RESEARCH ARTICLE

JOURNAL OF INTERNATIONAL HEALTH SCIENCES AND MANAGEMENT

RESEARCHING THE RELATIONSHİP BETWEEN ORGANIZATIONAL HEALTH AND WHİSTLEBLOWING BEHAVIOR: EDUCATION AND HEALTH ORGANIZATIONS VERSION*

Mustafa ALTINTAŞ[1]

Musa ÖZATA[2]

ABSTRACT

Whistleblowing behavior is considered as an important tool in exposing unethical or illegal behaviors occurring in education and health institutions. Whistleblowing behavior, which plays a role as a control system in organizations, is a starting point especially for organizations to control themselves. Organizational health is a state of integrity created by all kinds of physical, psychological and mental conditions that contribute to employee productivity and efficiency, job satisfaction, corporate loyalty and a sense of loyalty. In this context, the purpose of this research is to determine the relationship between the perception of organizational health and whistleblowing behavior.

The research is a study that investigates the relationship between the two concepts and quantitative research method was used in the research. The sample of the study consisted of a total of 370 people, including 212 education workers and 158 health workers, who voluntarily agreed to participate in the study. The survey technique was used to collect the data and the data obtained were analyzed using the SPSS 22.00 package program. Exploratory and Confirmatory Factor Analysis, Mann-Whitney U test, Kruskal Wallis Variance Analysis and Spearman Correlation Analysis were used to evaluate the findings in the study.

As a result of the findings obtained from the study, a positive, weak ($r = 0.143$; $p < 0.05$) but statistically significant relationship was found between organizational health perception and whistleblowing behavior. In addition, when the sub-dimensions of organizational health perception and whistleblowing behavior were examined, the presence of significant relationships in all dimensions were determined except for the "indifference" dimension.

Keywords: Education Organization, Health Organization, Organizational Health, Whistleblowing.

ARTICLE INFO

*This article is produced from the master thesis titled "Investigating the Relationship Between Organizational Health and Whistleblowing: The Case of Education and Health Institutions".

[1]Lecturer, Yozgat Bozok University Çekerek SHMYO, mustafa.altintas@bozok.edu.tr

Orcid Number: https://orcid.org/0000-0002-9846-5513

[2]Prof. Dr., Kırşehir Ahi Evran University Faculty of Health Sciences, musaozata@gmail.com

Orcid Number: https://orcid.org/0000-0003-1742-0215

Recieved: 19.08.2019 **Accepted:** 10.04.2020

Cite This Paper: Altıntaş M., Özata M. (2020). Researching the Relationship Between Organizational Health and Whistleblowing Behavior: Education and Health Organizations Version. Journal of International Health Sciences and Management, 6(10): 12-34.

1. INTRODUCTION

The reason for the existence of an organization is that certain objectives are realized as more than one person and a group. Organizations are social creatures that exist in social life, open to the influence of social conditions and able to adapt to changing conditions (Koçel, 2013: 71). Organizations are structures that are seen as systems. The system is a whole formed by the parts that come together for a purpose, by relying on each other and influencing each other. According to the system approach, the organization is an open system that consists of sub-systems that interact with each other and has an input-output relationship with its environment. Organizations take various inputs from the environment and process them and present them back to the environment. Therefore, the organization is in constant interaction with the environment (Ayduğ, 2014: 1). In our age, organizations should be able to adapt to rapidly changing environmental conditions, technological advances, transition to information society, global progress and changes in order to achieve their goals; they must target success by achieving competition in free market conditions. Organizations must first adapt to these environmental changes in order to survive and achieve their goals (Karacan, 2017:1).

It is possible to talk about many factors that affect the achievement of the targets and success and efficiency of the organizations in ensuring their continuity. The goals determined by the organization for success are the realization of the targets, leadership skills of the managers, the level of commitment of the employees to the organization, and whether or not the organization is healthy (Batmaz, 2012:6).

Improving health in organizations is a situation that can be monitored and determined by the behavior of people in the organization. To understand this situation, first of all, interpersonal relations are handled. As a result, the physical, mental and social health status of individuals can be determined and adapted to the organization. Geller (2004:11) investigated this situation and made a model proposal for multinational companies and their leaders. In the model, there are suggestions in the context of how the health status of the organization can be good in big companies. The commitment and motivation of the human resources working in healthy organizations to the organization is high. Efficiency and success will increase in organizations where there are managers who value human resources, have effective leadership, and employees with high organizational commitment (Çakınberk & Demirel, 2010: 104).

The concept of organizational health is a concept that emerged in the field of organizational behavior and work psychology. The concept was first introduced by Matthew Miles (Polatcı et al., 2008: 146). Although the concept of organizational health is used a lot in the literature, it appears as a concept that has been subjected to very weak definitions (McHugh & Brotherton, 2000). In general terms, organizational health refers to the skills that an organization can successfully adapt both to its internal and external environment, to collaborate among the employees and to achieve the goals of the organization (Köseoğlu & Karayormuk, 2009; Altun, 2001; Akbaba, 1997; Hoy & Tarter, 1997; Hoy & Miskel, 1991; Cox & Howarth, 1990; Cooper & Williams, 1994; Newell, 1995). According to another approach, organizational health is related to the fact that the employee is good and healthy both physically and mentally (Mchugh, 1993; Ho, 1997). According to some researchers, organizational health is a concept that can be explained with the help of learning organizations (Pettigrew & Whipp, 1991; Miller & Dess, 1996). Organizational health can be defined as not only maintaining its life in its environment, but also developing and sustaining its ability to cope and live in a long time (Miles, 1965). When the studies on organizational health are analyzed, it is observed that studies on organizational health of primary and secondary schools are carried out first (Kimpston and Sonnabend, 1975; Miller, 1983; Childer and Fairman, 1986; Hoy et al., 1990; Akbaba, 1997; Uras, 1998 ; 2000; Çakır, 2002; Korkmaz, 2005; Buluç, 2008). Later, studies were carried out in higher education organizations (Hoy and Feldman, 1999; Smith et al., 2001; Smith, 2002). When the studies conducted in the literature in recent years are examined, it is seen that the concept of "organizational health" is used extensively in other organizations (Emhan, 2005; Köseoğlu & Karayormuk, 2009; Tutar, 2010; Başar, 2011; Taş, 2014; Açıkgöz, 2015; Büyükyılmaz and others,

2018). The main purpose of determining organizational health is whether organizations are "healthy or unhealthy?" The answer to the question is not to seek. The main purpose is to identify and eliminate deficiencies by making situation analysis in organizations and to improve their good features. In addition, the strength and weaknesses of the organizations, opportunities, risks are seen and some sort of SWOT Analysis is performed (Açıkgöz, 2015: 4).

Organizations can be considered as units that provide developments that increase the welfare level of the society, offer new services, products, information and technologies to the service of people, and ensure the economic and social development of societies. In addition, organizations are structures that facilitate the revealing of corruption, immoral behavior and corruption that lead to the loss of ethical values in the society (Koçel, 2013: 72). The concept known as whistleblowing in the foreign literature has been named as "virtuous reporting" in this study. "Virtuous Reporting" behavior is seen as an important tool for revealing these facts. In the local literature, it is seen that the concept, which has different meanings such as disclosure of information, whistleblowing, reporting, reporting unethical behaviors, has started to be examined recently as an organizational behavior subject (Alpaslan Danışman, 2006; Sayğan, 2011; Demirtaş, 2014; Toker Gökçe & Oğuz, 2015; Yurur and Nart, 2016). It is stated that the concept was first included in the text presented to the US Senate Internal Security Commission by Otto Otepeka in 1963 (Nalcı Arıbaş, 2017: 14).

It is stated that the first scientific definition was made by Near and Miceli in 1985. By definition, whistleblowing; It is stated as “disclosure of illegal, immoral or illegitimate practices under the control of employers to the members of the organization (old or present) to the persons or organizations that can carry out the action” (Nalcı Arıbaş, 2017: 16). According to another definition, whistleblowing for organizations is defined as the action of "reporting the unethical or illegal behavior of another employee or supervisor to the public game or top management" (Fleddermann, 2012). It was seen that Nader and his colleagues used the concept of "whistleblowing" for the first time in their studies. Nader et al. (1971) described the concept of whistleblowing as "an act of notification because an individual who prioritizes the public interest over the interests of the organization he served, because the organization is involved in immoral, illegal, harmful or fraudulent activities". According to Near and Miceli (1985), whistleblowing is stated as the disclosure of the behaviors that occur. It is seen that there are many studies on the subject in domestic and foreign literature (Near and Miceli, 1985; 1996; Dworkin & Near, 1997; Rocha & Kleiner, 2005; Alpaslan Consultant, 2006; Sayğan, 2011; Toker Gökçe, 2014a; Demirtaş, 2014; Candan & Kaya, 2015; Yener, 2018; Aydan & Kaya, 2018). In studies on whistleblowing, it is stated that there are four main factors in the emergence of the action. These; The person reporting the action, the person or authority whose action is reported, is the occurrence of wrong or wrong action by a person or group and reporting of the action (Yarmacı, 2018: 71). It can be said that individuals' perspectives on moral situations, religious views and values, personality traits are effective in whistleblowing behavior. In addition, many managerial factors - trust, job satisfaction, retaliation - are the underlying causes of this behavior (Miceli et al., 1991; Miceli & Near 1992; Sims, Keenan 1998; Vadera et al., 2009; Cassematis & Wortley, 2012).

The health status of an organization is not only beneficial for the organization, but it also contributes to the society it interacts with. On the other hand, wrong practices, moral and unethical behaviors in an organization affect the society as well as the organization. In this context, it is important to apply organizational health and whistleblowing concepts in education and health organizations. Educational organizations serve as the main venue in terms of forming the next generations. Because the basic moral understanding of the students in it is shaped in these institutions (Güvercin, 2016: 3). Health organizations, on the other hand, are the institutions that produce the health services that all living things in the world benefit and need. The main element of health care is human. The basis of health policies is the best service to the human element; to present them in an effective, fair, fast and accessible way (Açıkgöz, 2015: 1). Education and health organizations must report wrong practices internally and externally. Education employees are of great importance for students benefiting from these services, healthcare professionals and individuals who receive these services. It is seen that the

studies examining whistleblowing behavior in our country have become widespread in recent years. In the solution of this problem, it will be tried to ensure that education and health professionals recognize both the concept of organizational health and whistleblowing and increase their awareness. Understanding the importance of the concepts and approaching the events with this awareness, from the lowest level employees to the highest level of education and health institutions, will be beneficial for both the organization and individuals who receive service from the organization and the society.

2. METHOD

This research is a study investigating the relationship between the two concepts and quantitative research method was used in the research. The research was carried out between the education personnel working in high schools affiliated to Kırşehir National Education Directorate and the health personnel working in Kırşehir Ahi Evran University Education and Research Hospital. It was conducted to determine the relationship between the organizational health perceptions of the participants and their whistleblowing behavior. In education and health organizations, the examination of whistleblowing behavior with the perception of organizational health is important for corporate effectiveness.

In the research, survey technique was used as a data collection tool. Two different scales were used in the research. Questions measuring the organizational health dimension were taken from the master thesis "Organizational Health: Research in a Municipality in Izmir" researched by Başar (2011). The questionnaire used in the organizational health research was developed by Rosen and Berger (1992) in order to measure the employees' perceptions of organizational health and consists of 20 statements.

In the research, survey technique was used as a data collection tool. Two different scales were used in the study. Questions that measure the organizational health dimension are taken from the master thesis on "Organizational Health: Research in a Municipality in Izmir" researched by Başar (2011). Organizational health scale consists of three dimensions. These are: "organizational level", "general level" and "individual level". The scale's score of 1-49 is unhealthy, the score of 50-84 is healthy and unhealthy, and the score of 85-100 is healthy. In the survey questions; 1) Never (2) Rarely, (3) Sometimes, (4) Often, (5) Always Likert scale structure was used (Başar, 2011: 69). In the relevant study, the reliability analysis of the measuring tool was found to be 0.94. In the reliability analysis for this study, the Cronbach Alpha coefficient was found to be 0.96 and the measurement tool was found reliable. Questions measuring the whistleblowing behavior were taken from Yılmaz (2015) master thesis on "Managerial Ethics and Disclosure of Women Entrepreneurship in Disclosure (Whistleblowing)". The questionnaire that measures whistleblowing consists of 8 questions and 3 dimensions. These are the dimensions of "external whistleblowing", "internal whistleblowing" and "indifference". In the survey questions; 1) I definitely disagree, (2) I disagree, (3) What I Agree, What I Disagree, (4) I Agree, (5) Likert I agree, Likert scale structure a used (Yılmaz, 2015: 82). As a result of the reliability analysis of the measurement tool, the Cronbach Alpha coefficient was found to be 0.70. Cronbach Alpha coefficient was determined as 0.84 in the reliability analysis for this study. The measuring tool has been found to be reliable.

The population of the study consists of 480 personnel working in high schools in the central district of Kırşehir National Education Directorate and 275 personnel working in polyclinics in Kırşehir Ahi Evran University Training and Research Hospital. In the study, simple random sampling method was used to determine the sample and the sample calculation was 214 for educational institutions and 162 for health institutions. A face-to-face survey was conducted. When missing surveys were removed, 370 surveys is included in the study.

2.1. Validity Analysis of the Scales Used in the Study

In this study, Exploratory and Confirmatory Factor Analysis was applied to analyze the validity of the data based on the data obtained from the sample. In this context, exploratory factor analysis was performed for the purpose of testing separation and merger validities. For these purposes, factor analysis was used using the Principle Components and Varimax factor rotation methods, and the correlation matrix used in this analysis was examined for discriminant validity. Whether factor

analysis is suitable for the structure is determined by the results of the Kaiser-Meyer-Olkin sample proficiency test and Bartlett's test of sphericity.

Factor analysis is a multivariate statistics that aims to find a small number of unrelated and conceptually meaningful new variables (factors, dimensions) by bringing together p variables. There are two types of factor analysis approaches, EFA (Explanatory Factor Analysis) and CFA(Confirmatory Factor Analysis). In EFA, action is taken to find factors based on the relationships between variables (Büyüköztürk, 2013: 133). In CFA, there is a test of a previously determined model or hypothesis about the relationship between variables. In terms of the operations performed, EFA is a method used to test the construct validity of newly created scales and aims to reach less factors based on the observed variables in the scale. CFA, on the other hand, is made to test whether the scales, which were previously discovered and combined under few factors, are similar in the sample in which the research was conducted (Meydan and Şeşen, 2015: 21).

2.1.1. Organizational Health Scale Exploratory Factor Analysis Results

Exploratory factor analysis was performed to reduce the organizational health scale to dimensions and to test the merger validities. The EFA results of the Organizational Health Scale are shown in Table 1 and Table 2.

Table 1. Organizational Health KMO (Kaiser-Meyer Olkin) and Bartlett's Test Results

Kaiser-Meyer-Olkin Sampling Adequacy Measure (KMO)		0.96
Sphericity Test	Chi-square Value	6332.712
	Df	190
	p	.000

Table 2. Organizational Health Scale Exploratory Factor Analysis Loads

	Organizational Level	General Level	Individual Level
Employees at the institution are not considered as cost factors. It is seen as the values that need to be invested.	0.769		
The policies of the institution are flexible, taking into account the employees and their families.	0.710		
Health and safety of employees is the first priority.	0.683		
Changes and crises that occur are well managed.	0.680		
Individual and group activities are rewarded.	0.680		
Employees' thoughts and lives are respected.	0.676		
In solving the problems that occur, the problems are shared with the employees and solutions are sought for.	0.649		
Employees are satisfied with the social opportunities provided by the institution.	0.642		
The institution has learning and career opportunities.	0.632		
Employees are treated fairly.		0.793	
The degree of participation of the employees in the decisions taken in relation to the work to be done in this institution is high.		0.752	
Employees come to their jobs with pleasure.		0.740	
Communication in the institution is clear and timely.		0.738	
Successful people are respected and appreciated within the organization.		0.664	
Employees value the quality of the service produced.			0.872
Employees spend their time on service delivery rather than complaining.			0.658
Employees have the resources they need to do their jobs.			0.621
Employees have information about the status of the institution.			0.538
There are feelings of solidarity and friendship among the employees.			0.508
Employees are able to cope with the work stresses that occur.			0.474

As seen in Tables 1 and 2, Bartlett's Sphericity value was found to be significant and KMO value was 0.96 in factor analysis using Principle Components and Varimax factor rotation methods. As a result of the exploratory factor analysis applied, it was observed that 20 questions in the organizational health variable were gathered under 3 factors. As a result of the factor analysis, it was determined that

the eigen value was 3 factors above 1, the items in the organizational health scale were loaded to 3 factors without any problems and the total variance value explained by 3 factors was 70.95%. This shows that there is an important relationship between the items in the scale and the factors to which the items belong.

Considering the relationship between the scale items and the factors they are loaded, the mentioned factors are determined as organizational level (factor 1), general level (factor 2) and individual level (factor 3), respectively. 61.73% of the total variance, which is 70.95%, is explained by the first factor, 5.30% by the second factor and 3.91% by the third factor.

2.1.2. Whistleblowing Scale Exploratory Factor Analysis Results

Exploratory factor analysis was performed to reduce the whistleblowing scale to dimensions and to test the validity of merger. Exploratory factor analysis results of the whistleblowing scale are shown in Table 3 and Table 4.

Table 3. Whistleblowing KMO (Kaiser-Meyer Olkin) and Barlett's Test Results

Kaiser-Meyer-Olkin Sampling Adequacy Measure (KMO)		0.78
Sphericity Test	Chi-square Value	1.81
	Df	28
	p	.000

Table 4. Whistleblowing Scale Exploratory Factor Analysis Loads

	External Whistleblowing	Intrinsic Whistleblowing	Indifference
Situations are shared with people outside the institution.	0.840		
The incident is reported to the relevant legal authorities.	0.762		
The event is disclosed to the public.	0.846		
Situations are forwarded to senior management		0.806	
The incident is reported to the hill manager.		0.742	
The incident is reported through people who deal with such situations within the organization.		0.919	
I ignore the situations. **			0.916
I keep quiet.**			0.905

** Reversed questions

As seen in Tables 3 and 4, Bartlett's Sphericity value was found to be significant and KMO value was 0.78 in the factor analysis using Principle Components and Varimax factor rotation methods. As a result of the exploratory factor analysis applied, it was seen that 8 questions in the virtuous reporting variable were gathered under 3 factors. As a result of the factor analysis, it was determined that the eigen value was 3 factors above 1, the items in the virtuous reporting scale were loaded to 3 factors without any problems, and the total variance value explained by 3 factors was 77.65%. This shows that there is an important relationship between the items in the scale and the factors to which the items belong.

Considering the relationship between the scale items and the factors they are loaded, the mentioned factors are determined as external virtuous reporting (1st factor), internal virtuous reporting (2nd factor) and indifference (3rd factor), respectively. 50.79% of the total variance, which is 77.65%, is explained by the first factor, 17.65% by the second factor and 9.20% by the third factor.

2.1.3. Confirmatory Factor Analysis Results of Organizational Health Scale and Whistleblowing Scale

Confirmatory factor analysis for the organizational health scale, which was determined to be composed of three dimensions as a result of exploratory factor analyzes, was created as a three-factor model from the confirmatory factor analysis models by paying attention to the theoretical relationships. The single factor model is defined as the model where all observable variables are gathered under one factor (Meydan and Şeşen, 2015: 22). By determining the primary level confirmatory factor analysis, the predictive power between the parameters in the structure of the

organizational health scale and latent factors was tested. Findings obtained according to CFA are shown in Table 5.

Table 5. Organizational Health Scale Fit Values

Fit Index	Before Modification	Post Modification	Acceptable Fit Value
$\chi 2$/df (CMIN/df)	3.271	2.546	$0 \leq \chi 2/df \leq 5$
GFI	0.872	0.901	$0.90 \leq GFI \leq 1.00$
CFI	0.940	0.960	$0.95 \leq CFI \leq 1.00$
RMSEA	0.078	0.065	$0 \leq RMSEA \leq 0.08$
NFI	0.916	0.937	$0.90 \leq NFI \leq 1.00$
RMR	0.061	0.049	$RMR \leq 0.08$

As can be seen in Table 5, the first values in the model are given under the heading "before modification". After the first values, the modification process was obtained to the model. Then new values were obtained. The model was found to be statistically significant because the RMSEA value was determined to be 0.065. The GFI value was found to be 0.901, which is consistent with the model's data. X2 / df = 2,546, because it is less than 5, it is within acceptable limits. Other values; NFI (0.937) was found as RMR (0.049), and values are among the good fit limits. These results show that the developed conceptual model is compatible with the data, the sample size is sufficient for the model and the model is statistically valid and significant. Goodness of fit values for the whistleblowing scale are shown in Table 6.

Table 6. Whistleblowing Scale Fit Values

Fit Index	Before Modification	Post Modification	Acceptable Fit Value
$\chi 2$/df (CMIN/df)	5.771	1.338	$0 \leq \chi 2/df \leq 5$
GFI	0.942	0.986	$0.90 \leq GFI \leq 1.00$
CFI	0.957	0.997	$0.95 \leq CFI \leq 1.00$
RMSEA	0.114	0.030	$0 \leq RMSEA \leq 0.08$
NFI	0.948	0.989	$0.90 \leq NFI \leq 1.00$
RMR	0.129	0.057	$RMR \leq 0.08$

As can be seen in Table 6, the first values in the model are given under the heading "before modification". After the first values, the modification process was applied to the model. Then new values were obtained. The model was found statistically significant because the RMSEA value was determined to be 0.030. The GFI value was found to be 0.986, which is consistent with the model's data. X2 / df = 1,338, since it is less than 5, it is within the acceptable fit limits. Other values; NFI (0.989) was found as RMR (0.057), and values are among the good fit limits. These results show that the developed conceptual model is compatible with the data, the sample size is sufficient for the model and the model is statistically valid and significant.

2.2. Normal Distribution Compliance Test

Nonparametric tests were used in the study. This is because the data do not conform to the normal distribution test. fitness distribution test is presented in Table 7.

Table 7. Normal Distribution Compliance Test

	Kolmogorov-	**Smirnov[a]**		**Shapiro-**	**Wilk**	
	Statistic	df	p	Statistic	df	p
Organizational Health	0.076	370	0.000	0.969	370	0.000
Whistleblowing	0.162	370	0.000	0.901	370	0.000

There are many methods to determine whether the data are suitable for normal distribution and it is another method to decide whether the data is suitable for normal distribution or not. Three different tests are shown in Table 7 above. Shapiro-Wilk test if the group size is less than 50, and Kolmogorov-Smirnov test if it is large, are two tests used to examine the appropriateness of scores. If the p value

calculated in the analysis is higher than 0.05, it means that the scores in this level of significance do not deviate excessively from the normal distribution. If the calculated p value is less than 0.05, this indicates a significant deviation from the normal distribution of scores at this level of significance (Büyüköztürk, 2013: 42). When Table 7 is examined; Since the p value is less than $p < 0.05$, it was seen that the data showed excessive deviation from the normal distribution. Based on this result, the application of nonparametric tests was found appropriate.

3. FINDINGS

In the study, descriptive statistics, socio-demographic variables and organizational health and whistleblowing total scores were analyzed using the Mann-Whitney U test and Kruskal Wallis variance analysis. In addition, Spearman correlation analysis was applied between organizational health and whistleblowing.

Table 8. Socio-Demographic Information of Educational Employees Examined in the Scope of the Research

	Variable	Number	Percent
Age	25-34 Age	43	20.3
	35-44 Age	100	47.2
	45 Years and older	69	32.5
Gender	Woman	81	38.2
	Man	131	61.8
Marital status	Married	191	90.1
	Single	21	9.9
Education status	Associate degree	15	7.1
	Undergraduate education	181	85.4
	Graduate education	16	7.5
Working Time in the Institution	1-4 Year	76	35.8
	5-9 Year	53	25.0
	10-14 Year	48	22.6
	15 Year and over	35	16.5
Working Time in the Profession	1-9 Year	31	14.6
	10-19 Year	93	43.9
	20 Year and over	88	41.5
Monthly Income	0-4000 TL	149	70.3
	4000 TL and over	63	29.7
Total		212	100.00

Table 8 presents the socio-demographic findings of the education workers examined within the scope of the research. As it is seen in Table 8, when the age distribution is examined, the number of personnel between the ages of 25-34 is 43 (20.3%); The number of personnel between the ages of 35-44 is 100 (47.2%); The number of employees aged 45 and over was 69 (32.5%). In terms of gender; 81 (38.2%) of the participants were female, 131 (61.8%) were male, and it was observed that men were more likely to participate. When the marital status is examined; 191 (90.1%) were married and 21 (9.9%) were single. In terms of educational status; The number of associate degree graduates is 15 (7.1%), the number of undergraduate graduates is 181 (85.4%) and the number of graduate graduates is 16 (7.5%). In terms of working time in the institution; 76 (35.8%) employees between 1-4 years, 53 (25.0%) employees between 5-9 years, 48 (22.6%) employees between 10-14 years, 15 years and over employees and 35 (16.5%) of the patients. In terms of working time in the profession; 31 (14.6%) of employees between 1-9 years, 93 (43.9%) of employees between 10-19 years, 88 (41.5%) of employees over 20 years were identified. When examined in terms of monthly income; It is seen that 149 (70.3%) people have an income of 4000 TL or less and 63 (29.7%) have an income of more than 4000 TL.

Table 9. Socio-Demographic Information of Health Workers Examined in the Scope of the Study

	Variable	Number	Percent
Age	25-34 Age	51	32.3
	35-44 Age	74	46.8
	45 Years and older	33	20.9
Gender	Woman	95	60.1
	Man	63	39.9
Marital status	Married	132	83.5
	Single	26	16.5
Education status	Associate degree	64	40.5
	Undergraduate education	72	45.6
	Graduate education	22	13.9
Working Time in the Institution	1-4 Year	33	20.9
	5-9 Year	56	35.4
	10-14 Year	26	16.5
	15 Year and over	43	27.2
Working Time in the Profession	1-9 Year	48	30.4
	10-19 Year	55	34.8
	20 Year and over	55	34.8
Monthly Income	0-4000 TL	134	84.8
	4000 TL and over	24	15.2
Total		158	100.00

Table 9 presents the socio-demographic findings of the health workers examined within the scope of the research. As seen in Table 9, when the age distributions are examined, the number of personnel between the ages of 25-34 is 51 (32.3%); The number of personnel between the ages of 35-44 was 74 (46.8%); The number of employees aged 45 and over was 33 (20.9%). In terms of gender; 95 (60.1%) of the participants were female and 63 (39.9%) were male. When the marital status was examined, it was found that the number of married staff was 132 (83.5%), while the number of unmarried staff was 26 (16.5%). In terms of educational status; 64 (40.5%) of the associate degree graduates, 72 (45.6%) of the undergraduate graduates and 22 (13.9%) of the graduate graduates. In terms of working hours, the number of employees between 1-4 years is 33 (20.9%), the number of employees between 5-9 years is 56 (35.4%), the number of employees between 10-14 years is 26 (16.5%). And 43 (27.2%) were employed for 15 years and over. In terms of working time in the profession; The number of employees between the years 1-9 was 48 (30.4%), the number of employees between 10-19 years was 55 (34.8%), and the number of employees 20 years and over was 55 (34.8%). When the monthly income is analyzed, it is seen that 134 (84.8%) people have an income of 4000 TL or less and 24 (15.2%) have an income of more than 4000 TL.

In order to determine the organizational health perception and whistleblowing behavior of the education and health care workers, analyzes were conducted between the scale total scores and socio-demographic variables. Non-parametric tests were used because the data obtained did not correspond to the normal distribution. Mann-Whitney U test was performed in paired groups and Kruskal Wallis analysis of variance was performed in more than two groups.

Table 10. Results of Kruskal Wallis Variance Analysis Showing the Organizational Health Levels of Education and Health Workers in Terms of Age.

	Age	N	Mean Rank	Chi-square	Sd	p
Organizational Health Total	25-34 Age	94	179.37	9.961	2	0.007
	35-44 Age	174	172.36			
	45 Years and older	102	213.56			
	Total	370				

As can be seen in Table 10, the organizational health perceptions of education and healthcare professionals examined within the scope of the research were compared in terms of age variable. As a result of the comparison, it was seen that the organizational health perceptions of the

personnel differed in terms of total organizational health scores (p <0.01). It is understood that the difference is generally caused by the age group of 45 and over.

Table 11. Mann-Whitney U Test Results Showing the Organizational Health Levels of Education and Health Workers in Terms of Gender

	Gender	N	Mean Rank	Mann-Whitney U	p
Organizational	Woman	176	167.42		
Health	Man	194	201.90	13889.500	0.002
Total	Total	370			

As seen in Table 11, the organizational health perceptions of education and healthcare professionals examined within the scope of the research were compared in terms of gender variable. As a result of the comparison, it was seen that the organizational health perceptions of the personnel differed in terms of total organizational health scores (p <0.01).

Table 12. Mann-Whitney U Test Results Showing the Organizational Health Levels of Education and Health Workers in Terms of Marital Status

	Marital status	N	Mean Rank	Mann-Whitney U	p
Organizational	Married	323	189.38		
Health	Single	47	158.83	6337.000	0.067
Total	Total	370			

As seen in Table 12, the organizational health perceptions of the education and health professionals examined within the scope of the research were compared in terms of the marital status variable. As a result of the comparison, it was seen that the perceptions of organizational health of the staff did not differ in terms of total organizational health scores (p> 0.05).

Table 13. Results of Kruskal Wallis Variance Analysis Showing Organizational Health Levels in Terms of Education and Health Workers' Educational Status

	Education status	N	Mean Rank	Chi-square	Sd	p
	Associate degree	79	142.23			
Organizational	Undergraduate education	253	203.31	22.670	2	0.000
Health	Graduate education	38	156.89			
Total	Total	370				

As can be seen in Table 13, the organizational health perceptions of the education and health personnel examined within the scope of the research were compared in terms of the learning status variable. As a result of the comparison, it was seen that the organizational health perceptions of the personnel differed in terms of total organizational health scores (p <0.01). It is understood that the difference in terms of organizational health total scores and scale sub-dimensions originated from the group having undergraduate education.

Table 14. Mann-Whitney U Test Results Showing the Organizational Health Levels of Education and Health Workers in Terms of the Institution Worked

	Organization	N	Mean Rank	Mann-Whitney U	p
Organizational Health	Education Organization	212	244.26	4291.000	0.000
	Health Organization	158	106.66		
Total	Total	370			

As can be seen in Table 14, the organizational health perceptions of the education and health professionals examined within the scope of the research were compared in terms of the institutional variable studied. As a result of the comparison, it was seen that the organizational health perceptions of the personnel differed in terms of total organizational health scores ($p < 0.01$).

Table 15. Results of Kruskal Wallis Variance Analysis Showing the Organizational Health Levels of Education and Health Workers in Terms of Working Time in the Institution

	Working Time in the Institution	N	Mean Rank	Chi-square	Sd	p
Organizational Health	1-4 Year	109	208.62	19.128	3	0.000
	5-9 Year	109	171.35			
	10-14 Year	74	209.36			
	15 Year and over	78	150.32			
Total	Total	370				

As seen in Table 15, the organizational health perceptions of the education and health personnel examined within the scope of the research were compared in terms of the working time variable in the institution. As a result of the comparison, it was seen that the organizational health perceptions of the personnel differed in terms of total organizational health scores ($p < 0.01$). It is understood that the difference generally results from the group working 15 years and more.

Table 16. Results of Kruskal Wallis Variance Analysis Showing the Organizational Health Levels in Terms of Education and Health Workers' Working Time.

	Working Time in the Profession	N	Mean Rank	Chi-square	Sd	p
Organizational Health	1-9 Year	79	172.98	5.279	2	0.071
	10-19 Year	148	176.73			
	20 Year and over	143	201.50			
Total	Total	370				

As can be seen in Table 16, the organizational health perceptions of education and healthcare professionals examined within the scope of the research were compared in terms of variable of working time in the profession. As a result of the comparison, it was seen that the organizational health perceptions of the personnel did not differ statistically from the total points of the organizational health ($p > 0.05$).

Table 17. Mann-Whitney U Test Results Showing the Organizational Health Levels of Education and Health Workers in Terms of Monthly Income.

	Monthly Income	N	Mean Rank	Mann-Whitney U	p
Organizational Health	0-4000 TL	283	173.57	8935.500	0.000
	4000 and over	87	224.29		
Total	Total	370			

As it can be seen in Table 17, the organizational health perceptions of education and healthcare professionals examined within the scope of the research were compared in terms of monthly income variable. As a result of the comparison, it was seen that the organizational health perceptions of the personnel differed in terms of total organizational health scores ($p<0.01$).

Table 18. Results of Kruskal Wallis Variance Analysis Showing the Whistleblowing Behaviors of Education and Health Workers in Terms of Age.

	Age	N	Mean Rank	Chi-square	Sd	Age
Whistleblowing Total	25-34 Age	94	197.81	1.701	2	0.427
	35-44 Age	174	182.01			
	45 Years and older	102	188.10			
	Total	370				

As seen in Table 18, whistleblowing behaviors of education and healthcare professionals examined within the scope of the study were compared in terms of age variable. As a result of the comparison, it was seen that whistleblowing behaviors of the staff did not differ statistically between the total scores of whistleblowing ($p> 0.05$).

Table 19. Mann-Whitney U Test Results Showing the Whistleblowing Behavior of Education and Health Workers in Terms of Gender.

	Gender	N	Mean Rank	Mann-Whitney U	p
Whistleblowing Total	Woman	176	169.00	14168.500	0.005
	Man	194	200.47		
	Total	370			

As seen in Table 19, whistleblowing behaviors of education and healthcare professionals examined within the scope of the research were compared in terms of gender variable. As a result of the comparison, it was determined that there was a significant difference between the whistleblowing behaviors of the staff and the total scores of the whistleblowing ($p <0.01$).

Table 20. Mann-Whitney U Test Results Showing the Whistleblowing Behavior of Education and Health Workers in Terms of Marital Status.

	Marital status	N	Mean Rank	Mann-Whitney U	p
Whistleblowing Total	Married	323	185.94	7449.500	0.836
	Single	47	182.50		
	Total	370			

As seen in Table 20, whistleblowing behaviors of education and healthcare professionals examined within the scope of the research were compared in terms of marital status variable. As a result of the comparison, it was determined that the whistleblowing behaviors of the staff and whistleblowing total scores did not differ ($p> 0.05$).

Table 21. Kruskal Wallis Variance Analysis Results Showing Education and Health Workers' Whistleblowing Behavior in Terms of Educational Status.

	Education status	N	Mean Rank	Chi-square	Sd	p
Whistleblowing Total	Associate degree	79	162.59	4.636	2	0.098
	Undergraduate education	253	191.69			
	Graduate education	38	191.93			
	Total	370				

As can be seen in Table 21, whistleblowing behaviors of education and healthcare professional examined within the scope of the research were compared in terms of educational status variable. As a result of the comparison, it was determined that the total scores of the whistleblowing behaviors of the staff did not differ statistically (p> 0.05).

Table 22. Mann-Whitney U Test Results Showing Education and Health Workers' Whistleblowing Behavior in Terms of the Institution Worked.

	Organization	N	Mean Rank	Mann-Whitney U	p
Whistleblowing	Education Organization	212	199.56	13768.000	0.003
	Health Organization	158	166.64		
Total	Total	370			

As seen in Table 22, whistleblowing behaviors of education and healthcare professionals examined within the scope of the research were compared in terms of the institution variable studied. As a result of the comparison, it was seen that the staff's whistleblowing behaviors differed in terms of their whistleblowing total scores (p <0,01).

Table 23. Kruskal Wallis Variance Analysis Results Showing Education and Health Workers' Whistleblowing Behavior in Terms of Working Time in the Institution.

	Working Time in the Institution	N	Mean Rank	Chi-square	Sd	p
Whistleblowing	1-4 Year	109	191.68	5.423	3	0.143
	5-9 Year	109	199.61			
	10-14 Year	74	175.98			
	15 Year and over	78	166.18			
Total	Total	370				

As can be seen in Table 23, whistleblowing behaviors of education and healthcare professionals examined within the scope of the study were compared in terms of working time variable in the institution. As a result of the comparison, it was determined that the staff did not differ in terms of whistleblowing behavior and whistleblowing total scores (p> 0.05).

Table 24. Results of Kruskal Wallis Variance Analysis Showing the Whistleblowing Behaviors of Education and Health Workers in Terms of duration of work in the profession.

	Working Time in the Institution	N	Mean Rank	Chi-square	Sd	p
Whistleblowing	1-9 Year	79	197.39	2.292	2	0.318
	10-19 Year	148	176.00			
	20 Year and over	143	188.77			
Total	Total	370				

As can be seen in Table 24, whistleblowing behaviors of education and healthcare professionals examined within the scope of the study were compared in terms of working time variable. As a result of the comparison, there was no significant difference between the staff's whistleblowing behavior and whistleblowing total scores (p> 0.05).

Table 25. Mann-Whitney U Test Results Showing Education and Health Workers' Whistleblowing Behavior in Terms of Monthly Income.

	Monthly Income	N	Mean Rank	Mann-Whitney U	p
Whistleblowing	0-4000 TL	283	177.35	100004.500	0.008
	4000 and over	87	212.01		
Total	Total	370			

As seen in Table 25, whistleblowing behaviors of education and healthcare professionals examined within the scope of the research were compared in terms of monthly income variable. As a result of the comparison, it was determined that the whistleblowing behaviors of the staff showed a significant difference in terms of the total scores of the whistleblowing ($p < 0.01$). Correlation analysis results for determining the relationship between organizational health perception and whistleblowing behavior are presented in Table 26.

Table 26. Correlation Analysis Results Between Organizational Health Perception and Whistleblowing Behavior

		Organizational Health Total	Organizational Level	General Level	Individual Level	Whistle-blowing	External	Internal	Indifference
Organizational Health Total	r	1							
	p	-							
	N.	370							
Organizational Level	r	0.971**	1						
	p	0.000	-						
	N.	370	370						
General Level	r	0.932**	0.858**	1					
	p	0.000	0.000	-					
	N.	370	370	370					
Individual Level	r	0.905**	0.828**	0.790**	1				
	p	0.000	0.000	0.000	-				
	N.	370	370	370	370				
Whistle-blowing	r	0.143**	0.122*	0.146**	0.156**	1			
	p	0.006	0.018	0.005	0.003	-			
	N.	370	370	370	370	370			
External	r	0.120*	0.103*	0.140**	0.101	0.784**	1		
	p	0.021	0.047	0.007	0.053	0.000	-		
	N.	370	370	370	370	370	370		
Internal	r	0.175**	0.164*	0.158**	0.194**	0.854**	0.478**	1	
	p	0.001	0.002	0.002	0.000	0.000	0.000	-	
	N.	370	370	370	370	370	370	370	
Indifference	r	0.092	0.079	0.070	0.120*	0.621**	0.334**	0.502**	1
	p	0.078	0.131	0.180	0.020	0.000	0.000	0.000	-
	N.	370	370	370	370	370	370	370	370

Correlation analysis was carried out to determine the relationship between organizational health perception and whistleblowing behavior. As can be seen in Table 26, a positive but weak ($r = 0.143$) but statistically significant relationship was found between organizational health perception and whistleblowing behavior ($p < 0.01$).

4. DISCUSSION AND RESULTS

The purpose of this study is to determine the relationship between the organizational health perception and whistleblowing behaviors of the staff working in the education and health sector. Within the framework of the aforementioned purpose, the research was conducted in high schools affiliated to the Provincial Directorate of National Education in Kırşehir and Kırşehir Ahi Evran University Training and Research Hospital. The data in the study were obtained from 370 education and healthcare professionals. In educational and health organizations, it is important to examine the perception of organizational health and whistleblowing behavior and to reveal the relationships between these concepts. When the related literature is examined, a study examining the relationship between organizational health and whistleblowing concepts could not be found. Considering these factors, the study is thought to have a original value.

When the findings are evaluated as a result of the analysis of the data obtained from the research, with the perception of organizational health; It was observed that there was a significant difference between age, gender, educational background, institution worked, duration of employment in the institution and monthly income. There is no significant difference between marital status and working time variables. On the other hand, there was a significant difference between whistleblowing behavior and gender, institution worked and monthly income variable. There is no significant difference

between age, education status, marital status, working time in the institution and working time in the profession.

When the findings of the organizational health perception in terms of age variable are examined, it is seen that the difference is caused by the group of participants aged 45 and over. It can be said that there is a direct relationship between the age of the individuals and the perception of organizational health. This situation is thought to be due to reasons such as professional experience of people working in educational and health institutions within the scope of the research, working in the state institution. It comes to mind that the ability of employees aged 45 and over to compare the events they encounter in their social lives at the organizational level is more developed. In parallel with our study, in the study of Kısa (2011) in educational organizations, significant differences were determined in terms of age variable. Similarly, it was determined that the difference in terms of age variable was significant in the study in which Soylu (2017) investigated the effect of organizational trust and leader-member interaction on organizational health in educational organizations. In line with the findings of our study, the age variable differs according to the perception of organizational health in the study of Lee et al. (2014). In contrast to the findings of our study, no significant difference was found in organizational health scores in terms of age in the studies of Gül (2018) and Başar (2011). The fact that different results have been achieved in the researches may depend on reasons such as the organization in which the study is conducted, the personal characteristics of the individuals and cultural differences.

When the findings of the organizational health perception are examined in terms of gender variable, it is seen that male participants have more organizational health perception than female participants. Education and health institutions within the scope of the research; It is thought that women are not flexible enough to consider their families and there is no equal reward system among the staff, women experience more problems in their work environments than men, and women are responding negatively about the organization's health. On the other hand, as in many sectors in our country, it can be said that such results have occurred due to organizational discrimination between women and men in the education and health sector, women having less say in management, and women being pushed aside in some cases. Similar to the findings of our study, organizational health showed a significant difference in terms of gender in the study of Kısa (2011). Again, in the study of Başar (2011) in the municipal institution, there is a significant difference in terms of gender variable. Unlike the findings of our study, there is a significant difference in terms of gender in organizational health scores in the studies of Karacan (2017) and Ertaş and Töre (2016). It can be said that there are more than one reason for different results in terms of gender in studies. Socially; It is thought that gender discrimination in many areas is reflected in the business life of individuals and affects their thoughts. It is thought that situations such as putting women into the second plan, not seen as a part of life, trying to apply the situations that people see in their families and in their organizations are effective.

Considering the findings of whistleblowing behavior in terms of gender variable; male participants were observed to tend to show more whistleblowing behavior than female participants. It can be said that this situation stems from the social status differences in our society. Considering that the life of the Turkish society still depends on tradition, tradition and culture, it can be said that a woman brings up a wrong, immoral or illegal incident, and her retaliation behavior is higher than that of a man. In parallel with the findings of our study, in the study of Topgül (2018) investigating the effect of demographic characteristics on whistleblowing behavior in an educational institution, it was stated that whistleblowing perceptions differed significantly in terms of gender. In the related study, it was concluded that male participants were more prone to whistleblowing behavior compared to women.

Similarly, in the study that Toker Gökçe (2014) examined the action of whistleblowing in educational institutions, a significant difference was found between gender and whistleblowing scores. According to the related study, male participants were found to be more prone to whistleblowing action than women. The research conducted by Cassematis and Wortley (2013) in the foreign literature, which examines the effect of demographic variables on whistleblowing behavior, supports our study. In the related study, it was determined that gender influenced whistleblowing action; men were found to have more whistleblowing tendencies than women. Similarly, similar results were obtained in the study of Buckley et al. (2010); In this study, it was concluded that the gender variable influenced the whistleblowing action and that male participants had more whistleblowing tendencies than women. Unlike the findings of our study, Büyükarslan (2016) and Kızıltaş (2015) did not show any significant difference between gender and whistleblowing in different studies.

When the findings of the organizational health perception in terms of the educational status variable are examined; It was observed that the difference occurred due to the group of participants who had undergraduate education. It is thought that individuals will be able to look at the events more positively and make healthier decisions with the increase in the level of education. In line with the findings of our study, in the study of Ertaş and Töre (2016), organizational health scores showed a significant difference in terms of educational status. In the related study, it is stated that the graduates of "Vocational High School" have more perception of organizational health than other groups. Similar to our findings, in the study of Vural (2013), perceptions of organizational health showed a significant difference in terms of education level. In the relevant study, similar to the findings of our study, organizational health sub-dimensions differ in terms of educational status. In contrast to the findings of our study, in the study conducted by Güllü (2018) in sports enterprises and examining the mediating role of organizational health, no significant difference was found in terms of educational status. In the studies of Deniz (2016) and Ayduğ (2014), no significant difference was found in terms of educational status. The perception that people with high educational level are respected and valued in Turkish society may have been shaped in the world of thought of individuals in this research. Therefore, giving importance to the opinions of organizations with high education level may play an important role in improving their health status. Especially, benefiting from the knowledge, experience and history of the experts in the field can produce positive results for the organization.

When the findings of the organizational health perception in terms of the "institution worked" variable are examined; it can be thought that this situation is caused by the stress in the workplace, the mass served, the environment in interaction. In terms of educational organizations, it can be said that it is generally a more stress-free and comfortable working environment. From the point of view of health institutions, it is thought that the people who receive services are sick, as well as the relatives of the patients with aggressive attitudes, abnormal working hours, and previously experienced health workers have less perception of organizational health. In line with the findings of our study, in the organizational health study conducted by Gül (2018), the hospital type was considered as private and public sector. According to the findings obtained from the relevant study, the institution variable studied differs in terms of organizational health scores. In contrast to our study, the organizational health scores of Yıldız (2014) and Kıvrak (2013) in high school dimension did not differ significantly in terms of the institution variable studied.

When the findings of the whistleblowing behavior in terms of the "institution studied" variable are examined; It can be said that the working environment of educational institutions is more comfortable than the working environment of health institutions. Similar to the findings of our study, significant

differences were found between the whistleblowing sub-dimension, the internal whistleblowing, according to the institution variable studied in Alper (2018). In the study carried out in educational institutions, it was stated that the difference originated from Commercial Vocational High School. Similarly, the education and packaging sector was examined in the study of Oran (2018). In the relevant study, a significant difference was found between the internal, external, implied, formal and informal sub-dimensions of whistleblowing subscales in terms of the institution variable studied in these sectors.

When the findings of organizational health perception in terms of "working time in the institution" variable are examined; It was observed that the difference occurred was caused by the group of participants who had 15 years or more working time in the institution. In this case, it is thought that the employees have become accustomed to working environments because they have been in their institutions for a long time, and that their friendship relations in their institutions have become stronger during this period. In addition, it can be said that employees differentiate their perception of organizational health because they learn the functioning of the institution they work for too long, have knowledge in that institution and act accordingly. Similar to the findings of our study, in the study where Deniz (2016) investigated organizational health in high schools, perceptions of organizational health showed a significant difference in terms of working time in the institution. Unlike the findings of our study, no significant difference was found between the perception of organizational health in terms of working time variable in the institution in different studies conducted by Soylu (2017) and Uğur (2017).

When the findings of organizational health perception in terms of "monthly income" variable are examined; It was observed that those who earn 4000 TRY or more have higher perceptions of organizational health than those who earn 4000 TRY or less. Therefore, it can be said that the excessive salaries of employees affect the perception of organizational health positively. It is thought that the wages received by the employees in terms of maintaining their lives satisfy the people. When the relevant local literature is analyzed, it is seen that there are few studies where the monthly income variable is used. Similar to the findings of our study, in Arıkan (2011), it was determined that the total scores of organizational health differ in terms of monthly income variable. In the related study, it was stated that those who earn 650 TL or less find the institution they work more unhealthy than those who earn 650 TL or more. Therefore, overpayment differs employees' perception of organizational health.

When the findings of whistleblowing behavior in terms of "monthly income" variable are examined; It is seen that whistleblowing tendency is high in those earning 4000 TL and above. Similar to our study, in the study of Yarmacı (2018), whistleblowing perceptions differ significantly in terms of monthly income. According to the related study, it is stated that employees who have income between 1300-1900 TL perform less whistleblowing action.

In the study, correlation analysis was applied to examine the relationship between organizational health perception and whistleblowing behavior. According to the results of the correlation analysis, a positive weak ($r = 0.143$) but statistically significant relationship was found between organizational health perception and whistleblowing behavior ($p < 0.01$). In this case, the increase in whistleblowing action also creates an increase in the perception of organizational health. According to the results of the study, reporting the wrong, unethical or illegal incidents in an institution to the relevant authorities, exposing the incident directly affects the health status of the institution. On the other hand, it can be said that whistleblowing behaviour can be more in healthy organizations. Especially considering the educational institutions, considering the institutions that respect the thoughts and lives

of the employees, the behaviour of the employees in their whistleblowing can be respected. One of the features seen in healthy organizations; The fact that the opinions of the employees are taken into consideration in the solution of the problems that may arise may also be effective in this. When employees have the perception that their ideas are important, they may tend to perform whistleblowing behaviour easily.

It is possible to say that features such as loyalty to authority, loyalty to power and loyalty to communities, which are traditionally seen in Turkish society, are reflected in the modern business management of Turks. It can be argued that these situations make Turks more introverted and utilitarian individuals. In cases that do not belong to them, their preference to remain silent can be counted as indicators of this understanding. Turks expect the act of providing public services by someone else depending on the culture (Alper, 2018: 207). In studies between culture and whistleblowing, Turks are separated as individualist and socialist. In a study conducted by Zamantılı Nayır (2012) in private and public institutions, the relationship between individualism and communityism, which is considered as one of the personal factors, with whistleblowing forms is revealed. When the results of this research are analyzed, it is stated that individualist people prefer internal reporting; however, it is understood that there is no meaningful relationship between whistleblowing behavior being tacit or public and formal or informal, and between individualistic and collective personality traits. In fact, it can be expected that individuals with individualistic characteristics prefer external whistleblowing behavior. Different research findings also support this expectation. It can be thought that individualist individuals adopt exogenous whistleblowing behavior because their organizational commitment is weaker than socialist individuals. On the other hand, individualistic individuals may reach a different conclusion when they evaluate the results of their external and internal whistleblowing behavior in terms of egoistic and utilitarian ethical theories. In a study examining the relationship between Machiavelism and whistleblowing, Demirtaş and Biçkes (2014) found a finding that the intention to disclose negative situations decreased as the level of Machiavelism increased. According to this result, it is understood that people who focus on self-interest avoid the behavior of reporting unethical and illegal actions and behaviors in working life.

Although there are no legal regulations regarding whistleblowing, the existence of whistleblowing policies is noticeable in some private companies. Pirelli brand, which is a world-renowned tire company, state this on its official website as "Group Information Policy" (corporate.pirelli.com, 2018). As another example, Netafim Drip Irrigation Company state that they implemented it in their institutions with the “Information Whistleblowing Policy” declaration published (www.netafim.com.tr, 2018).

There is "CIMER (Presidential Communication Center)" as another complaint and notification mechanism in our country. This app provides a service about people's requests, complaints, suggestions or information. However, the missing aspect of the "CIMER" service is that the identity information of the people is given to the complaining authority. Therefore, sanctions can be imposed on the person making the complaint by the relevant authority. Especially people working in state institutions do not prefer to use this service with the concern that they will face various reprisals.

There are various complaints centres within the Ministry of National Education and the Ministry of Health. "Ministry of Health Communication Center" (SABİM), established within the Ministry of Health, is an application that helps people to get information and make complaints about health services (www.sabim.saglik.gov.tr, 2019). The Ministry of National Education has the "Ministry of National Education Communication Center" (MEBİM) application. It is ensured that people receive

information or make a complaint by phone (www.meb.gov.tr, 2019). When these applications are examined, it is seen that the channels in the concept of whistleblowing are not fully fulfilled. Therefore, "whistleblowing" channels should be established legally in all public institutions, especially education and health institutions.

5. SUGGESTIONS

The study was carried out to determine the relationship between organizational health and whistleblowing in education and health institutions. In order for this research to be a guide for future studies, when the findings and statistical results of the research are evaluated, the suggestions to be made are listed as follows:

- According to the results of this research, it is revealed that the concept of organizational health in high schools and hospitals in Kırşehir is unknown and not applied naturally. Therefore, first of all, organizational health concept awareness should be provided in these organizations.
- To establish a healthy educational organization, a healthy communication network should be established within the organization, and the concepts of student-teacher, teacher-manager, family-teacher and family-manager should be addressed more. Staff should be seen as values in educational institutions. In addition, an organizational climate should be created where everyone values the concept of respect. The morale and motivation of the employees should be increased.
- Organization managers should develop their internal whistleblowing channels in order to be aware of wrong, immoral or illegal events that may arise. The constructive reporting behavior and the opposing reporting behavior should be separated from each other, and a rewarding system should be introduced within the organization to those who do so. In addition, it should be ensured by the manager that the employees within the organization feel confident that they will not be retaliated and dismissed in an uncovering incident. Considering the cultural features, internal whistleblowing channels should be created at a level that every employee can easily access.
- For the whistleblowing behavior, government agencies should establish policies specifically for them, remember that whistleblowers work for the benefit of organizations and avoid being referred to as bad adjectives. In addition, problems arising from the lack of management in organizations should be addressed. This issue should be handled appropriately by experts in this field. Finally, the legal dimension regarding whistleblowing should be fully established.

The following suggestions can be made for future research:

- This research is limited to two of the public institutions. The field of application can be done in public and private organizations in different regions, but also with business organizations operating in the public and private sectors. It is also possible to conduct the research among different professional groups. Thus, comparisons can be made between different professional groups and sectors. In order to generalize the results of the study, it may be suggested to conduct studies with more organizations and samples.
- Studies can be conducted with the qualitative research method on the subject of the research.
- Moreover, studies can be made by adding new variables such as leadership characteristics and social culture characteristics of managers to the socio-demographic variables used in this research. The underlying causes of whistleblowing behavior can be investigated in the future studies.
- Finally, it is thought that the concept known as whistleblowing in the foreign literature and which does not have a complete equivalent in Turkish is appropriate to be used as "virtuous reporting" in future research. Considering the scientific understandability of the researches and the aims of contributing, the concept of "virtuous reporting" should be used.

5. REFERENCES

Açıkgöz, N. (2015), The Relationship between Organizational Health and Value Creation Culture in Hospitals. (Master Thesis). Selçuk University / Institute of Health Sciences, Konya.

Akbaba, S. (1997), Organizational Health of Secondary Schools (Bolu Province Case), Unpublished Doctoral Thesis, Ankara University Institute of Social Sciences, Ankara.

Alpaslan Danışman, S. (2006), Whistleblowing as a Social Responsibility. Journal of Business Ethics. 227-238.

Alper, M. (2018), The Effect of Organizational Culture on the Relationship Between Whistleblowing and Organizational Silence and A Research. (PhD Thesis). Marmara University / Institute of Social Sciences, Istanbul.

Altun, S. A. (2001), Organizational Health, 1st Edition, Ankara: Nobel.

Arıkan, E. (2011), Effects of Organizational Health on Job Satisfaction: An Application on Five Star Hotels in Afyonkarahisar (Master Thesis). Afyon Kocatepe University / Institute of Social Sciences, Afyon.

Aydan, S., Kaya, S. (2018), Whistleblowing in Health Sector: An Application on Nurses and Secretaries Working in a University Hospital. Hacettepe Journal of Health Administration, 21 (1): 1-29.

Ayduğ, D. (2014), Investigation of Relationships between Organizational Health of Primary Schools and Organizational Trust Levels of Teachers. (Master Thesis). Anadolu University / Institute of Educational Sciences, Eskişehir.

Başar, İ. (2011), Organizational Health: Research in a Municipality in Izmir. (Master Thesis). Celal Bayar University / Institute of Social Sciences, Manisa.

Batmaz, M. (2012), The Effects Of The Manager's Management Styles To The Personnel's Work Satisfaction (Master Thesis). Ufuk University / Institute of Social Sciences, Ankara.

Buckley, C., Cotter D., Hutchinson, M. (2010), Empirical evidence of lack of significant support for whistleblowing. Corporate Ownership and Control, 7(3), 275-283.

Buluç, B. (2008), The Relationship Between Organizational Health and Organizational Citizenship Behaviors in Secondary Schools, Turkish Journal of Educational Sciences, 6 (4), 571-602.

Büyükarslan, B.A. (2016), Research on Determining The Relationship Between Whistleblowing and Organizational Citızenship Behavior. (Master Thesis). Dumlupınar University / Institute of Social Sciences, Kütahya.

Büyükyılmaz, O., Yurdasever, E., Horuzoğlu, K. (2018), A Research on Determination of The Organizational Health Perceptions of The Employees Working in Kardemir Inc. Balkan Journal of Social Sciences, 7 (14), 60-79.

Candan, H., Kaya, T.P. (2015), A Research on Examining The Relationship Between Whistleblowing and Percieved Organizational Support in a Public Institution. Kahramanmaras Sutcu Imam University Journal of Economics and Administrative Sciences, 5 (2), 305-330.

Cassematis P. G. and Wortley R. (2012), Prediction of Whistleblowing or Non-reporting Observation: The Role of Personal and Situational Factors. Journal of Business Ethics 117 (3): 615–634.

Cassematis, P. G., R. Wortley (2013), Prediction of Whistleblowing or Non- reporting Observation: The Role of Personal and Situational Factors, Journal of Business Ethics, 117, 615-634.

Childer, J.H. and M. Fairman (1986), The School Counselor as Facilitator Of Organizational Health, The School Counselor, 332-337.

Cooper, C. L. & Williams, S. (1994), Creating Healthy Work Organizations, Chichester: John Wiley.

Cox, T. & Howarth, I. (1990), Organizational Health, Culture and Helping, Work&Stress, 4, pp.107- 110.

Çakınberk, A., Demirel, E.T. (2010), Leadership as a Determinant of Organizational Commitment: A Case of Health Care Personnel. Selcuk University Institute of Social Sciences Journal, 24, 104-119.

Çakır, L. (2002), İlköğretim Okullarının Organizasyon Sağlığı Açısından Değerlendirilmesi, Yayınlanmamış Yüksek Lisans Tezi, Selçuk Üniversitesi Sosyal Bilimler Enstitüsü, Konya.

Demirtaş, Ö. (2014), The whistleblowing impact on ethical climate: Moderator role of mobbing perception. Istanbul University Journal of Business Administration, 43 (1), 136-156.

Demirtaş, Ö., & Biçkes, M. (2014), The Effect of Machiavelism on Intention to Disclose Negative Situations: A Field Study. "Business, Power" Journal of Industrial Relations and Human Resources, 16 (2), 98-112.

Deniz, N. (2016), Vocational High Schools, According to The Study of The Health of The Organization, The Perception of a Teacher in. (Master Thesis). Zirve University / Institute of Social Sciences, Gaziantep.

Dworkin, T. M. ve Near, J. P. (1997), A Better Statutory Approach to Whistle-blowing. Business Ethics Quarterly, 7 (1), 1-16.

Emhan, A. (2005), Organization Health and an Application in Business Organizations. (PhD Thesis). Selcuk University / Institute of Social Sciences, Konya.

Ertaş, G., Töre, E. (2016), Effect of Organizational Communication Skills on Organizational Health. Journal of Management and Economics Research, 14 (3): 85-100. Doi: http://dx.doi.org/10.11611/JMER193782.

Fleddermann C. B. (2012), Engineering Ethics (Fourth Edition). Pearson Prentice Hall, Upper Saddle River.

Gül, İ. (2018), The Effect of Organizational Commitment and Organizational Openness to Change in Organizational Health in Health Institutions: An Research in Afyonkarahisar City Center Hospitals. (PhD Thesis). Süleyman Demirel University / Institute of Social Sciences, Isparta.

Güvercin, D. (2016), Administrators' and Teachers' Opinions on The Reasons of Whistleblowing and Whistleblowing Process in High Schools. (Master Thesis). Uşak University / Institute of Social Sciences, Uşak.

Ho, J. T.S. (2000), Managing Organizational Health And Performance In Junior Colleges, The International Journal Of Educational Management, 14(2), pp. 62.

Hoy, W. K. & Miskel, C. G. (1991). Educational administration: Theory, Research and Practice, New York: McGraw-Hill.

Hoy, W. K. and J. Feldman (1999), Organizational Health Profiles for High Schools, in Frieiberg, J. (Eds.), School Climate: Measuring, Sustaining and Improving, Falmer Pres, London.

Hoy, W. K. and Tarter, C. J. (1997), The Road to Open and Healthy Schools: A Handbook for change: Middle and Secondary School Edition, Thousand Oaks, CA: Corwin Pres.

Hoy, W. K., C. J. Tarter Ve J. R. Bliss (1990), Organizational Climate, School Health and Effectiveness: A Comparative Analysis, Educational Administration Quarterly, 26(3), 260-279.

http://www.meb.gov.tr/duyurular/duyurular2012/basinmus/mebim.php (Access Date 24.02.2019).

https://sabim.saglik.gov.tr/login.aspx (Accessed Date 24.02.2019).

https://www.netafim.com.tr/ (Access Date: 11.02.2019).

Karacan, K. (2017), The Relationship Between Organizational Health and Organizational Citizenship Behaviors According to Perceptions of Primary and Secondary School Teachers. (Master Thesis). Gazi University / Institute of Educational Sciences, Ankara.

Karakuş, H. (2008), The Organizational Health Views of Teachers Working in The Primary Education Schools. (Master Thesis). Firat University / Institute of Social Sciences, Elazig.

Kısa, N. (2011), The Relationship Between Emotional Intelligence Skills of Primary School Administrators and Organizational Health of Primary Schools. (Master Thesis). Hacettepe University / Institute of Social Sciences, Ankara.

Kimpston, R. D. and L. C. Sonnabend (1975), Public Secondary Schools: The Interrelationships Between Organizational Health and Innovativeness and Between Organizational Health and Staff Characteristics, Urban Education, 10(1), 27-45.

Koçel, T. (2013), Business Management (13th Edition), Istanbul: Beta.

Korkmaz, M. (2005), The Relationship Between Organizational Health and Student Success in Primary Schools, Journal of Educational Administration in Theory and Practice, 44, 529-548.

Köseoğlu, M., Karayormuk, K. (2009), What is Organizational Health: Is There Any Difference Between Managers? Atatürk University Journal of Economics and Administrative Sciences, 23 (2), 175-193.

Lee, J.C., Chen, C.L. and Xie, S.H., (2014), The Influence of School Organizational Health and Occupational Burnout on Self-Perceived Health Status of Primary School TGeachers.Procedia - Social and Behavioral Sciences, 116 (2014), 985-989.

McHugh, M. (1993), Stres at Work: Do Managers Really Count the Costs, Employee Relations, 15(1), pp. 18-38.

McHugh, M. and Brotherton, C. (2000), Health is Wealth- Organisational Utopia or Myopia?, Journal Of Managerial Psychology, 15(8), pp.744.

Miceli M. P. and Near J. P. (1992), Blowing the Whistle: The Organizational and Legal Implications for Companies and Employees. Lexington, New York.

Miceli M. P., Dozier J. B. and Near J. P. (1991), Blowing the Whistle on Data Fudging: A Controlled Field Experiment. Journal of Applied Social Psychology 21(4): 271-295.

Miles, M. B. (1965), Planned Change and Organizational Health: Figure and Ground. R. O. Carlson, A. Gallaher, M. B. Miles, R. J. Pellegrin ve E. M. Rogers (der.), Change Processes in the Public Schools, Center for the Advanced Study of Educational Administration, Oregon, 11-35.

Miller, A. and Dess, G. G. (1996), Startegic Management, International Edition, New York: McGraw-Hill.

Miller, C. (1983), The Relationship of Elementary Principals' Sex-Role dentifications to the Organizational Health of Schools, Dissertation Abstracts International, 45(5), 1259-1260.

Nader R., Petkas P. and Blackwell K. (1972), Whistle Blowing. Nicholas M Rongine (Ed.), Toward a Coherent Legal Response to the Public Policy Dilemma Posed by Whistleblowing. American Business Law Journal 23(2): 281-297.

Nalcı Arıbaş, N. (2017), "Whistleblowing" Mechanism to Prevent Wrongdoings in Public Administration: A Model Proposal. (Unpublished PhD Thesis). İnönü University / Institute of Social Sciences, Malatya.

Near J. P. and Miceli M. P. (1985), Organizational Dissidence: The Case of Whistle-blowing. Journal of Business Ethics 4(1): 1-16.

Near, J. P. ve Miceli, M. P. (1996), Whistle-Blowing: Myth and Reality. Journal of Management, 27 (3), 507-526.

Newell, S. (1995), The Healthy Organizations: Fairness, Ethics and Effective Management, London: Routledge.

Oran, F.Ç. (2018), The Effects of Leadership Styles on Organizational Trust and Disclosue of Unethical Behaviours (Whistleblowing): A Practical Research (PhD Thesis). Trakya University / Institute of Social Sciences, Edirne.

Pettigrew, A. and Whipp, R. (1991), Managing Change for Competitive Success, Oxford: Blackwell Business.

Polatçı, S., Ardıç, K., Kaya, A. (2008), Organizational Health in Academic Organizations and The Analysis of Factors Affecting Organizational Health. Management and Economics: Celal Bayar University Journal of the Faculty of Economics and Administrative Sciences, 15 (2), 145-161.

Rocha, E. ve Kleiner, B. H. (2005), To Blow Or Not To Blow The Whistle? That Is The Question. Management Research News, 28 (11/12), 80-87.

Sayğan, S. (2011), A Practice in Order to Analyze The Relationship Between Whistleblowing and Organizational Ethical Climate. (Master Thesis). Selcuk University / Institute of Social Sciences, Konya.

Sims R. L. and Keenan J. P. (1998), Predictors of External Whistleblowing: Organizational and Intrapersonal Variables. Journal of Business Ethics 17(4): 411–421.

Smith, P. A. (2002), The Organizational Health of High Schools and Student Proficiency in Mathematics, International Journal of Educational Management, 16(2), 98-104.

Smith, P. A., W. K. Hoy and S. R. Sweetland (2001), Organizational Health of High Schools and Dimensions of Faculty Trust, Journal of School Leadership, 11, 135-151.

Soylu, İ. (2017), The Effect of Organizational Trust and Leader-Member Interaction on Organizational Health: A Research on Private Schools. (Master Thesis). Gaziosmanpaşa University / Institute of Social Sciences, Tokat.

Taş, F. (2014), A Field Research About Relationship Between Concept of Organizational Justice, Organizational Citizenship and Organizational Health. (Master Thesis). Kahramanmaras Sutcu Imam University / Institute of Social Sciences, Kahramanmaras.

Toker Gökçe, A. (2014a), Teachers' Value Orientations as Determinants of Preference for Different Whistle-Blowing Modes. Trakya University Journal of the Faculty of Education, 2 (4), 1-11.

Toker Gökçe, A. (2014b), Whistle-blowing at Schools: The relationship between Job Satisfaction and Organizational Commitment. Dicle University Journal of Ziya Gökalp Education Faculty, 22 (2014) 261-282.

Toker Gökçe, A., Oğuz, E. (2015), Prospective Teachers' Cultural Orientations as Determinants of Preference for Different Modes of Whistle-Blowing. Sakarya University Journal of Education, 5 (1), 55-69.

Topgül, S. (2018), The Impact of Demographic Characteristics on Whistleblowing Behavior and A Research on Public Institutions. Journal of Productivity, (4), 153-183. http://dergipark.gov.tr/verimlilik/issue/39530/304890.

Tutar, H. (2010), The Link between Employee Alienation and Organizational Health: a Case Study in the Banking Sector. Ankara University Journal of Social Sciences, 65 (01), 175-204.

Uras, M. (2000), Lise Öğretmenlerinin Örgüt Sağlığının Moral, Yenilikçilik, Özerklik, Uyum ve Problem Çözme Yeterliliği Boyutlarına İlişkin Algıları, Pamukkale Üniversitesi Eğitim Fakültesi Dergisi, IV. Ulusal Sınıf Öğretmenliği Sempozyumu Özel Sayısı.

Ünlü, M. (2011), The Influence of Organizational Health Perception on Working Life Quality: An Application on Secondary Schools in Gaziemir Town of Izmir City. (Master Thesis). Dokuz Eylül University / Institute of Social Sciences, İzmir.

Vadera A. K., Aguilera R. V. and Caza B. B. (2009), Making Sense of Whistle-Blowing's Antecedents: Learning from Research on Identity and Ethics Programs. Business Ethics Quarterly 19(4): 553–586.

Vural, T. (2013), The Effect of Transformational Leadership Behaviors on Organizational Health in Hotel Businesses: A Study in Afyonkarahisar Province. (Master Thesis). Afyon Kocatepe University / Institute of Social Sciences, Afyon.

Yarmacı, N. (2018), The Impact Employees Perceptıons of Organizational Ostracism on Organizational Silence and Whistleblowing: Hotel Establishments Case. (Master Thesis). Adnan Menderes University / Institute of Social Sciences. Intellectual.

Yener, S. (2018), The Moderating Role of Employee Voice on the Relationship between Burnout and Whistleblowing. Journal of Management Sciences, 16 (31), 217-236.

Yılmaz, A.İ. (2014), The Role of Organizational Culture in the Relationship Between Whistleblowing and Turnover Intention. (Master Thesis). Marmara University / Institute of Social Sciences, Istanbul.

Yılmaz, N. (2015), Women's Entrepreneurship In The Managerial Ethics And Disclosure (Whistleblowing). (Master Thesis). Mersin University / Institute of Social Sciences, Mersin.

Yürür, S., Nart, S. (2016), Do Organizational Justice Perceptions Influence Whistleblowing Intentions of Public Employees?. Journal of Public Administration, 49 (3), 117-148.

Zamantılı Nayır, D. (2012), Corporate Ethics and Whistleblowing. (1st Edition), Istanbul: Positive.