthless	Yes	2871	30.9	.89	.006	.88	.90	
	No	6407	69.1	.89	.004	.88	.90	0.034
Defect of vision	Having difficulty	4054	43.7	.90	.005	.89	.91	
	Not having difficulty	5224	56.3	.89	.004	.88	.89	0.000
Disease Health Status	Yes	6168	66.5	.91	.004	.90	.91	
	Not	3110	33.5	.86	.006	.85	.87	0.000
Restriction of vital activities related to health problems	Restricted	5188	55.9	.91	.004	.90	.92	
	Not Restricted	4090	44.1	.87	.005	.86	.88	0.007
Physical pain	Too much	503	5.4	.87	.015	.84	.90	
	Much	1726	18.6	.91	.007	.89	.92	
	Moderate	2407	25.9	.90	.006	.89	.91	
	Little	1992	21.5	.89	.007	.88	.91	
	Very Little	2650	28.6	.88	.006	.86	.86	
Pain blocking life	Blocking	7723	83.2	.90	.003	.89	.91	0.000
	Not Blocking	1555	16.8	.85	.009	.84	.87	0.754
Difficulty hearing when chatting in quiet room	Having difficulty	1616	17.4	.89	.008	.88	.91	
Difficulty hearing when chatting in noisy room	Nothing difficulty	7662	82.6	.89	.004	.88	.90	0.028
	Having difficulty	2810	30.3	.90	.006	.89	.91	
	Nothing difficulty	6468	69.7	.89	.004	.88	.90	0.000
Hypertension	Yes	2521	27.2	.94	.005	.93	.95	
	No	6757	72.8	.87	.004	.86	.88	0.547
Stroke/paralysis	Yes	130	1.4	.91	.025	.86	.96	
	No	9148	98.6	.91	.003	.88	.90	0.007
Asthma	Yes	1156	12.5	.91	.008	.90	.93	0.000
	No	8122	87.5	.89	.003	.88	.89	
Chronic Bronchitis	Yes	1054	11.4	.91	.009	.89	.93	0.052
	No	8224	88.6	.89	.003	.88	.89	
Arthrosis	Yes	1355	14.6	.93	.007	.91	.94	0.000
	No	7923	85.4	.89	.004	.89	.89	
Kidney disease	Yes	952	10.3	.90	.010	.88	.92	0.209
	No	8326	89.7	.89	.003	.89	.90	
Depression	Yes	1112	12.0	.92	.008	.90	.93	0.004
	No	8166	88.0	.89	.003	.89	.89	
Diabetes	Yes	1428	15.4	.93	.007	.92	.95	0.000
	No	7850	84.6	.88	.004	.88	.89	
Infarction	Yes	356	3.8	.90	.016	.87	.94	0.417
	No	8922	96.2	.89	.003	.88	.90	
Coronary heart disease	Yes	1067	11.5	.91	.009	.90	.93	0.017
	No	8211	88.5	.89	.003	.88	.90	
Low back problems	Yes	4185	45.1	.90	.005	.89	.91	0.006
	No	5093	54.9	.88	.004	.87	.89	
Neck region diseases	Yes	2937	31.7	.91	.005	.90	.92	0.000
	No	6341	68.3	.88	.004	.88	.89	

According to the results of Model 2, individuals' age increases their likelihood of applying for family medicine service by 1,012 times, having a concentration problem by 1,18 times, household income by 1,075 times, treatment costs covered by SGK by 1,74 times, having reliable relatives by 1,42 times, getting help from neighbors 1,13 times and delay in receiving health services due to long appointment system 1,37 times. However, gender decreases the probability of individuals to apply for family medicine service by 0.64 times and their employment status by 0.79 times.

According to the results of Model 3, individuals' age increases their likelihood of applying for family medicine service by 1 time, having a concentration problem by 1,27 times, household income by 1,072 times, treatment costs covered by SGK by 1,72 times, having reliable relatives by 1,39 times, getting help from neighbors 1,41 times and delay in receiving health services due to long appointment system 1,35 times, having hypertension disease 1,62 times and having diabetes 1,31 times. However, gender decreases the probability of individuals to apply for family medicine service by 0.69 times and their employment status by 0.81 times. (Table 2)

4. DISCUSSION AND LIMITATIONS

Within the scope of this research, the factors affecting the status of receiving services from the family medicine were examined within the framework of the behavioral model developed by Andersen. In the study, the frequency of using a family medicine was found to be high with 89.1%. In similar studies on the subject, the rate of application to the family medicine was between 35.3% and 84.6% (Hirshfield et al., 2018; Fortin et al., 2018; Franck et al., 2020). In this study, it was revealed that women (63.5%) mostly used the family medicine in terms of gender. This result is in line with similar studies. Within the scope of other studies, between 50.6% and 61.7% of women used health care (Dhingra et al., 2010; Hong et al., 2019; Conner, 2012; Jin et al., 2019; Roh et al., 2017; Liu et al., 2019). However, some studies determine that men (around 53%) receive more health services (Holtzman et al., 2015; Kaya et al., 2019).

In this study, it was revealed that the most married people (72.7%) used a family medicine. If we look at similar studies on the subject, it was determined that 52.9% to 84% of the married people use health service (Heider et al., 2014; Hong et al., 2019; Jin et al., 2019; Ogunsanya et al., 2016; Kaya et al., 2019; Franck et al., 2020; Liu et al., 2019). Some studies determine that those who receive health services (66% and 84.6%) are not married (single, divorced and widows) (Fortin et al., 2018; Hirshfield et al., 2018; Lee et al., 2020). In terms of educational status, it was found out that primary school graduates (43.5%) used family medicine more. Fortin et al.'s study also found that primary school graduates (53.5%) mostly used health care. According to the research conducted by Kaya et al. (2019: 377), it was revealed that primary or secondary school graduates (46.1%) mostly used healthcare services. However, studies are showing that this situation varies from country to country. In some countries, university graduates are more likely to use family medicine services, while in others, high school graduates are reported to receive more services (Dhingra et al., 2010; Heider et al., 2014; Hirshfield et al., 2018; Hong et al., 2019; Conner, 2012; Jin et al., 2019; Ogunsanya et al., 2016; Franck et al., 2020; Roh et al., 2017; Liu et al., 2019; Lee et al., 2020).

In terms of employment status, it was revealed that people who did not work (67,1%) used family medicine the most. If we look at similar research on the subject; According to the research conducted by Conner (2012: 372), it was revealed that people who could not do work physically (desk workers; white collar) (60,6%) use health care. However, according to the research conducted by Hong et al. (2019: 44), it was determined that the working people (53,1%) used the health services the most.

Table 2: Binary Logit Regression Analysis for Factors Affecting the Status of Receiving Services from Family Medicine

Variables	First Model					Second Model					Third Model				
	Coefficient	OR	p	95% CI		Coefficient	OR	p	95% CI		Coefficient	OR	p	95% CI	
Gender	-,535	,585	,000	,504	,681	-,435	,647	,000	,555	,755	-,363	,695	,000	,594	,814
Calculated Age	,016	1,016	,000	1,012	1,021	,012	1,012	,000	1,008	1,017	,007	1,007	,018	1,001	1,012
Marital Status	-,119	,888	,123	,763	1,033	-,064	,938	,411	,805	1,093	-,092	,912	,244	,781	1,065
Education	,085	1,088	,001	1,036	1,143	,013	1,013	,630	,960	1,069	,023	1,023	,401	,970	1,080
Place of Birth	,351	1,420	,143	,888	2,271	,290	1,337	,229	,833	2,147	,306	1,357	,209	,843	2,186
Employment Status	-,206	,814	,009	,697	,950	-,236	,790	,003	,676	,923	-,211	,810	,009	,691	,948
Concentration Problem	,126	1,134	,124	,966	1,332	,172	1,187	,039	1,008	1,398	,244	1,276	,014	1,050	1,550
Learning	-,224	,800	,029	,654	,977	-,125	,882	,229	,719	1,082	-,128	,880	,239	,712	1,088
Recalling	,037	1,038	,676	,872	1,236	,039	1,039	,669	,871	1,240	,002	1,002	,987	,834	1,203
Alcohol use status	,133	1,142	,124	,964	1,352	,098	1,103	,262	,929	1,308	,101	1,106	,252	,931	1,315
Receiving inpatient service for the last 12 months	-,006	,994	,951	,825	1,198	,019	1,019	,844	,844	1,230	-,027	,974	,787	,802	1,182
Receiving psychologist consultation for the last 12 months	,110	1,116	,630	,715	1,742	,086	1,090	,708	,696	1,707	,015	1,015	,948	,642	1,606
Receiving psychotherapist consultation for the last 12 months	-,001	,999	,994	,702	1,421	,004	1,004	,983	,703	1,434	-,095	,910	,622	,624	1,326
Household income						,072	1,075	,017	1,013	1,141	,069	1,072	,023	1,010	1,138
Treatment cost SGK						,556	1,744	,000	1,471	2,069	,545	1,725	,000	1,453	2,049
Reliable Relative						,356	1,428	,006	1,108	1,840	,329	1,390	,012	1,075	1,796
Interest From the Environment						,058	1,060	,121	,985	1,141	,069	1,072	,069	,995	1,154
Help From Neighbors						,126	1,134	,000	1,058	1,216	,132	1,141	,000	1,064	1,224
Unofficial Aid						,121	1,128	,293	,901	1,412	,117	1,124	,312	,896	1,411
Delay due to long appointment time						,316	1,372	,003	1,116	1,687	,304	1,355	,004	1,100	1,670
Delay due to transportation						-,147	,864	,205	,688	1,083	-,141	,868	,226	,691	1,092
Payment Difficulty in Medical Care						-,012	,988	,912	,795	1,227	-,044	,957	,696	,768	1,193
General Health Status											-,054	,948	,345	,847	1,060
Disease Health Status											-,015	,985	,884	,809	1,201
Asthma											,106	1,112	,407	,865	1,430
Chronic Bronchitis											-,055	,947	,677	,733	1,224
Infarction											-,196	,822	,349	,546	1,239
Coronary heart disease											-,006	,994	,967	,766	1,291
Hypertension											,485	1,624	,000	1,317	2,003
Stroke/paralysis											-,033	,968	,918	,517	1,810
Arthrosis											,178	1,195	,146	,940	1,518
Low back problems											-,045	,956	,575	,815	1,120
Neck region diseases											,051	1,053	,557	,887	1,250
Diabetes											,273	1,314	,027	1,032	1,674
Kidney disease											-,051	,951	,680	,747	1,209
Depression											,259	1,295	,050	1,000	1,677
Physical pain											,047	1,048	,161	,981	1,119
Pain blocking life											,303	1,355	,001	1,131	1,623
Feeling the Pleasure											-,084	,920	,363	,768	1,101
Distress											,084	1,088	,368	,905	1,308
Feeling worthless											-,220	,802	,025	,662	,973
Restriction of vital activities related to health problems											,293	1,341	,003	1,108	1,623
Hearing (in silence environment)											-,309	,734	,026	,559	,963
Hearing (in noisy environment)											,133	1,142	,251	,910	1,432
Defect of vision											-,100	,905	,204	,775	1,056

In terms of household income, it was revealed that people with the second group (1265-1814 TL) income (27.8%) used the family medicine. If we look at similar research; according to the research conducted by Dhingra et al. (2010: 526), it was revealed that people with the third group ($ 20000-49999) income (34.3%) used health care. According to the research conducted by Franck et al. (2020: 54), it was revealed that people with the highest fifth group (2800-4200 €) income (28.4%) used health care. According to the research conducted by Hirshfield et al. (2018: 791), it was revealed that people with the third group ($ 50,000 and above) income (51%) used health care.

It was found that people (83.3%), whose treatment expenses were covered by the SGK, used the family medicine the most. If we look at similar studies on the subject, individuals under a social security umbrella were found to use health care between 62.8% and 92.2% (Dhingra et al., 2010; Heider et al., 2014; Hong et al., 2019; Jin et al., 2019; Roh et al., 2017; Lee et al., 2020).

In the study, it was revealed that people with a reliable relative (94,1%) used the family medicine the most. If we look at similar research on the subject; those with close social relationships and reliable relatives were determined to use health care between 51,6% and 89,7% (Kaya et al., 2019; Liu et al., 2019). In the study, it was revealed that people who did not have difficulty in payment in medical care (87.7%) used the family medicine the most. Similar studies on the subject reveal that

41,6% to 85,4 % of people who did not have payment difficulties turned out to be using the health services the most (Graham et al., 2017; Hong et al., 2019).

The study showed that people with moderate overall health conditions (38,8%) used a family medicine the most. Considering similar researches on the subject, it was determined that people with the highest general health status (33,9%) used health care the most according to the research conducted by Dhingra et al. (2010: 526). According to the research conducted by Franck et al. (2020: 55), it was found that people (58,1%) whose health status ranged from good to very good used health services the most. According to the research conducted by Liu et al. (2019: 6), it was determined that the people whose general health status was ordinary, good or very good (76%) used health services the most. According to the research carried out by Ogunsanya et al. (2016: 11), it was found that people (48,8%) with a very good or excellent general health status used the health service the most.

In terms of psychological factors, in this study, it was revealed that people who are suffering from depression (55.2%), who do not feel pleasure (50.2%) but who also feel worthless (69.1%) use the family medicine the most. Considering similar researches on the subject, it was determined that people with mood disorders (44%) used health care the most according to the research conducted by Fortin et al. (2018: 590). According to the research conducted by Dhingra et al (2010: 526), it was revealed that people (64.8%) who did not have difficulty remembering used health care the most. According to the study conducted by Fortin et al. (2018: 110), it was revealed that individuals (81.8%) who experienced somatic disorder (a condition that occurs when people are overly concerned about physical symptoms such as fatigue or pain) use health care the most. According to the research conducted by Franck et al. (2020: 55), it was revealed that people who did not experience depressive disorder (70.9%) used health care

the most. According to the research conducted by Graham et al. (2017: 173), it was revealed that people (74%) who experienced the most psychological problems used health care the most.

In this study, it was found that people whose lives were restricted (55.9%) used family medicine the most. According to a similar study conducted by Franck et al. (2020: 55), it was revealed that people without a functional limitation (44.4%) due to a health-related problem used health care the most. In this study, the prevalence of twelve chronic diseases ranged from 1.4% to 45.1%. The most common chronic disease is a low back problem. The least common chronic disease is stroke- paralysis. Chronic diseases affecting the state of going to the family medicine are only hypertension (1,624 times increased) and diabetes disease (1,314 times increased). Considering similar researches on the subject, depression (Holtzman et al., 2015; Chong et al., 2018), schizophrenia (Fortin et al., 2018), diabetes, hypertension, an endocrine disorder, gynecology, cancer and obesity diseases (Jin et al., 2019; Franck et al., 2020; Liu et al., 2019), AIDS and heart diseases (Hirshfield et al., 2018) affect the state of going to healthcare professionals. According to the studies conducted by Jin et al.(2019) and Jane et al. (2020), cancer disease affects the condition of receiving treatment. According to the studies conducted by Liu et al.(2019: 6), hypertension and diabetes diseases affect the condition of receiving treatment. According to the studies conducted by Travers et al.(2020: 3) (Travers et al., 2020) diabetes, hypertension and heart diseases affect the condition of receiving treatment.

In Babitsch et al.'s systematic review study in 2012, a large number of variables evaluated within the Behavioral model was identified. Of the variables obtained from all studies, the names of which are given in quotes below were not included in the analysis because they are not in the Turkish Health Survey data. (Babitsch et al., 2012: 3): there are no data on the number of children in the country, area of

residence (urban, rural, etc.), family structure, ability to speak English, health beliefs, trust in healthcare institutions, acculturation, stress factor at work, life satisfaction, number of first aiders, age-gender interaction, racial discrimination, health monitoring, prison history, victimization, homelessness, exposure to violence.

In addition, there are no data on doctor's diagnosis, full-time studentship, the time between referral and mental health assessment, people's preparation for access barriers, special medical needs, preparation for ethnic or cultural distinctions, availability of health-related information, crime rate, foreign language skills of medicine and preparing people for unemployment.

There are no data on perceived health, cancer, high cholesterol, thyroid, anxiety, suicidal ideation, metabolic syndrome, epilepsy, birth control pill use, history of violence, ulcers, number of hospital admissions, the relationship between quality of life and health, injuries, pregnancy, flu infection, prostate problems, blood circulation status, a gastrointestinal condition, gynecological problems, pulmonary status, and need for help with alcohol or substance use problem, which are among the ""requirement/need factors".

5. RESULT

Understanding healthcare-seeking behavior and its determinants help governments adequately allocate and manage existing health resources. B This is particularly important in countries with limited resources, such as Turkey. Inequalities in the use of the public and private health sectors remain a widespread problem. Informal healthcare providers (traditional healers, unskilled medical practitioners, faithful healers) remain the first point of contact in some areas. Because health service search behavior is linked to worse health outcomes, identified determinants can provide valuable insights into designing personalized health interventions and capacity building for health care providers.

Two of the biggest barriers to accessing the service are particularly significant. Having low income and not being able to pay for the service to be received are among the problems that reduce inequalities. Social policy tools should come into play for these two obstacles. In addition, priority should be given to preventive health services in order to combat diseases such as diabetes, waist and neck problems, hypertension and arthrosis, which are found to increase the workload of family medicine statistically. In this regard, governments should apply the method of resource allocation.

As a result, policymakers should conduct prioritization studies aimed at the factors that increase and decrease individuals' family medicine service use behavior. It is important that the monitoring and investigation of these components in the execution of the services to ensure that the family medicine system is sustainable and more preferable, is a guide for health managers in creating and executing related policies

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