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THE RELATIONSHIP BETWEEN CYBER LOAFİNG AND JOB SATISFACTION IN HEALTHCARE EMPLOYEE

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Abstract

The high job satisfaction of employees, a significant influence on the company's strong competitiveness. On the other hand, the development of communication technologies led to the appearance of cyber-loafing behaviors in employees. In this study, the relationship between job satisfaction and cyber-loafing in healthcare employee is examined. The aim of this study is to examine the relationship between cyber-loafing and job satisfaction in health care employee. In this study, quantitative research methods were used. The easy sampling method is preferred A face-to-face questionnaire was applied to 300 personnel. In order to determine differences in the analysis of the study, t-test and one-way variance analysis were applied in independent groups and pearson correlation test was applied in order to search for relationships. It was determined that the participants ' cyber-loafing levels were moderate and the job satisfaction levels were above the middle. As a result of the research, a very weak positive relationship was found between cyber-loafing and job satisfaction. Increasing use of technology and internet is also expected to increase the cyber-loafing activities. If control is not achieved, it seems inevitable that it will lead to loss of productivity.

1. INTRODUCTION

The widespread use of communication and information technologies brings with it negative consequences such as cyber-loafing behaviors as well as effective and efficient work of the employees in a short period of time (Candan and İnce, 2016:229; Lim and Teo 2005:1082). One of the main points in the success of organizations in the global age is that employees are effective and productive (Vitak et. al., 2011:1751). In addition, employees' motivations, organizational commitment and high job satisfaction are important factors in the firm's strong competitiveness (Çavuşoğlu and Palamutçuoğlu, 2017:431).

The cyber-loafing is defined as the use of the internet and mobile technology for personal purposes during working hours (Vitak et al., 2011:1751). Cyber-loafing activities include the use of the internet for personal use by the employee at work and during working hours. These activities include the external and malicious use of the Internet by preventing employees from doing their jobs (Afacan Fındıklı, 2016:35; Çivilidağ, 2017:357). The researches show that the cyber-loafing actions tend to increase as the internet becomes an integral part of the business and private life (Ünal and Tekdemir, 2015:96). When it is thought that cyber-loafing leads to loss of productivity, it is seen that management and underlying causes are important facts to be investigated (Örücü and Yıldız, 2014:100; Kanten 2014:14). Job satisfaction is explained as pleasure and positive feelings described in the evaluation of business life (Nal and Nal, 2018:132). Job satisfaction According to Locke (1976:1300), "a positive emotional state arising from a person's assessment of work or work experience". Job satisfaction is important for every profession, but it is more important for health workers who serve people's health (Hoş and Oksay, 2015:2).

When the academic studies on cyber-loafing and job satisfaction were examined, it was realized that the studies between the two variables were very limited (Çavuşoğlu and Palamutçuoğlu, 2017; Çelik, 2014; Çivilidağ, 2017) and there were no studies in the field of Health in Turkey. This study is based on the hypothesis that as employees' job satisfaction increases, cyber-loafing behavior may decrease. The purpose of the study is to determine the differences between the cyber-loafing and the job satisfaction according to the demographic variables and also to examine the relationship between the cyber-loafing behavior and job satisfaction.

2. METHOD

In this study, quantitative research methods were used. The Minnesota Job Satisfaction Scale developed by Weiss et al. (1967) was used to measure job satisfaction. This scale is Cronbach's α 0,77. The cyber-loafing scale of Örücü and Yıldız (2014) was used in order to measure the level of cyber-loafing. Cronbach's α value of the scale is 0.88. The sample of the research consists of 300 employees of a university hospital. The average number of employees of the hospital is 2500. The number of samples was calculated as 286 (Yazıcıoğlu and Erdoğan, 2004:50). In this research, a face-to-face questionnaire was applied to 300 employees with easy sampling method. SPSS 20 program was used for the analysis of the study. In order to determine differences in the analysis of the study, t-test and one-way variance analysis were applied in independent groups and pearson correlation test was applied in order to search for relationships. The level of significance for the analyzes was accepted as 0.05.

Table 1. Socio-Demographic Data Of Healthcare Staff Participating in the Research

Gender	**N**	**%**	**Marital Status**	**N**	**%**
Male	164	54,7	Married	177	59
Female	136	45,3	Single	123	41
Position	**N**	**%**	**Experience in Health Sector**	**N**	**%**
Administrative Affairs	172	57,3	Less than 5 years	100	33,3
Healthcare staff	92	30,7	5 to 10 years	122	40,7
Other Staff	36	12	More than 10 years	78	26
Educational Status	**N**	**%**	**How Old are You**	**N**	**%**
Primary/High School	46	15,3	18 to 24 years old	35	11,7
Associate Degree	66	22	25 to 34 years old	85	28,3
Bachelor's Degree	144	48	35 to 44 years old	137	45,7
Master's Degree	44	14,7	45 years old and older	43	14,3
Economic Status	**N**	**%**	**Choosing the Job Willingly**	**N**	**%**
Low	106	35,3	Yes	180	60
Middle	167	55,7	No	120	40
High	27	9	**Total**	**300**	**100**

3. FINDINGS

Table 1 contains the demographic information of the participants. When table 1 is examined, it can be seen that 54.7% of the participants are male and 45.3% of the participants are female. When the marital status is examined, it is seen that 59% of the participants are married. 57.3% of the participants were administrative, 30.7% were health and 12% were assistant staff. 48% of the participants are undergraduate graduates. It is also seen that 40.7% of the participants have between 5-10 years of employment and 55.7% of the participants have middle income. 60% of the participants stated that they were willing to choose the profession and the others were unwilling to choose.

Table 2. Analyzes related to socio-demographic features of the participating in the research (T-test in independent samples and one way analysis of variance)

			N	X	t/F	p
Gender	Cyber-loafing	Male	164	2,856	-,334	,738
		Female	136	2,895		
	Job Satisfaction	Male	164	3,654	-,189	,850
		Female	136	3,671		
Marital Status	Cyber-loafing	Married	177	2,793	-1,656	,099
		Single	123	2,989		
	Job Satisfaction	Married	177	3,644	-,482	,630
		Single	123	3,688		
Choosing the job willingly	Cyber-loafing	Yes	180	2,758	-2,450	,015*
		No	120	3,047		
	Job Satisfaction	Yes	180	3,686	,673	,502
		No	120	3,625		
Economic Status	Cyber-loafing	Low	106	2,883	2,499	,084
		Middle	167	2,933		
		High	27	2,468		
	Job Satisfaction	Low	106	3,520	3,010	,051
		Middle	167	3,725		
		High	27	3,831		
Educational Status	Cyber-loafing	Primary/High School	46	2,939	,149	,930
		Associate Degree	66	2,890		
		Bachelor's Degree	144	2,868		
		Master's Degree	44	2,800		
	Job Satisfaction	Primary/High School	46	3,801	,878	,453
		Associate Degree	66	3,711		
		Bachelor's Degree	144	3,619		
		Master's Degree	44	3,583		
Age	Cyber-loafing	18 to 24 years old	35	3,102	,775	,509
		25 to 34 years old	85	2,840		
		35 to 44 years old	137	2,869		

		45 years old and older	43	2,770		
	Job Satisfaction	18 to 24 years old	35	3,454	2,362	,071
		25 to 34 years old	85	3,576		
		35 to 44 years old	137	3,782		
		45 years old and older	43	3,618		
Experience in Health Sector	Cyber-loafing	Less than 5 years	100	2,987	1,747	,176
		5 to 10 years	122	2,888		
		More than 10 years	78	2,705		
	Job Satisfaction	Less than 5 years	100	3,639	,108	,898
		5 to 10 years	122	3,686		
		More than 10 years	78	3,653		
Position	Cyber-loafing	Administrative Affairs	172	3,029	5,075	,007
		Healthcare Staff	92	2,632		
		Other Staff	36	2,748		
	Job Satisfaction	Administrative Affairs	172	3,675	,084	,919
		Healthcare Staff	92	3,652		
		Other Staff	36	3,620		

When Table 2 is examined, there is no significant difference between the average of job satisfaction and cyber-loafing according to gender and marital status variables. However, there was a significant difference between the selection of the profession and the cyber-loafing ($p<0.005$). According to this, it is seen that those who voluntarily choose their profession have a lower level of cyber-loafing than those who voluntarily choose not. In addition, it is seen that there is no significant difference between the participants' cyber-loafing and job satisfaction point averages and economic status, education status, age and working year variables. However, there was a significant difference between cyber-loafing and working areas (* $p <0.005$). It is observed that this difference is among the administrative and health personnel and the levels of cyber-loafing of administrative personnel are higher.

Table 3. The relationship between cyber-loafing and job satisfaction

		Job Satisfaction
Cyber-loafing	r	,172**
	p	,003
** p<0,01 meaningful at level		

In Table 3, it is seen that there is a weak positive relationship between cyber-loafing and job satisfaction.

Table 4. The relationship between important and trivial cyber-loafing and external job satisfaction

		External Job Satisfaction
Important Cyber-loafing	r	,228**
	p	,000
Trivial Cyber-loafing	r	,215**
	p	,000
** p<0,01 meaningful at level		

In Table 4 it is seen that there is a weakly positive relationship between significant and trivial cyber-loafing and external job satisfaction.

4. DISCUSSION AND CONCLUSION

As a result of the research, it was found that participants' level of cyber-loafing (2.87), significant cyber-loafing (2.78) and trivial cyber-loafing (2.93) were in the middle level, general job satisfaction (3.66), internal job satisfaction (3.70) and external job satisfaction (3.60) were above the middle level. In addition, there was no significant difference in the gender, marital status, econoımic status, educational status, age and working year variables of work satisfaction with cyber-loafing. However, it was found that there was a significant difference between the state of voluntary choice of the profession and cyber-loafing (P <0.005). According to this, the level of cyber-loafing of those who voluntarily choose their profession is lower than those who reluctant choose it. On the other hand, there was a significant difference between cyber-loafing and working areas (* p <0.005). It is seen that this difference is between the administrative personnel and the health personnel and the cyber-loafing levels of the administrative personnel are higher. In addition, there is a weak positive relationship between cyber-loafing and job satisfaction. It has also been found that there is a weak positive relationship between important and trivial cyber-loafing and external job satisfaction.

According to the results of Garrett and Danziger (2008) and Civilidag (2017), there is a low relationship between job satisfaction and cyber-loafing. The results are consistent with this study. In the study conducted by Çavuşoğlu and Palamutçuoğlu (2017), it was determined that job satisfaction affected the cyber-loafing negatively. According to Çelik (2014)'s study, there is a positive relationship between job satisfaction and cyber-loafing. The fact that the results are not similar to those of this study may be due to the fact that the research is conducted on different sector employees. There was no significant difference between the cyber-loafing and gender in this study. However, according to the studies performed by Seçkin and Kerse (2017), Güngör (2016), Candan and İnce (2016), males have more cyber-loafing behavior than females. Vitak et al. (2011) found that individuals with a young, male and racial minority have a higher rate of Internet use in the workplace.

According to Candan and İnce (2016), as the number of years of work increases, there is a decrease in cyber-loafing behaviors. According to this study, as the working year increases, the level of cyber-loafing decreases. As a result of the research conducted by Örücü and Yıldız (2014), it has been determined that single

emloyees behave more in cyber-loafing. According to Çelik (2014), married individuals both have more job satisfaction and a tendency to cyber-loafing. In this study, there was no significant difference between marital status and cyber-loafing behavior and job satisfaction. According to Kaplan and Çetinkaya (2014), as the level of education decreases, trivial cyber-loafing activities are increasing. According to Afacan Fındıklı (2016), health employee with high educational status are lower in the behavior of impportant cyber-loafing. According to the data of this study, it was found that as the education level increases, the level of cyber-loafing decreases.

Today, the use of computers and mobile devices is increasing. Thus, virtual rescue activities can increase and lead to loss of productivity. If the business can not meet the expectations of the employees, it is likely that negative consequences will arise for both the institution and the individual. In this case, managers must prevent any negative cyber-loafing behavior in the organization. Organizations can provide control of cyber-loafing by applying balanced interventions to their employees. This research is limited to data obtained from employees of a university hospital. In future research, similar issues can be investigated for different sectors. In addition, the relationship between the behavior of cyber-loafing and psychological state can be examined.

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PHYSICAL QUALITY ASSESSMENT IN HEALTHCARE ORGANIZATIONS

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ABSTRACT

Hospitals are health organizations that provide preventive, curative, rehabilitative and health promoting health services. The understanding that the health services offered by hospitals in order to meet the needs of the patients should be consistent with the existing professional knowledge and techniques and to provide the desired outputs has brought the concept of quality in health services to the agenda. There are two approaches about the quality of health care services; technical quality and perceived quality. While technical quality is the ability to present the routine knowledge of health professionals, perceived quality is the general judgment of health care users regarding the excellence of the health service offered. Inasmuch as patients can assess the quality as perceived quality more, this study is designed to allow patients to assess the health care they receive in terms of perceived quality. The objective of this study is to measure the physical qualities of public and private hospitals in Ankara and to evaluate the results a comparative way. The population of this study is composed of patients who visit public and private hospitals operating in Ankara between October 2015 and April 2016. Easy sampling method was used in the selection of the sample and 557 patients were evaluated by asking questions about the physical characteristics dimension specified in the Servqual Service Quality Scale. As a result of the analysis performed, statistically significant difference was found in all the expressions forming the physical quality dimension of the hospitals according to the properties of the hospitals ($p < 0,05$). According to this, it is found that private hospitals have higher average score than public hospitals have in expressions of the hospitals have technological suitability and modern equipments (4,07 ± 1,07), hospital buildings are visually attractive (3,95 ± 1,09), hospital employees have good and clean appearance (4,30 ± 0, 99) and hospital is attractive with additional services as well as basic services offered (3,89 ± 1,07).This result can be explained by the fact that private hospitals are more recent structures, have more modern technology and equipments, they are profit-oriented institutions and therefore pay more attention to physical characteristics, taking into account patients' quality perceptions.

1. INTRODUCTION

Healthcare services are all of the services provided to maintain and improve health; prevent the occurrence of diseases; diagnose and treat the patients at the earliest possible time; prevent injuries; provide medical and social compassionate services to the disabled people and provide people with a qualified, happy and long life. (Tengilimoğlu et al., 2015:72).

Until today, it is possible to allocate the healthcare services to three periods. In the first period, rapid progress was made in medical and medical technology; cost control efforts in healthcare services have gained importance in the second period. Finally, the third period that we are in can be considered as evaluation and accountability period. (Tomes and Peng, 1995: 25). In this period, healthcare professionals and managers have gave more importance to the quality ofthe

services which they provided, because it is necessary to define and measure the perceptions of the quality of the healthcare services that the patients receive and what these perceptions are guided. (Sofaer and Firminger, 2005: 513).

In terms of general terminology, quality is defined as the ability to obtain the desired results using legal means (Donabedian, 1988: 173). Quality in healthcare is the degree to which health services offered to individuals are consistent with current professional knowledge and techniques and provide the desired outcomes (Lohr and Schroeder, 1990: 707; McAlexander et al., 1994: 34). Quality in healthcare can be assessed relaying on structure, process, and result. Structural quality refers to the characteristics of the health system; process quality refers to the interactions between health professionals and patients between patients and the results product evidences about changes in the patient's health status. These three dimensions are also important in determining the quality of healthcare services (Schuster et al., 1998: 518).

There are two conceptual dimensions that health service providers need to address regarding quality of healthcare services. These are clinical (technical) quality and perceived quality. Clinical quality is the ability to provide the routine knowledge of health professionals and it is often judged by outcomes (eg, a physician's surgical skill) (Devebakan, 2006: 131). Perceived quality is the general judgment of healthcare users regarding the superiority or excellence of the healthcare service provided and is concerned with both the process and the results. (Zeithaml, 1988: 3). Patients generally assess quality in terms of perceived quality (Zifko- Baliga and Krampf, 1997: 28). This is why perceived quality is a subjective concept (Erdem and Uslu, 2010: 169).

Accordingly, in this study, it has been strived to determine fundamentally how patients perceive the healthcare they receive physically. Moreover, physical quality perceptions of patients and administrators have been compared.

2. METHOD

This study has been conducted to determine the perceptions of hospital administrators and patients who receive healthcare service from the hospitals about the physical qualities of hospitals. The population of this study constitutes public hospitals and private hospitals serving Ankara metropolitan area. The sample selection has not been made in the selection of the hospitals and it has been targeted to reach all the hospitals. As a result, a total of 19 hospitals have been reached. 13 of them are public and rest of these are private. Patients who received services from the internal diseases and general surgery services where the patient intensity is higher, have been included in the scope of the study. In the selection of patients, easy sampling method have been used and patients who had received service from each hospital before and received service again have been included in the study. In addition to the patients, administrators working at various levels to represent their hospitals have been also included in the study. A total of 557 patients and 75 administrators participated in this study.

The physical quality questions of the SERVQUAL Service Quality Scale developed by Parasuraman et al. (1977) and adopted to the healthcare services by Babakuş and Mangold (1992) has been used to determine the physical quality perceptions of the hospitals administrators relating their hospitals as the data collection tool in the study and a questionnaire consisting of 11 questions that consist the physical quality perceptions of the same Scale has been used to determine the physical quality perceptions of the patients .

SPSS (Statistical Package for the Social Sciences) 22.0 have been used in the analysis of the data obtained within the scope of the study. The significance level (p) in the statistical tests has been accepted as 0.05. The Independent Samples t test (for those with normal distribution).and

the Mann-Whitney U test (for those with no normal distribution) have been used in the comparison of the differences between the two group average scores in the study.

The results of the study are limited to 19 hospitals operating in the metropolitan area of Ankara and can not be generalized to other hospitals.

3.FINDINGS

In this section, the perceptions of patients and hospital managers about the physical quality of the hospitals have been evaluated.

Table 1 contains demographic informations of the patients participating in the study.

Table 1. Demographic Informations of the Patients

Variables	Demographic Features	f	%
Sex	Man	245	45,2
	Women	305	54,8
Marital Status	Married	385	69,1
	Single	172	30,9
Age	≤25	114	20,5
	26-35	163	29,3
	36-45	119	21,4
	≥46	161	28,9
Education	Illeterate	12	2,2
	Literate	14	2,5
	Primary education	129	23,2
	High school	198	35,5
	Undergraduate	174	31,2

	Graduate	30	5,4
Job	Unemployed	69	12,4
	Officer	73	13,1
	Worker	131	23,5
	Housewife	115	20,6
	Retired	59	10,6
	Other	110	19,7
Income	My income is less than my expense	169	30,4
	My income is equal my expense	310	55,8
	My income is more than my expense	77	13,8
Frequency of Receiving Healthcare Services	Never	48	8,6
	At most 1 time per month	362	65
	2 or 3 times per month	99	17,8
	More than 3 times per month	48	8,6
Preferred Healthcare Organization	Family practice	44	7,9
	Public hospital	334	60,2
	University Hospital	60	10,8
	Private Hospital	117	21,1
Have You Ever Received Healthcare Services From Another Hospital?	Yes	476	85,6
	No	80	14,4

According to Table 1, 69.1% of the patients with the majority of women (54.8%) are married. Education status with high school (35.5%) and undergraduate (31.2%) are the majority. When the income status of the patients participating in the study has been examined, it has been found that the patients who their incomes are equal their expenses are majority with 55.8%. 65% of the patients have stated that they go to the hospital at most once per month in terms of the frequency of receiving healthcare services. The majority of the patients (60.2%) have preferred the public hospitals. In addition, 85.6% of the patients have stated that they have also

received services from other health institutions than their own.

Table 2. Distribution of Physical Quality Perceptions of Patients According to Hospital Ownership

Physical Quality Dimension Expressions	Hospital	f	Mean	Std.	t	p
The hospital is equipped with technological and contemporary equipment	Public Hospitals	359	3,284	1,234	-6,870	<0,001
	Private Hospitals	154	4,071	1,079		
The hospital's buildings are visually stunning	Public Hospitals	359	2,744	1,331	-9,928	<0,001
	Private Hospitals	154	3,955	1,099		
The employees of the hospital are clean and good appearance	Public Hospitals	359	3,362	1,254	-8,285	<0,001
	Private Hospitals	154	4,305	0,992		
The service provided by the hospital as well as the additional services offered are also attractive	Public Hospitals	359	2,836	1,302	-8,890	<0,001
	Private Hospitals	154	3,896	1,074		

As shown in Table 2, statistically significant differences ($p < 0,05$) have been found in all the expressions that constituted the physical quality dimension of the hospitals as a result of the analysis. According to this, relating to the expressions that the hospital is equipped with technological and contemporary equipment (4,07 ± 1,07), the hospital's buildings are visually stunning (3,95 ± 1,09), the employees of the hospital are clean and good appearance (4,30 ± 0,99) and the service provided by the hospital as well as the additional services offered are also attractive (3.89 ± 1.07) have been found that private hospitals'average scores are higher than public hospitals.

Table 3. Distribution of Patients' Perceptions of Physical Quality According to Previously Received Healthcare Services from Another Hospital

Physical Quality Dimension Expressions	Have You Ever Received Healthcare Services From Another Hospital?	f	Mean	Std.	t	p
The hospital is equipped with technological and contemporary equipment	Yes	440	3,605	1,193	0,618	<0,001
	No	72	2,986	1,399		
The hospital's buildings are visually stunning	Yes	440	3,150	1,378	0,316	0,71
	No	72	2,833	1,384		
The employees of the hospital are clean and good appearance	Yes	440	3,739	1,195	0,683	<0,001
	No	72	3,056	1,462		
The service provided by the hospital as well as the additional services offered are also attractive	Yes	440	3,182	1,303	0,223	0,186
	No	72	2,958	1,467		

According to Table 3, with reference to whether patients can receive healthcare service before, relating to the expressions that the hospital is equipped with technological and contemporary equipment (3,60 ± 1,19) and the employees of the hospital are clean and good appearance (3,73±1,19) have been found that there has statistically significant difference (p <0.05) between the two groups. The averages of the "Yes" answers given in both expressions are higher than the average of the "No" answers.

Table 4. Distribution of Physical Quality Perceptions of Patients and Administrators by Hospital Ownership

Hospital	Groups	n	Mean	Mean Rank	MWU	p
Public Hospitals	Patient	13	3,037	8,85	24,000	0,002
	Administrator	13	3,885	18,15		
Private Hospitals	Patient	6	3,972	5,67	13,000	0,419
	Administrator	6	4,250	7,33		
All Hospitals	Patient	19	3,332	14,53	86,000	0,006
	Administrator	19	4,00	24,47		

In Table 4, there are findings about physical quality perception scores of patients and administrators. According to the results of the analysis, there has been a statistically significant difference relating to average of the physical quality perception scores of the public hospitals and the average of the physical quality perception scores of all the hospitals by groups (p <0,05). In public hospitals as well as in all hospitals, administrators' averages of the physical quality perception scores are higher than patients' averages of the physical quality perception scores.

Table 5. Physical Quality Evaluations Perceived by Administrators and Patients

Hospitals	Averages of Physical Quality Perception Scores	
	Administrators	Patients
PbH-1	2,75	3,43
PbH-2	4,00	2,62
PbH-3	4,00	3,7,0
PbH-4	3,75	3,10
PbH-5	3,25	2,80
PbH-6	4,00	3,16
PbH-7	4,50	2,74
PbH-8	3,75	2,00
PbH-9	3,25	3,29
PbH-10	3,75	2,72
PbH-11	5,00	2,80
PbH-12	4,00	2,97
PbH-13	4,50	4,15
PH-1	5,00	3,91
PH-2	5,00	4,44
PH-3	4,00	3,73
PH-4	3,25	4,34
PH-5	5,00	4,42
PH-6	3,25	2,99
Public Hospitals	3,88	3,04
Private Hospitals	4,25	3,97
All Hospitals	4,00	3,33

As shown in Table 5, it has been found that while average of the highest physical quality perception scores is 4.25 in private hospitals (PH), this average score in public hospitals (PbH) is 3.88, according to hospital administrators'assessments. Among the public hospitals, average of the highest physical quality perception scores is 5.00 (PbH-11) and the lowest one is 2.75 (PbH-1). Among the private hospitals, PH-1, PH-2 and PH-5 have the highest average scores

(5.00) while PH-4 and PH-6 have the lowest average scores (3.25). According to patients' assessments, the average of the highest physical quality perception scores is 3.97 in private hospitals and this average is 3.04 in public hospitals.

4. DISCUSSION

In this section, the findings obtained from this study have been discussed honestly by taking into consideration the findings of other studies.

In other studies conducted, participants' physical quality perceptions have differed. According to this, in a study conducted by Gürsoy (2013), it has been found that the patients have given the lowest score to the physical quality (tangibles) dimension with an average score of 4.05 in the dimension of 5 service quality (reliability, assurance, responsiveness, tangibles and empathy). In another study, the patients receiving service from a public hospital have given the lowest score to the physical quality dimension with an average score of 3.78 (Yazgan, 2009: 68). In another study conducted by Torun (2009), patients have gave the lowest score to the physical quality dimension with an average score of 4.71. In another study which the scores have been determined as percentage, the physical quality dimension has been scored lowest (10.4%) by patients (Taş, 2009: 105).

In a study conducted by Yörük (2011) in five different hospitals, physical quality dimension of service quality containing dimensions such as medical science services, nursing services, tangibles and accessibility have been found to be ranked as third highest score with an average score of 3,23. In another study, the physical quality dimension has been found to be ranked as third highest score by patients with an average score of 4.62 (Harput, 2014: 92). Likewise, physical quality dimension has been found to be ranked as third highest score in studies conducted on patients by Pramanik (2016) and Li et all (2005).

In another study conducted by Has (2015), patients have given the second highest score to physical quality (in 5 service quality dimensions) with an average score of 4.64. In another study conducted on patients, it has been found that the average score given to the physical quality has been ranked as second highest score with an average score of 3.74 (Ramanujam, 2011: 193-194).

In another study conducted in India, it has been found that while the patients have ranked as forth highest score to the physical quality dimension with an average score of 1,03 in the dimensions of service quality (reliability, assurance, responsiveness, tangibles, empathy and financial condition) in public hospitals, this average score is 0,66 in private hospitals and has been ranked as sixth highest score with adding accesibility dimension to these dimensions.

5. CONCLUSION

According to the assessments made by both patients and administrators and showing the physical quality perceptions of hospitals, it has been concluded that private hospitals have higher physical quality perception. This result can be explained by the fact that private hospitals are more recent structures, have more modern technology and equipments. Morover, because they are profit-oriented organizations, taking into account patients' quality perceptions, they pay more attention to physical features of their hospitals. When private and public hospitals have been assessed holistically, it has been found that physical quality perception levels of administrators have been higher than patients as expected. In the emergence of this result, it may have

been effective that administrators have ideas which we may be better by adopting the philosophy of continuous improvement and also patients have low expectations. However, contrary to expected, in PbH-1, PbH-9 and PH-4 hospitals, the perception level of the patients has been higher than the administrators. This result can be explained by the fact that when they see the hospital environment, due to the low expectations of patients they wrap oneself up in high quality perceptions and the administrators have low expectation levels in these hospitals.

Public hospitals can increase the physical quality perceptions of managers and patients positively by having more technological and contemporary equipment, building more visually appealing buildings, employing employees who have cleaner and better appearances and attracting more with the additional services providing as well as core service providing; private hospitals can further their current situation by carriying out these improvements and have more patient admission capacity.

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PROGRESS OF MOBILE HEALTH: USES AND BENEFITS

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Abstract

Due to rapid raise in phone-enabled technologies, demand for faster process of data and access to medical records, use of mobile health technologies increased and became a necessity of life for individuals. The term "mobile health" or "m-Health", also written as m-health, stands for mobile-based or mobile-enhanced health solutions. It describes the use of mobile telecommunication integrated within mobile and wireless health care delivery systems. M-Health can be used in different purposes like fitness, wellness, disease management. Mobile applications assist to healthcare professionals in management of information, time organizing, health records maintenance and access, communications and consulting, clinical decision making, medical education and training. This study emphasized current state of mHealth applications, development and progress in last five years. As mHealth applications market is still at the beginning many great opportunities are still waiting ahead. In this study statistics like number of mHealth Apps, total downloads of m-Health Apps, mHealth Apps developers and mHealth Apps by category is analyzed for last five years. Data were retrieved from different surveys, reports and scientific studies and combined in order to provide meaningful data about mHealth technologies for researchers.

1. INTRODUCTION

As the adoption of phone-enabled technologies has increased widely and rapidly, the mobile internet technologies became a necessity of life for all individuals. Like other sectors, in health sector, people began to use tens of thousands of online medical applications in last years. The term "mobile health" or "m-Health", also written as m-health, stands for mobile-based or mobile-enhanced health solutions. It describes the use of mobile telecommunication integrated within mobile and wireless health care delivery systems (Istepanian and Lacal, 2003). M-Health improves consumers' health and helps them to access their health data by mobile applications. According to Wallace et al. (2012), mobile apps are defined as software programs that have been developed to run on a computer or mobile device to achieve a specific purpose.

Wyne (2015), says that the following three factors have contributed to the growth of m-Health:
Demand for faster processes and access to information; growing mobile usage around the globe; opportunity for entrepreneurs to create new solutions to lasting problems. With the help of mobile applications individuals can record their data about diseases, health status, daily exercise, total calorie gained and amount of water drunk. On the other hand, telemedicine and telemonitoring systems provide patients to communicate with health staff without going out from home by the help of internet. It works by an early warning sign from the patients or a family member of them. Additionally, by the help of improved technologies such as microsystems, nanotechnologies, textile fibers, biomedical sensors, wireless technology, mobile communications integrated with tele medicine, patients can improve their health (Kiser,2011).

A Deloitte report defines that m-Health reaches to its full potential by four critical dimensions such as people, places, payment and purpose. The reports indicate that demographics like gender, age and income may affect preferences of mHealth users. Place can be important in the supplementation of local networks, wireless download speeds and etc. Also, mHealth decreases payment of patients by the help of delivering health service outside the hospital anytime and anywhere. mHealth can be used in different purposes like fitness, wellness, disease management. (https://www2.deloitte, 2017)

The trends emerging throughout the m-Health can be defined as increase in mobile usage, and mobile health applications, personalized mobile experience about habits, likes or dislikes, enhancements in wearables and new mobile devices such as online videos. Also increase in data and analytics and electronic health records, led m-Health recording of this big data (www.businessinsider.com/, 2014).

The most common use of wearable devices are smart watches for fitness, glucose monitors for diabetic patients, diagnostic wearables with sensors measuring very small concentrations of metabolite gassers which are emitted through human skin and breath. Also, cardiac monitors measuring heart rates are used in different forms such as watches and arm bands (Faridi,et.al, 201;Gröschel et al.2004; Hundert et al.2014).

Wearable devices allow physicians to gather information used for following-up and treatment purposes. From the practitioners' side, it can be said that they utilize from mobile health applications very often. Mobile applications assist to healthcare professionals in management of information, time organizing, health records maintenance and access, communications and consulting, clinical decision making, medical education and training. Practitioners require access to many types of records in clinical settings. They expect

communication capabilities, voice calling, video conference, access to hospital information technologies, electronic medical records and laboratory information systems from medical applications (Nasır,2015; Kalem, 2015; Arsand et al.,2012).

2. MATERIAL AND METHOD

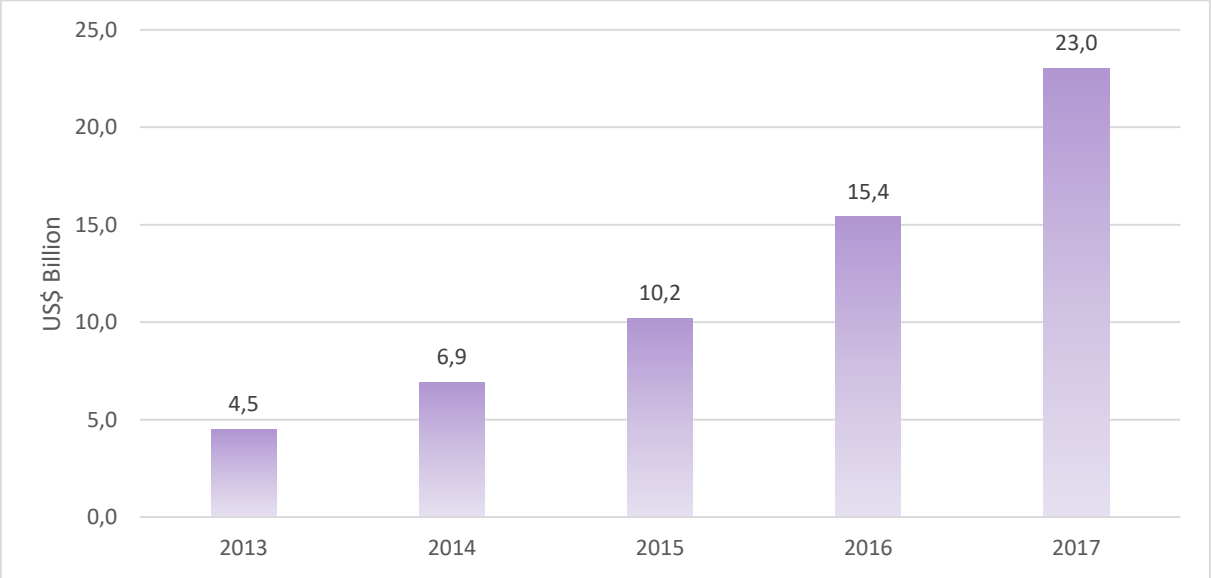
In this study, adoption, progress, opportunities and challenges in mobile health is introduced. In order to examine the fact, reports and statistics, articles, scientific results, surveys related to mobile health applications data were investigated. Graphics including of mHealth Apps, total downloads of m-Health Apps, m-Health Apps developers and mHealth Apps by category were retrieved from various resources according to different years and combined in order to provide meaningful data. Data of the graphics were gained from PwC analysis and HIT Consultant "Touching Lives through Mobile Health: Assessment of Global Opportunity PWC report",2015 and 2016 data from Norwegian Centre for E-health Research, 2013-2014 data from IQVIA Institute, 2017 data from Research2Guidance, m-Health App Developer Economics study 2017, IQVIA AppScript Database, Allied Market Research; Transparency Market Research; Statista All data were summarized, categorized and converted in order to compare according to years. Findings of the study can be followed in results.

3. RESULTS

The market of mobile health applications is about to ten years old. The first application was launched in 2008. The traditional healthcare industry is slow paced. For example, the average time to develop a new drug is ten years. But, digital industry is fast paced. Digital industry has brought disruptive change to the market since entered to healthcare industry.

The market for mobile health has been growing steadily over the last years. Worldwide mobile health revenue (US$ Billion), for 2013 -2017 years and percentage of overall market,2017 is presented in Figure 1.

Figure 1. Worldwide Mobile Health Revenue



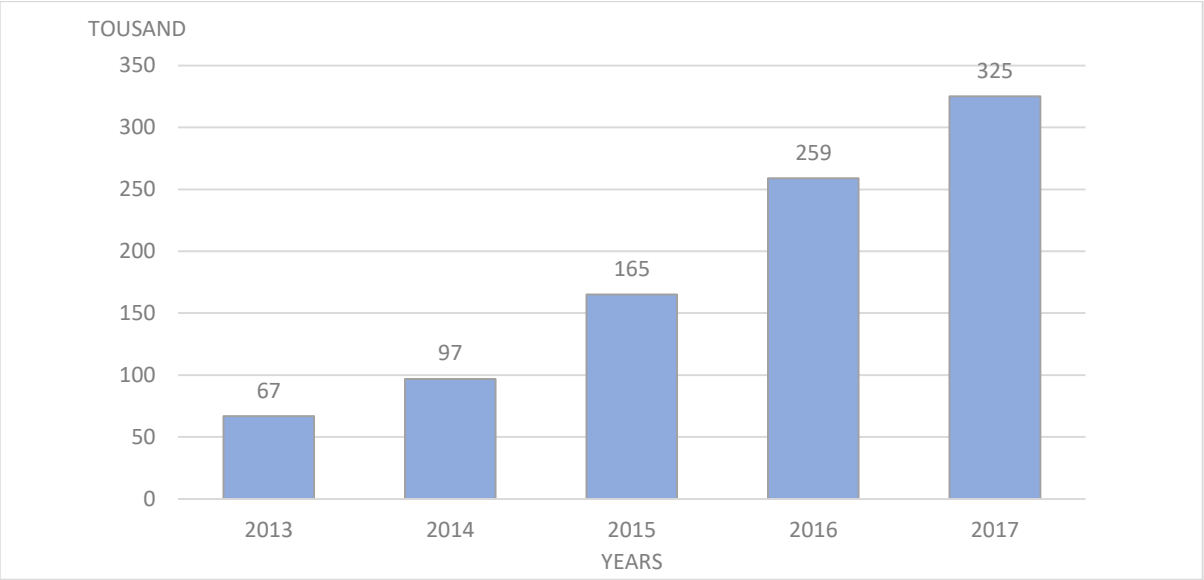
Source: PwC analysis and HIT Consultant "Touching Lives through Mobile Health: Assessment of Global Opportunity PWC report".

In 2013, mobile health revenue was 4.5 billion US$, in 2017 this value has reached 23 billion US$. Mobile health revenue has increased more than five times in last four years. These results indicate that there is great improvement in mobile health industry.

mHealth applications have seen a considerable growth over the past few years. The number of mobile healthcare applications are presented in Figure 2. According to latest data of applications number, there has been 485% growth in the number of mhealth applications for four years. Application data consist of published m-health applications in different applications' platforms such as Apple App Store, Google Play Store, Windows Phone Store, Amazon App Store and Blackberry World.

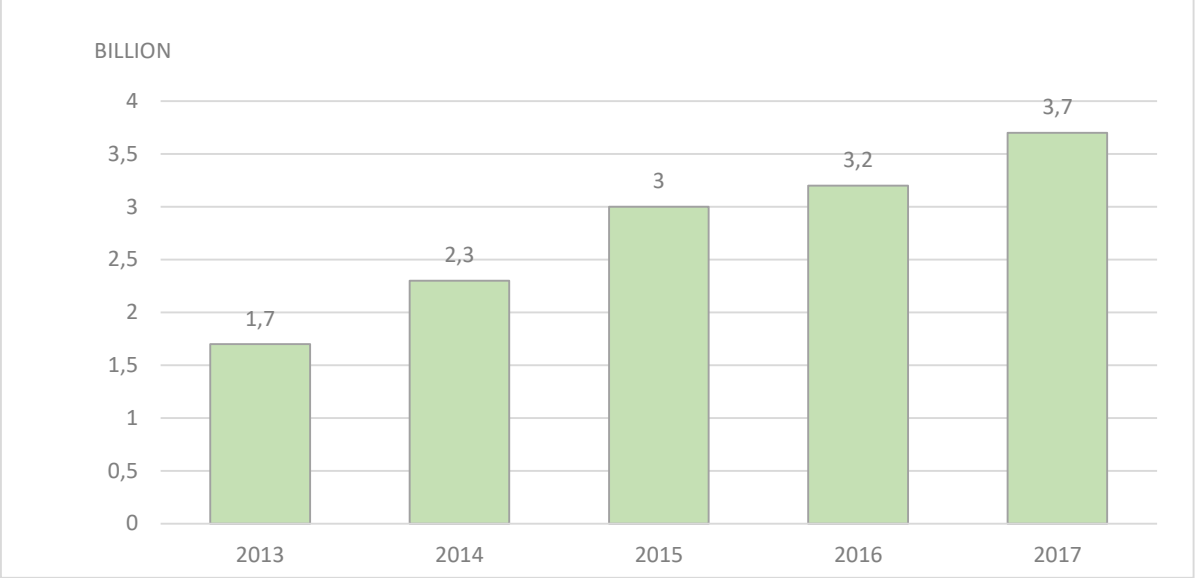
Estimated total downloads number of mobile healthcare applications is presented in figure 3. 3.7 billion health applications were downloaded in 2017. The biggest share of these is android applications. Growth rates of downloads decreased compared to previous years. While In 2014, download number increased 36% compared the previous year, this rate decreased 16% in 2017.

Figure 2. Number of Mobile Healthcare Applications 2013-2017



Source: 2015 and 2016 data from Norwegian Centre for E-health Research, 2013-2014 data from IQVIA Institute, 2017 data from Research2Guidance.

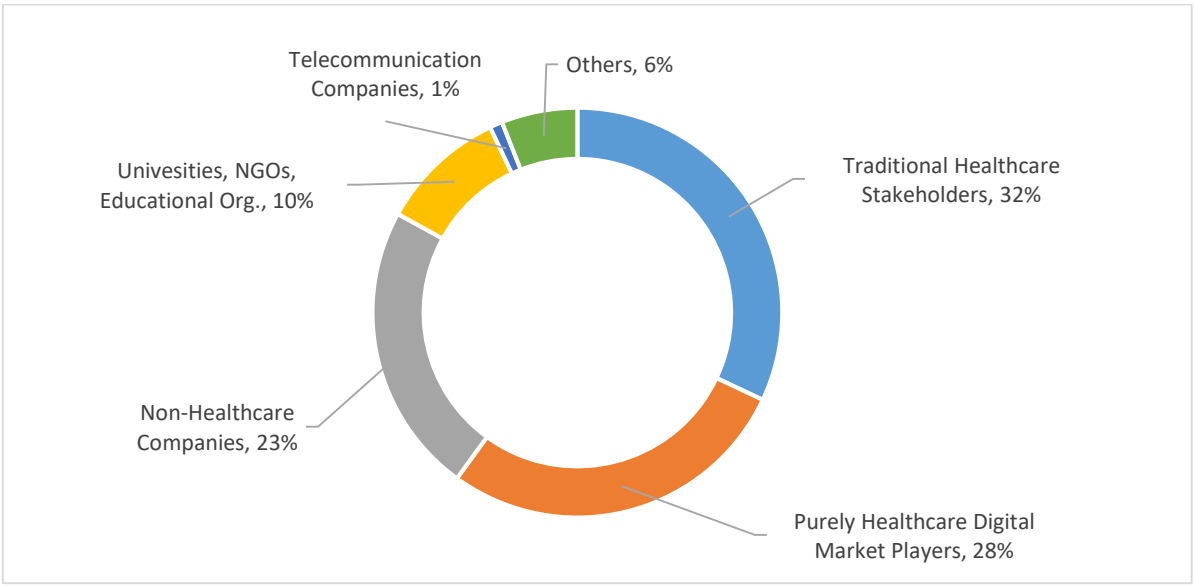
Figure 3. Total Downloads of m-Health Applications 2013-2017



Source: Research2Guidance m-Health App Developer Economics study 2017.

mHealth application developers' origin for 2017 is shown in Figure 4. Most of applications are developed by traditional healthcare stakeholders with 32%. Purely healthcare digital market players are second largest group with 28%. Application developers those are non healthcare companies are third largest developer with 23%.

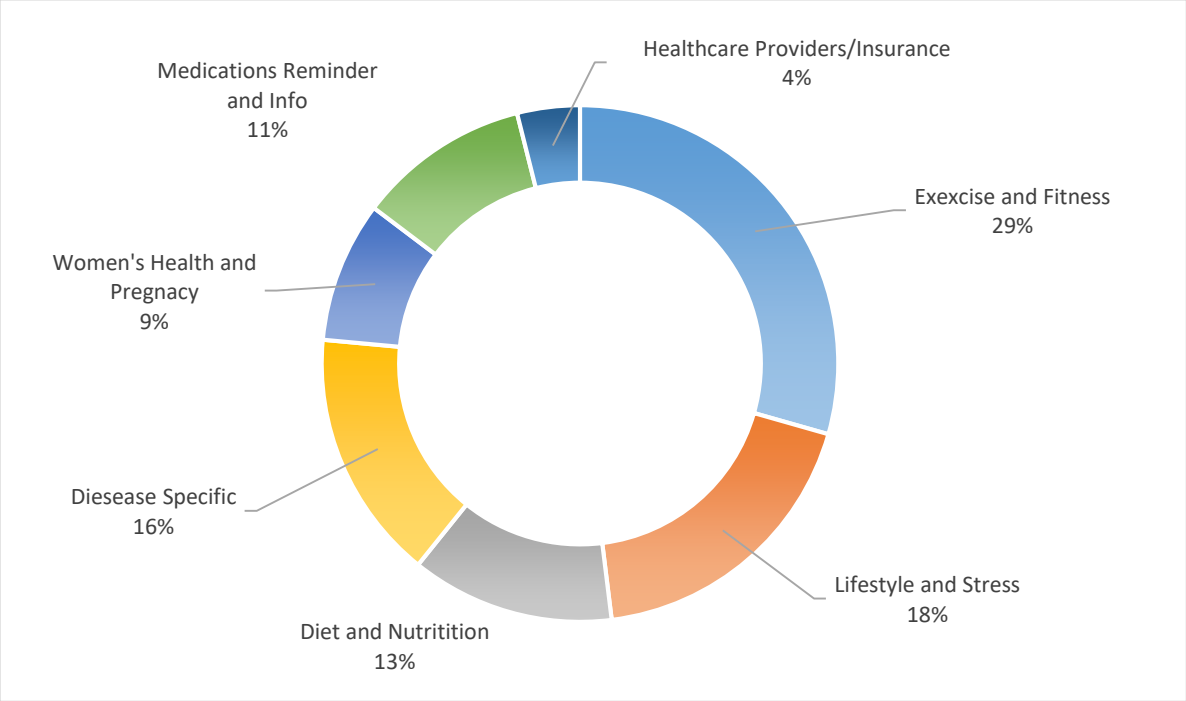
Figure 4. m-Health Application Developers in 2017.



Source: Research2Guidance m-Health App Developer Economics study 2017, 2013-2014 data from IQVIA Institute

Most widely used mobile health applications by consumers were analyzed by using category. Mobile health applications can be divided into two main categories as wellness management and health condition management. Wellness management consists of three category which are exercise and fitness, lifestyle stress, diet and nutrition. The other categories belong to health condition management. These categories is presented in Figure 5. Since 2015, consumer mobile health applications targeting wellness management have dropped as a proportion of total applications from 73% to 60%. In contrast, health condition management applications have rised as a proportion of total applications from 27% to 40%.

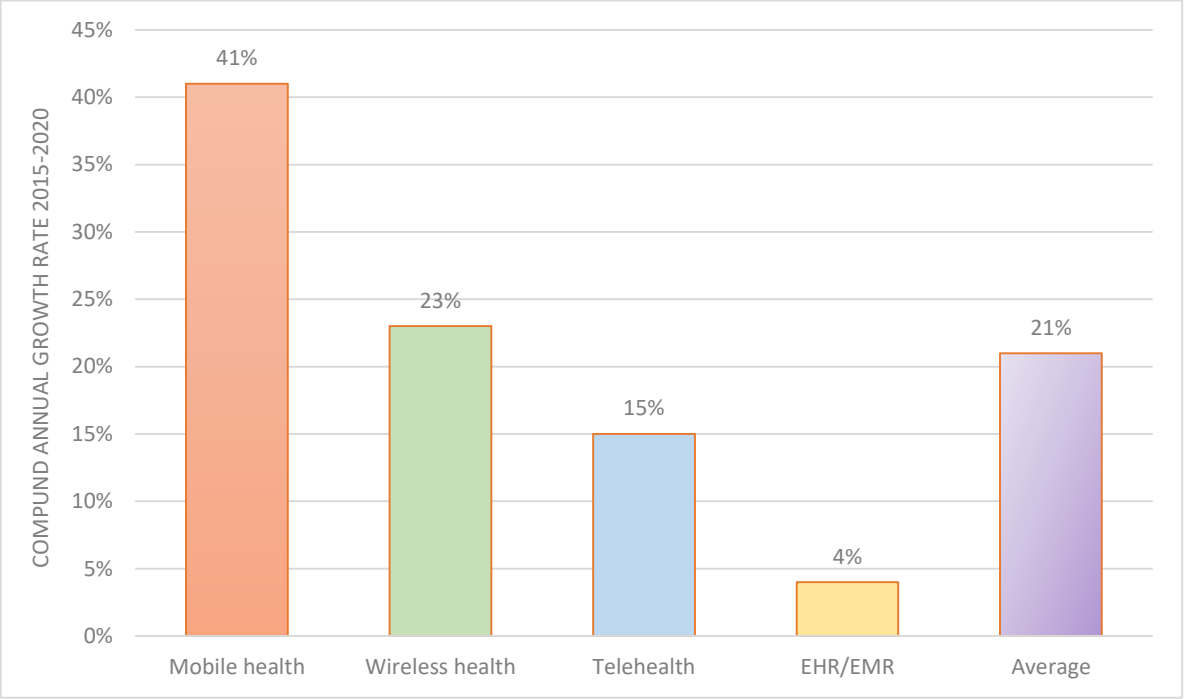
Figure 5. Mobile Health Applications by category for 2017



Source: IQVIA AppScript Database. 2017 data includes unique 11,216 applications. Data categorized by author from IQVIA Institute report.

According the future projection, digital health market grows average 21% rate annually. It is envisaged that mobile health which is one of major components of digital health will grow by 41%. Projected compound annual growth rate for global digital health market in the period 2015-2020 by major segment is shown in Figure 6.

Figure 6. Projected compound annual growth rate for global digital health market in the period 2015-2020 by major segment



Source: Allied Market Research; Transparency Market Research; Statista

4. DISCUSSION

A lot of scientific researches and surveys are found in order to state relationships between mHealth use and demographics, most used mHealth applications, benefits and conflicts about mHealth applications, security problem and patient privacy. While some researches dealt with patients the others dealt with health professionals' opinions about mHealth applications.

Kathooria summarized various researches about m-Health and presented interesting ratios and statistics. According to the article, wellness applications including fitness, lifestyle and nutrition comprise 2/3rd of m-Health applications space. 40%of physicians believe that m-Health Technologies can decrease number of visits of patients to hospitals. Additionally, 75% of them believe that ER visits can be handled over phone or video. On the other hand, 74% of hospitals who use technologic devices to record data of patients work more efficiently (Kathooria, 2016) An other article combined results of different researches and implemented that mobile devices are being used for access to drug information such as dosage calculations, side effects, interactions,etc), communicate with health staff, access to medical research, access to evidence based clinical reference tools at the point of core with patients (Referrel,2015). As we have mentioned that since 2015, consumer mobile health applications targeting wellness management have dropped as a proportion of total applications from 73% to 60%.but health condition management applications have rised as a proportion of total applications from 27% to 40%, these findings are compatible with the results of this study.

Carroll reported a survey conducted with 3677 people in 2014. According to the findings of the survey participants who used m-Health applications were younger, had more education, reporting excellent health and had higher income. Also participants who used m-Health applications lived more healthy and more active (Carroll et al.,2017). Merrel reported that, 58% of smartphone users downloaded a health application. Moreover, 41% downloaded more than five applications (Merrell,2016). McCarthy summarizes a report conducted by 2597 participants in 2017 and says that 64% of patients use medical applications to manage their health. 71% of them believe it is useful for their doctor to access their information (McCarthy,2017). In this study it was found that number of applications downloaded in recent years have been increased, findings of the study are compatible with these results.

Ventola reports that 24% of m-Health applications are used as medical information, 22% are dedicated to the monitoring of physical parameters, 18% to track disease, 16% for education and management, 6% for diagnosis (Ventola,2014). Ventola's findings are similar to this study.

Sahaidah implements that m-Health applications for individual prevention diseases focus mostly on diabetes, stroke, flu, gout and bowel disease. Author says that current mHealth applications can be categorized in terms of individual prevention disease, personal health safety, improving health, improving well being and giving advice on response treatment (Shaidah, 2017). These findings are compatible with the findings of the study.

5. CONCLUSION

It is obvious that medicine is one of the disciplines that has been profoundly affected by the avaibility of mobile devices. This is evident in many studies conducted on physicians that reveal a high ownership rate of these tools, which physicians use in both clinical practice and education. Smartphones and tablets have been even replaced desktop systems as the prefferred computing devices for physicians who need fast access to information at the point of care. On the other hand it is a necessity for health care users to use mHealth applications in order to manage their health.

We know that world's population is getting older and coronary heart disease, hypertension, diabetes and obesity will the main problems of health professionals and individuals in the future. Additionally, the amount of money spent on healthcare will rise. By the help of wearable technologies and mHealth applications patients will be able to monitor and maintain their health and wellness.

In this study the status of mHealth applications is stated for last five years by statistics. It is obviously seen that market has developed very fast and it will continue to grow in the future.This study emphasized current state of mHealth applications, development and progress in last five years. As mHealth applications market is still at the beginning many great opportunities are still waiting ahead. If all healthcare stakeholders such as physicians, institutions, healthcare workers, software publishers, researchers and individuals can be involved in mHealth market, success of the market will be inevitable.

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THE EFFECTS OF INTERNAL MARKETING ACTIVITIES ON ORGANIZATIONAL CITIZENSHIP BEHAVIOR

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A R T I C L E I N F O

Keywords*:* internal marketing, organizational citizenship behavior, rewarding and communication.

Abstract

It is not possible for external customers to be satisfied without motivating internal customers. The purpose of this study was to examine the effect of internal marketing activities on organizational citizenship behavior. This study is important in terms of showing how internal marketing activities contribute to organizational citizenship behavior and to human resources management practices. A survey was conducted on 171 people in a hospital that produces hospital furniture and medical equipment. For the analysis of data in the study, exploratory factor analysis, correlation and multiple regression analyzes were used. In the research findings, there was a positive and significant correlation between internal marketing and organizational citizenship. As a result, increasing of internal marketing activities led to an increase in organizational citizenship behavior. Especially, from internal marketing activities an increase the importance of rewarding and communication dimensions, led to an increase in organizational citizenship behavior.

1. INTRODUCTION

Internal marketing is a concept that emerges and emerges in the late 1970s and early 1980s, focusing not only on external consumers, but also on internal constitutes (Kaplan,2017). Internal marketing term, used to describe the work done within an organization with the aim of training, motivating and communicating with employees, has been largely developed in the service sector. If an organization does not have internal marketing activities, it can not focus on how employees interact with their customers (Wilson and Gilligan,1995).

Stating clearly the importance of internal marketing, the chairman of Southwest Airlines' board of directors stated in 1996: "Who comes first for businesses?, customers, employees or shareholders? I have never hesitated to answer this question. Employees come first. If they are happy, satisfying, self-empowered and energetic, they will do what is best for their consumers, and therefore customers will come again; this will make also the shareholders happy "(Demir et al., 2008).

Internal marketing activities are closely related to employee satisfaction and performance. Employees in internal marketing are seen as internal customers. Thus, as the level of employee satisfaction increases, the likelihood of creating external satisfaction and loyalty for external customers will also increase (Ahmed and Rafiq, 2003). In internal marketing studies, organizational commitment (Joung et al.,2015; Chi et al.,2016); job satisfaction (Marques et al.,2018; Al-Ababneh et al., 2018), service quality (Sohail and Jang, 2017; Bang et al.,2016; Bonyadinaeini et al., 2015), Organizational performance (Ullah and Ahmad, 2017) and turnover intentions (Kim et al., 2016), institutional reputation (Fettahlioglu et al. 2016) has been identified as having significant impact. Yüce and Kavak (2017) determined that internal marketing activities reduced the intention to leave work, where organizational commitment increased.

Başaran et al. (2011) found that internal marketing directly affected perceived quality of service, rewards and development dimensions, they found that job satisfaction is mediating between the rewarding dimension of internal marketing and perceived service quality. Internal marketing activities have been found to be an effective tool for organizational citizenship behavior (Yıldız, 2016; Salajeghe t al., 2015).

Today, the rapid development of customer expectations has increased the importance of human resources management. There is a greater need for organizations to fulfill their assets and to achieve their strategic goals, employees who behave beyond job descriptions (Bolat and Bolat, 2008). In other words, employees who exhibit organizational citizenship behavior have become more preferred.

Attaching importance to internal marketing activities that closely related to human resources management practices in increasing organizational citizenship behaviors in an organization, will bring forth the importance given to the employees of the organizations. In this study, internal marketing and organizational citizenship behavior are discussed together. When the literature is examined, there is a limited number of directly related researches in which internal marketing and organizational citizenship issues are studied together. These results show that there is a positive relationship between internal marketing practices and organizational citizenship behavior (Yildiz,2016; Kamalinasab et al., 2014; Kamalinasab et al., 2017; Alshurideh et al.,2015; Salajeghe t al.,2015). This study is important in terms of showing how internal marketing activities contribute to

organizational citizenship behavior. It is also important in terms of contributing to human resources management practices.

2.THEORETICAL FRAMEWORK

2.1. Internal Marketing

Today, the concept of internal marketing is one that has become intensely debated by researchers. The concept of internal marketing that emerged in the service marketing literature began to be addressed at the end of the 1970s (Ene, 2013), but nowadays it is among the topics that are examined in detail. Internal marketing has become increasingly important for organizations as the service industry and knowledge base grows in importance. Internal marketing, however, is not only concerned with the service sector, but also with the organizations that market the products (Dunmore 2002).

Internal marketing is a management philosophy that requires organizations to treat their employees as customers (Başaran et al., 2011). Internal marketing means that a service organization makes great investments in employee quality and performance. It is necessary to educate and motivate them effectively in order to ensure customer satisfaction and for employees to work in teams (Kotler et al., 1999). As a marketing "understanding", the satisfaction and motivation of employees in internal marketing are emphasized. Accordingly, internal marketing is an understanding of marketing aimed at attracting, retaining and motivating employees in order to enable an entrepreneur to effectively externally marketing (Rafiq and Ahmed 1993, Shepherd, 2004). Internal marketing focuses on employees and helps the company achieve competitive advantage(Abbas and Riaz,2018). Internal marketing is a philosophy of management that envisages "acting like a customer" to employees, which offers actions to meet their demands in order to gain employee loyalty and organizational loyalty (Kocaman et al., 2013).

The dimensions of internal marketing can be expressed as career development, vision development, rewarding and intra-organizational communication from the definitions given in the literature and Money and Foreman's (1996) internal marketing scale (İşler and Özdemir, 2010). Internal marketing activities require that employees of the organization be informed, trained, developed, rewarded and motivated in order to meet the needs and expectations of the internal customers (Kocaman et al., 2013).

Internal marketing is closely related to human resource management practices. In internal marketing, which is a management philosophy that aims to shape business products to the needs of employees, everyone who works in the business is regarded as an internal customer and the service will be sold to the internal customers before the external customers, so that they are happy in the business (Uygun, et al., 2013). Internal marketing; human resources development, strategic management, staff relations, quality management, intra-organizational communication and macro marketing, is combination characteristic of many different management technologies (Özdemir, 2014).

2.2. Organizational Citizenship Behavior (OCB)

As a concept, organizational citizenship first appeared in the literature in 1983 by Organ and colleagues. Organizational citizenship behavior is one of the most researched topics today (Bateman and Organ, 1983) because of the contribution of employees to performance evaluations and to the success and effectiveness of organizations. The organ expressed organizational citizenship behavior as "good soldier behavior" (Organ 1997). According to Organ (1990), organizational citizenship behavior, is

defined as "are useful behaviors for the organization that do not arise from the contractual compensation indemnity, can not be applied on the basis of official role obligations". Organizational citizenship behavior, which is crucial for the effective functioning of organizational functions, voluntarily indicates more of the required role requirement for employees to benefit the organization (Organ 1990). The organizational citizenship behaviors shown by the employees in the organization mainly appear in two ways. First, requires employees to actively participate in the organizational structure, practices and targets. Secondly, requires that the employee should avoid harmful behavior (Sökmen and Boylu, 2011).

It shows that social change, equality and reciprocity are related to norm theories, reward allocation, job satisfaction and organizational citizenship behavior and justice. Employees can improve their performance when they perceive fair behavior and job satisfaction. Demonstrating organizational citizenship behavior will be a possible way for employees to respond to their organizations (Netemeyer and Boles, 1997).

Organizational citizenship behavior, on the decisions, can be effective such as, managers' performance evaluations, wage increases, and promotion. Organizational citizenship behavior improves organizational effectiveness and performance in the long run. It will also increase employees' internal motivations and achieve employee achievement, competence and contribution to belonging feelings. Organizational citizenship behavior is closely related to job satisfaction, organizational commitment, organizational justice, turnover and anti-citizenship behavior (Gürbüz, 2006). Organizational citizenship behavior provides the ability to attract and retain qualified workforce by making the working environment of the organization attractive (Karaman et al., 2008). It is known that organizational citizenship behaviors, organizational social mechanisms facilitate the functioning, reduce conflicts and increase effectiveness. As a result, exhibiting organizational citizenship behavior can increase organizational performance (Şehitoğlu ve Zehir, 2010).

Organizational citizenship behavior is classified in two ways. Individually directed organizational citizenship behavior (OCBI) is a citizen's behavior indirectly contributed by members. They are behaviors that help employees to their colleagues and thus indirectly contribute to the organization. Organizationally directed organizational citizenship behavior (OCBO) is voluntary behavior that members of the organization actively undertake in their duties and demonstrate to the benefit of the organization (Fu, 2013).

It is seen that there are different dimensions in organizational behavior dimensions in the literature (Oğuz, 2011). Organ (1997), however, has combined these dimensions under five headings. These are the dimensions "Altruism","Constientiousness", "Courtesy" "Sportmanship" and "Civic Virtue". Altruism, is voluntary behavior to help other people or to prevent work-related problems from occurring (Basım ve Şeşen, 2006). It is used to help certain people who contribute to the activity (such as colleagues, partners, customers or boss) (Organ, 1997). Conscientiousness is a voluntary demonstration of a role behavior beyond the minimum role behaviors expected of employees. Courtesy is behavior based on informing others before making moves or making decisions that affect others' affairs (Basım ve Seşen, 2006). Sportsmanship means that the employees do not complain about the unavoidable or imposed situations related to the work. Civil virtue is the act of participating actively in the organization's activities, protecting the interests of the

organization against possible changes and losses (Podsakoff et al. 2000).

Job satisfaction, employee engagement and job embeddedness, organizational commitment, HR practices, Self-efficacy, transformational leadership, self-serving motives and Culture are antecedents/determinants of OCB (Ocampo et al.,2018).

Determining the organizational citizenship behavior tendencies of candidates applying for employment in the selection of employees regarding human resources management activities can help to increase the efficiency and effectiveness of the organization (Çavuş and Develi, 2015: 239). In addition, training and development activities to increase the qualifications and activities of employees will contribute to exhibit organizational citizenship behavior (Çorum and Öge, 2018: 30).

Liu and the others explored (2017), explore the mediating effect of compulsory citizenship behavior in the relationship between organizational citizenship pressure and work–family conflict. Acaray and Akturan (2015) determined that prosocial organizational silence has a positive effect on organizational citizenship behavior. Moorman et al. (2018) explained the importance of trust in organizational citizenship behavior. Ghanbari and Eskandari (2014) found a positive correlation between organizational climate and job motivation and organizational citizenship behavior. Lee and Woo (2017) found that job satisfaction partially mediated the relationship between organizational citizenship behavior and emotional labor.

Tabancalı and Çakıroğlu (2017) found that ethical leadership behaviors increased their organizational citizenship behaviors. Avcı (2016) stated that the organization's positive and strong organizational culture will contribute to the development of organizational citizenship behaviors. Dinka (2018) determined that employee performance is positively linked to organizational citizenship behavior. Seeing employees as internal customers will lead to the development of organizational citizenship behavior and will lead to an increase in service quality (Kamalinasab et al., 2014). Demirel and Güner (2015) found a positive relationship between internal customer relationships and organizational citizenship behavior. SeyedJavadin and by his friends (2012), it determined that organizational citizenship behavior is mediated between internal marketing and service quality.

An organization that has employees who demonstrate organizational citizenship behavior, according to other competitors, will have employees who give more importance to organization and work. The fact that the organization attaches more importance to its internal marketing activities, its the most important resource "human resource', will reveal the significance given. For this reason, it was thought that increasing the organizational citizenship behavior would be an effect of the internal marketing activities and the hypothesises of the research was determined as follows.

H1: Internal marketing dimensions have a positive and significant effect on organizational citizenship.

H1a: Developing education and vision from internal marketing dimensions has a positive and significant impact on organizational citizenship behavior.

H1b: Rewarding and communication from the internal marketing dimensions has a positive and significant impact on organizational citizenship behavior.

H2: Internal marketing has a positive and significant effect on (general) organizational citizenship (general).

3. MATERIAL AND METHOD

The main purpose of this research is to determine the effects of internal marketing activities on organizational citizenship behavior. This study constitutes the universe, which has many international design awards, hospital furnishings and producing medical equipment, a company that he in Sivas (Turkey) "Nitrocare" is situated under the name activity. The population of the research is 225 employees. The sample of the study consisted of 171 people who worked actively between November and December 2017. The sample is 76% of the universe. A written consent was obtained from Nitrocare Anonim Şirketi before it started to work. It seems that the number of samples is sufficient for the 5% confidence interval. 143 people were calculated to be adequate. (http://www.raosoft.com/samplesize.html).

The questionnaire was used in the study included questions about demographic characteristics consisting of 8 questions; consisting of 15 items "Internal Marketing Scale" developed by Money and Foreman (1996) (Kocaman et al., 2013) ; and "Organizational Citizenship Behavior Scale" consisting of 19 items which were combined with two different scales and made valid and reliable in Turkish by Basım ve Şeşen (2006). The intrinsic marketing scale was implemented in the form of a 5-point Likert scale, which " I absolutely disagree " with (1) and " strongly agree " with (5); whereas the organizational citizenship scale was used " never" (1) and "always" (6) in the form of a 6-point Likert scale. For the analysis of data in the study, percentage, frequency, arithmetic mean, descriptive (explanatory) factor analysis, t test, anova, correlation and regression analyzes were used with SPSS program.

Explanatory factor analysis was used to determine how many dimensions of internal marketing and organizational citizenship scales could be examined. The statistics on factor analysis for the following internal marketing scale are shown in table I. KMO sample fit was found to be 0,929, and the Barlett normal distribution test result was significant. Accordingly, since the value of KMO is significant, it can be said that there is a data suitable for factor analysis. For the internal marketing scale, two dimensions above of 1 the eigenvalues, were derived using varimax transformation. There are no substances that can be loaded in more than one factor in the scale items. For this reason, the substance was not removed. These two factors account for 70% of the total variance. It is usually sufficient that this ratio is above 50%. When the subcomponents and factor structures that make up these factors are examined, the first factor (F1) which consists of 8 questions is composed of training and vision development components. The second factor (F2) consists of 7 questions and rewards and communication components.

Table I. Results of factor analysis on internal marketing perceptions

Internal Marketing	*F1*	*F2*
10- This organization collects information from employees to improve employee duties and improve the organization strategy.	,824	
14- This organization has the flexibility to supply the different needs of employees.	,808	
13- Employees in this organization, for performing service roles, they are grown appropriately.	,801	
11- This organization, transmit the importance of service roles to employees, .	,795	
15- Communication with employees in this organization is of greatimportance and the importance of communication is placed in the organization.	,788	
12- Employees who provide excellent service to this organization are rewarded for their efforts.	,787	
9- This organization measures and rewards the performances of employees who often contribute to the vision of the organization.	,764	
8- This organization's performance measurement and reward systems, encourages their employees to work together.	,652	
1- This organization provides a vision for their employees will be able to believe.		,852
3- This organization prepares its employees to perform well in their jobs.		,847
4- This organization sees the development of its employees' knowledge and skills sees it as an investment rather than a cost.		,826
2- This organization transmits its vision appropriately to its employees.		,821
7- This organization, beyond the training of its employees, at the same time educates.		,702
5- The knowledge and skills of the employees in this organization, evolves in the organization process.		,633
6- This organization teaches its employees not how to do need things, teaches "why" should be done need that.		,623
Factor eigenvalue	8,914	1,629
Variance Percent of Factor Explained	59,429	10,857
Total Variance Explained (%):	70,287	
Tests: Kaizer-Meyer-Olkin test (KMO): 0.929 Barlett's test of Sphericity: 2144,586 (p<0.000*)*		

The scale of organizational citizenship behavior was combined with two different scales and the validity and reliability of Turkish version were made by Basım and Şeşen (2006). There are five dimensions in the scale consisting of 19 items. In this study, the scale was done re-reliability and validity because it was applied to a different business. Kaiser-Meyer-Olkin (KMO) and Barlett test were performed with explanatory factor analysis for the data. KMO sampling suitability was found to be 0.892, and Barlett normal distribution test result was significant. Since the KMO value is significant, can be said to be an appropriate data to do factor analysis. For the organizational citizenship behavior scale, 4 dimensions were derived above the eigenvalue 1 using varimax transformation. These items have been removed because more than one factor can be loaded in the 16th and 14th items (F1 and F3) and 5th item (F2 and F4).(Table II). These

four factors account for 66% of the total variance. It is usually sufficient that this ratio is above 50%. When examining the sub-components and factor structures that make up these factors; consists of the first factor (F1) courtesy that contains a total of 5 questions, the second factor (F2) Altruism with 4 questions, third factor (F3) civil virtue with 3 questions, and the fourth factor (F4) Conscientiousness with 3 questions.

Table II. Results of factor analysis on perceptions of organizational citizenship behavior

Organizational Citizenship Behavior	*F1*	*F2*	*F3*	*F4*
11- I try not to create problems for the other people I work with	,826			
10- When unexpected problems occur, not to be harmed their, I warn the other employees	,759			
9- I show respect for the rights and laws of other employees	,703			
12- I do not waste time complaining about minor problems	,660			
13- I try to see the positive direction of events rather than focus on problems related to the workplace environment	,659			
18- I keep pace with changes to the company structure .	,594			
2- I help a company employee who is overworked		,778		
1-I do the day's work for an employee who gets daily leave.		,748		
3- I help someone who starts a new job learn.		,685		
4- I do not avoid sharing materials with others when there are business problems		,658		
15- I am actively involved in the resolution of conflicts within the company			,725	
17- I voluntarily agree to the company's social activities.			,712	
19- I take part in research and project groups that perform all kinds of developer activities.			,697	
8- I do not spend time for personal work within working hours.				,722
7- I would like to participate in all activities that will create a positive image for my company.				,716
6- I spend most of my time in business related activities.				,700
Factor eigenvalue	8,351	1,645	1,521	1,111
Variance Percent of Factor Explained	43,953	8,659	8,007	5,846
Total Variance Explained (%):	66,464			
Tests: Kaizer-Meyer-Olkin test (KMO): 0.892 Barlett's test of Sphericity: 1868,175 ($p<0.000$)				

Unlike the original of the scale, the sportmanship did not create the factor with the dimension. For this reason, the sportmanship dimension was not included in this study and a total of 16 items were evaluated on scale. Reliability analysis of the scales was done after factor analysis. When the reliability analysis results of the scales are examined, it can be said that Cronbach Alpha values (> 0.70) are quite reliable. The mean scores of the scale dimensions are also shown below (Table III).

Table III. Reliability levels for general and lower dimensions of scales

	Number of items	*Reliability*	*Average*	*Standard deviation*
Courtesy	6	0,886	4,84	0,99
Altruism	4	0,819	4,43	1,12
Civil virtue	3	0,739	4,34	1,14
Conscientiousness	3	0,779	4,59	1,13
Organizational Citizenship Behavior (General)	16	0,911	4,60	0,87
Training and vision development	8	0,941	2,99	1,14
Rewarding and communication	7	0,924	3,29	1,02
Internal marketing (general)	15	0,951	3,13	1,00

4. FINDINGS

The distribution of 171 participants according to their socio-demographic characteristics is given in Table IV. According to this, 44.4% of the participants were in the 28-37 age group, 81.9% were male, 70.8% were married, 32.2% of them had a bachelor's degree, 41.5% of the experience were between 1-5 years, 42.7% were employed as workers, 52% had a monthly income between 1500-3000 and 64.9% did not have managerial duty.

Table IV. Distribution of Participants according to Demographic Characteristics (n=171)

Age	*N*	*%*	Educational status	*N*	*%*
18-27	47	27,5	Primary education	47	27,5
28-37	76	44,4	High school	39	22,8
38 and over	48	28,1	Associate Degree	20	11,7
			License	55	32,2
			Master's degree	10	5,8
Gender			*Marital status*		
Woman	31	18,1	Married	121	70,8
Male	140	81,9	Single	50	29,2
Experience			*Title*		
1-5 years	71	41,5	Administrative staff	61	35,7
6-10 years	58	33,9	Technical personnel (engineer, technician and technician)	37	21,6
11-15 years	20	11,7	Worker	73	42,7
16 years and ve over	22	12,9			
Income status			Management task		
1500 and below	55	32,2	Yes	60	35,1
1501-3000	89	52,0	No	111	64,9
3001 and over	27	15,8			

In table V, there was a positive correlation between education and vision dimension from internal marketing dimensions and marital status of employees (r = 0.187) and education level (r = 0.188). Positive correlation was found between the level of civil virtue (r=0,153), which is the dimension of organizational citizenship behavior, and the level of education. However, the correlation between education level and organizational citizenship behavior (general) is not significant. There was no correlation between gender, age, marital status, experience, title, managerial duty, and monthly income variables. There was a positive and significant correlation between internal marketing (general) and organizational citizenship (general) (r = 0,335). There were positive and significant correlations between internal marketing dimensions and organizational citizenship dimensions. There were significant and positive relationships between, in education and vision of internal marketing dimensions, between courtesy (r = 0,276), civil virtue (r = 0,274) and conscientiousness (r = 0,192) of organizational citizenship behavior dimensions. There were significant and positive relationships between, in the rewarding and communication of internal marketing dimensions between of all of organizational citizenship behavior dimensions. [courtesy (r = 0,287), altruism (r = 0,285), civic virtue (r = 0,277) and conscientiousness (r = 0,310)]. However, with the development of education and vision, which is the internal marketing dimension, there was no significant correlation between altruism.

Table V. Findings of Correlation Analysis of Relationships Between Internal Marketing And Organizational Citizenship Behavior

	Gender	Age	Marital status	Education Status	Experience	Title	Management task	Income status	Training and vision development	Rewarding and communication	Internal marketing (general)
Gender									-,026	,072	,019
Age									-,073	-,073	-,079
Marital status									**,187***	,101	,161*
Education status									**,188***	,147	,184*
Experience									,014	-,087	-,033
Title									-,084	-,023	-,062
Management task									-,133	-,053	-,106
Income status									,056	,052	,058
1.Courtesy	-,072	-,008	,047	,062	-,067	-,020	-,072	-,024	,276**	,287**	,304**
2.Altruism	,013	-,029	,023	-,011	-,029	,003	-,035	-,003	,131	,285**	,215**
3.Civil virtue	,026	,009	,099	**,153***	,054	-,131	-,119	,131	,274**	,277**	,298**
4.Conscientiousness	,010	-,117	,003	-,038	-,137	,061	-,050	,000	,192*	,310**	,264**
OCB (general)	-,018	-,039	,052	,051	-,058	-,025	-,083	,021	,273**	,356**	,335**

According to regression findings, about 13% (R^2 = 0.128) of organizational citizenship behavior variable is explained by the variables of internal marketing dimension. No significant effect of training and vision development on organizational citizenship behavior (p> 0,5). Rewarding and communication dimension had a positive and significant effect on organizational citizenship (ß = 0,324, t = 3,207, p = 0 <0,5). H1b hypothesis was therefore accepted, while H1a hypothesis was rejected. Accordingly, the dimension of internal marketing, rewarding and communication, leads to an increase in organizational citizenship behavior (Table VI).

Table VI. Findings of Multiple Regression Analysis On The Effects of İnternal Marketing Dimensions On Organizational Citizenship

Independent Variables	Dependent Variable	Model Summary		ANOVA		Regression coefficients			Hypotheses	Result
		R	R^2	F	p	Beta	T	p		
1.Education and Vision Development	OCB	0,357	0,128	12,300	0,000	0,046	0,455	0,650	H_{1a}	Reject
2. Rewarding and Communication						0,324	3,207	**0,002***	H_{1b}	Accept

*p< 0.05.**p< 0.01; Durbin-Watson=1,762

According to regression analysis findings, 11% of the organizational citizenship variable (R^2 = 0.112) is explained by the internal marketing variable. Internal marketing has a positive and significant effect on organizational citizenship (ß = 0,335, t = 4,621, p = 0 <0,5). Hence, the H2 hypothesis has been accepted. Accordingly, as internal marketing activities increase, organizational citizenship behavior may increase(Table VII).

Table VII. Simple regression analysis regarding the effects of internal marketing activities (general) on organizational citizenship behavior (general)

Independent Variables	Dependent Variable	Model Summary		ANOVA		Regression coefficients			Hypothesis	Result
		R	R^2	F	p	Beta	T	p		
Internal Marketing	OCB	0,335	0,112	21,350	0,000	0,335	4,621	**,000***	H_2	Accept

*p< 0.05.**p< 0.01; Durbin-Watson=1,697

5. DISCUSSION AND RESULT

In today's organizations, it is more preferable to have employees who demonstrate extra-rol behaviors that exceed the limits of their job descriptions in order to achieve their goals. Organizations have to pay attention to the needs of the human resource, which is the most important resource. If internal marketing activities that closely concern human resources management practices are given importance, organization employees may increase organizational citizenship behavior exhibits and it can provide contributions of qualified personnel to remain in the organization.

This study was conducted to determine the effect of internal marketing activities on organizational citizenship behavior. It has been examined whether there is a significant difference between the variables according to socio-demographic characteristics in the study. According to the results of the research, no significant difference was found between organizational citizenship behavior and demographic variables. Similarly, in the Akindobe (2011) study, it was determined that personal factors did not have significant determinants of organizational citizenship behavior, but extroversion and experiential openness dimension of personality factors were significant determinants of organizational citizenship behavior. Similarly, Podsakoff et al. (2000: 527) did not find a significant difference in their research in terms of gender and duration of duty, organizational citizenship behavior (general) and organizational citizenship behavior.

In the perceptions of intrinsic marketing activities; in terms of education level, perceived level of internal marketing activities of high school graduates was found to be significantly lower than that of associate degree graduates. Furthermore, according to the marital status variable, the perception of inner marketing was higher than that of married ones. In other words, in high school graduates and married employees, the internal marketing activities performed by the organization are perceived as lower. Accordingly, it may be suggested that the emphasis should be placed on the provision of opportunities and environments for the company, especially for high school graduates and married employees, in terms of internal marketing activities.

Similarly, in the research of Çoban et al. (2008), there was a difference between level of education and marital status and level of satisfaction with internal marketing activities. In terms of education level, internal marketing practices, internal communication, internal integration and level of satisfaction with internal product activities was higher in associate and university graduates. On the other hand, according to marital status, satisfaction levels of internal product activities were found to be higher for married employees than for single employees.

In study there was found a positive and significant correlation between internal marketing (general) and organizational citizenship (general) ($r = 0{,}335$). Accordingly, the increase in internal marketing activities can lead to an increase in organizational citizenship behavior. However, there was no significant correlation between education and vision development, which is the dimension of internal marketing activities, and the altruism dimension of organizational citizenship. In other words, increasing education and vision development, it also leads to an increase in courtesy, civil virtue and conscientiousness in the dimensions of organizational citizenship, it does not cause an effect on altruism behaviors.

According to the findings of regression analysis, no significant effect of organizational citizenship behavior was found on education and vision development (H1a hypothesis was

rejected). On the other hand, positive and significant effect of rewarding and communication dimension on organizational citizenship was found (H1b hypothesis was accepted). Accordingly, rewarding and communication, the dimension of internal marketing, caused an increase in organizational citizenship behavior.

Moreover, according to the findings of simple regression analysis, a positive and significant effect of internal marketing activities on organizational citizenship was determined. (H2 hypothesis was accepted). Accordingly, as internal marketing activities increase, organizational citizenship behavior increases. These results support research in the literatüre (Yildiz,2016; Kamalinasab et al., 2014; Kamalinasab et al., 2017; Alshurideh et al.,2015; Salajeghe t al.,2015; Abzari and Ghujali, 2011; Mahmood et al.,2013; Barzoki, and Ghujali, 2013).

Similarly, Demirel and Güner (2015) investigated the relationship between internal customer relationships and organizational citizenship behaviors. In their research, the dimensions of internal customer relationships (effective management, internal customer orientation, collaboration and communication, internal customer satisfaction and technology competence) was positively related to the dimensions of organizational citizenship behavior (Individually directed (OCBI) and organizationally directed (OCBO) organizational citizenship behavior). Alshurideh et al., (2015), in their research, on organizational citizenship behavior, internal marketing dimensions of motivation and communication have a strong impact, but less impact on the dimensions of training and development has been determined. These results support the results of the study.

As a result, increasing internal marketing activities led to an increase in organizational citizenship behavior. In particular, importance given to rewarding and communication dimensions from internal marketing activities, led to an increase in organizational citizenship behavior. Accordingly, attaching importance to the internal marketing activities of organizations can contribute to the increase of employees who exhibit organizational citizenship behavior. In particular, more emphasis on rewarding and communication activities can be suggested to increase organizational citizenship behavior.

Attaching importance to internal marketing activities that closely related to human resources management practices in increasing organizational citizenship behaviors in an organization, will bring forth the importance given to the employees of the organizations. If organizations want to maintain external customer satisfaction and commitment, it is necessary first to give importance to the internal customer. In other words, you can not please the outside customer without being motivated the internal customer. For this reason, firstly, the giving importance internal customers, meeting their needs, and thus giving more importance to rewarding and communication as internal marketing activities for motivation, will also increase the organizational citizenship behaviors.

In order to increase the generalizability of the results of the study, it is recommended to reproduce the study in large samples in public and private institutions. This study is important in terms of encouraging internal marketing practices and contributing to organizational citizenship behavior. This study has an impact on future theoretical and empirical research. In future research, I encourage both the internal marketing and organizational citizenship behavior to be addressed clearly. In future research, achieving different or similar results may also contribute to organizational behavior and

human resource management as well as to internal marketing practices.

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THE PERCEPTIONS OF OLDER TURKİSH IMMIGRANTS OF THE HEALTHCARE PROFESSIONALS IN THEIR HOME AND HOST COUNTRIES

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Key Words: health professionals' attitudes, older immigrants, staff-patient relationship, heath services

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Abstract

The Turkish immigrants use of the health services in Turkey has increased because during their retirement they spend more time in Turkey and also since they are at an older age they have more chronic illnesses. This research is focused on the perceptions of Turkish immigrants living in Europe towards healthcare professionals in Turkey and their host countries. The qualitative method has been used, whereby Turkish immigrants living in Denmark, Britain (UK) and Germany (a total of 67 individuals over the age of 50) have been interviewed between 2011-2015, using a semi-structured questionnaire.

The immigrants' perception about healthcare professionals is found to be two-dimensional. The Turkish physicians are preferred for prompt diagnosing and treatment, however, the health professionals of the host countries were found to be more humane and reliable. The respondents are frequently treated by their family physicians in their host countries and are generally satisfied. The main dissatisfaction from family physicians are the barriers to advanced investigations and specialist referrals. The respondents use the Turkish health system in order to be examined by specialists and get advanced investigations done. Their perceptions of healthcare professionals are shaped pragmatically at the practical level.

Key words: health professionals' attitudes, older immigrants, staff-patient relationship, heath services

1. INTRODUCTION

Cross-border health care use attracts more attention in the last few decades. Immigrant workers develop closer relations with their home countries due to increased transportation and communication opportunities as a result of globalization. The increased demand for natives and immigrants to foreign countries in order to seek cheaper, accessible and satisfactory health care created a need for new national health care policies (Österle at al., 2013). Besides, the common use of cross-border health care services resulted in increased research in this area (Lokdam at al., 2016; Şekercan at al., 2015; Horton, and Cole, 2011; Lee at al., 2010). Research findings show that in general, immigrants are shown to have more illness and a worse health status compared to native citizens, and they use healthcare services more frequently. They are considered to be disadvantaged in terms of health (Steinbach, 2017; Leduc and Proulx, 2004; Warnes et al., 2004; Papadopoulos et al., 2007; McDonald and Kennedy, 2004; Lai and Chau, 2007; Fokkema and Naderi, 2013; Martin, 2009; Topal et al., 2012). The language barrier, socioeconomic disadvantages, working conditions and culture are all factors creating those disadvantages. The use of healthcare services abroad appears to be an important problem in terms of health system use, quality and cost.

Turkish immigrants compose the majority of the immigrant population in Europe and show a different pattern of cross-border health care use compared to immigrants of other ethnic origin. Turkish immigrants living in Europe generally maintain their relationships in Turkey through regular visits and owned properties back home. Longer visits to the home countries, basically due to retirement, results in the higher use of national and transnational healthcare services (Razum et al., 2005; Şekercan et al., 2014). In this case the immigrants come into contact with healthcare professionals of both countries and, as a result, their perceptions about healthcare systems and healthcare professionals in both countries are constantly reshaped, affecting their decisions of the country of preference for the use of healthcare services (Lee et al., 2010).

Cross-border health care service use of migrants and their motives concerning their use of health systems have been researched widely (Glinos et al., 2010). The effect of healthcare providers within the range of variables has not received sufficient attention. In this context, the present study discusses perceptions of the immigrants of the healthcare professionals in their host (Denmark, Britain, Germany) and home countries (Turkey). The term “health care professionals” refers only to physicians and nurses in the study as they undertake the main role in terms of diagnosis and treatment.

Health systems in Britain, Denmark and Germany are based on public services. In all those three countries specialized health services are accessed only through referrals by general physicians. Health services are financed under the social security system and individuals pay health insurance contributions (Ozdemir, Ocaktan, Akdur, 2003). Private health services are not widely used. In Turkey, however, there is still no referral obligation as in the case of Denmark, Britain and Germany (Erol, and Özdemir, 2014) which enables people to see the specialist directly on demand. Since the 1990’s public health services were transformed (**Saygın Avşar at al., 2017)** and the share of health services given by the private sector has been gradually increased.

The study mainly focused on the following question: "What is the perception of older Turkish immigrants on healthcare professionals in their host country and in Turkey and how do those perceptions influence their health care use practices?”

2. MATERIALS AND METHOD

The present study uses qualitative methodology to study immigrants' perceptions of physicians and the ways in which their perceptions influence their use of healthcare.

This study is drawn from a project called "First Generation Turkish Migrants in Europe" which was lead by Akdeniz University, Department of Gerontology. Three different field studies were carried out by both of the authors. The first one is carried out at 2011-2012 in Kopenhagen, Denmark, with the collaboration of *Copenhagen University Centre for Healthy Aging* whereby 27 interviews have been carried out. The second fieldwork has been done in London, Britain at 2012-2013 with the collaboration of *Oxford University Institute of Aging,* and the third fieldwork has been carried out in Hildesheim, Germany at 2015 with the collaboration of *Hildesheim University,*

Department of Social Pedagogy. 20 interviews have been carried out in fieldworks both in London and Hildesheim. A total of 67 interviews were completed. Throughout the process of this study, the authors conducted all interviews in person, supported by collaborative Institutions and centers (Arbeiterwohlfahrt – AWO center, Alevi Associations, Muhabbet etc.).

The chronological age of 65 years is defined as old age in most of the developed countries however this limit is under discussion for several developing countries (**Ferreira and Kowal, 2006)**. Certain life conditions such as disasters, poverty, climate change and migration affect health and healthy life expectancy. In the example of Turkish older immigrants, difficult working conditions, poverty and difficulties of integration have created physical and mental health problems resulting in disability and early retirement (Schenk, 2008; Wengler, 2011). Therefore we have decided to lower the age limit of the participants to 50 years and older for this research. Older individuals use health care services in their home and host countries more often than younger individuals and have more contact with health professionals.

Data collection

A semi-structured questionnaire has been used to gather information. A semi-structured questionnaire allows for detailed analysis and creates a flexible interview environment (Glesne, 2012). The content of the interviews was based on the migration stories, daily life, current health conditions, the use of health services in home and host country and their perceptions of health professionals. Data were collected from November 2011 through March 2015. Face to face interviews was 60-120 minute voice recorded. Being over the age of 50 and using health care services both in the home and host country were determined as inclusion criteria.

The sample was chosen purposely to represent different groups as different motives for immigration, different religious views and different educational levels using a snowball technique. The interviews were generally conducted in participants' houses (n=40), at work (n=2), and at community centres (n=25) depending on the preference of the participants. The interviews were generally conducted in Turkish (one interview was conducted in English; two in Kurdish). A significant number of the participants interviewed immigrants in Britain are refugees and immigrants of Kurdish origin. In Denmark and Germany however, the majority of respondents are Turkish worker immigrants. This distinction did not impact the results in the three field sites and for the sake of consistency, the participants are referred to as "Turkish immigrants". The term "Turkish" should be understood as representing citizenship rather than ethnic origin.

Data analysis

All the recorded interviews were audio transcribed. Data analysis began with repeated readings of interview transcripts. Interviews were grouped in three according to their host countries. The purpose was to reveal similarities and differences in perceptions of older immigrants related to the countries they live. All opinions about physicians were noted and recorded using standard manual qualitative techniques of open coding. The main categories were determined using descriptive analysis methods and analysed by separating them into sub-themes. In the second stage, sub-themes were identified. Both researchers analysed the data independently and the final decision about sub-themes was made unanimously. The interviews were named with an abbreviation of the country, sex and age respectively (e.g. Germany, female, 70 : G.f.70).

Strengths and limitations

An environment of trust was created because potential participants were contacted through associations and personal contact and by the virtue of the fact that both researchers are Turkish. The fact that the majority of the respondents were female might have caused a gender bias as the perceptions about health care professionals can differ by gender.

3. RESULTS

Participants

The characteristics of the participants are shown in Table 1. Among the 67 participants, 25 were male and 42 were female. The gender balance was tried to be considered whereas participants from Germany showed an apparent female predominance. The reason for this is that the fieldwork, Hildesheim received primarily female labor immigrants in contrast to other cities. The mean age was 62.6, participants from Germany

being the oldest (64.1). The number of participants still working was 5, the rest were unemployed, on sick leave. 35 participants were either on early retirement or retired. The majority of the respondents (70%) were either illiterate or primary school graduates.

Table 1. Demographic characteristics of the respondents

		Denmark (N=27)	UK (N=20)	Germany (N=20)	Total (N=67)
Age	Mean	61,5	62,3	64,1	62,6
	Minimum	50	50	51	50
	Maximum	83	82	78	83
Gender	Female	15	10	17	42
	Male	12	10	3	25
Education	Illiterate	6	5	5	16
	Primary school	14	12	5	31
	Secondary school	1	2	5	8
	University	6	1	5	12
Retirement	Retired	16	5	14	35
	Nonretired*	11	15	6	32
Chronic Illness	Yes	26	16	17	59
	No	1	4	3	8

Themes about Perceptions

Analysis of the responses revealed frequently used themes. Personal attitudes, diagnosis and treatment and communication were determined as three main themes.

In discussing these experiences with health care professionals, the participants concentrated more on personal relations, culture- language differences, system related problems and the different approach to health in home and host countries. Nurses were mentioned under the category of personal attitudes only. All other categories are focused on physicians.

Personal Attitudes

Experiences with physicians were concentrated on primary care, while in contrast, experiences with nurses mainly focused on hospital care. Respondents mentioned different perceptions about physicians and nurses. In all host countries, the participants frequently came into contact with family practitioners. As a result of this close relationship, their perception about physicians is shaped largely by their experience with their family practitioners. Time spent with the physician, getting the right information about the disease or illness also play important roles in their perceptions. Respondents reveal that the *interest* of the physicians is mostly felt by their "touching" and behaving in a humane way:

> "My blood pressure was about 240, my physician walked with me to the taxi. He (physician) calls my home at 8 o'clock in the morning, and asks "how are you today, are you better than yesterday?" I really cannot receive such care and interest and humane behaviour in Turkey" UK.m.65

> "In my country, Turkey, does the physician stand up and shake hands

*onsickleave, social security aids, early retirement

with a villager when s/he goes to the hospital? Does the physician walk him/her out? No, they do not, they do not even stand up from their desks. I want and look for such care and interest " G.f.63

During the treatment process in hospitals, patients have the closest contact with the nurses and aides. The participants believe that in all three host countries healthcare professionals in hospitals are *caring*. It was stated that, at their first hospital experiences in the countries they came to as immigrants, the participants were surprised at the close and caring behavior of nurses and mentioned that they were pleased with that. Many participants expressed that healthcare professionals in host counties are "extremely" compassionate and caring:

> "The nurses here are like a man's mum. They love talk, an approach like a man's mum. But those there (Turkey) are coming into the room rude, screaming and shouting. ..... " DK.f.60

In contrast to nurses in the host countries, the nurses in Turkey provide mainly medical treatment and the provision of personal care is expected from the patients' relatives. It has been a matter of complaint that nurses in Turkey do not take care of many things related to patient care, that patient relatives are made to do those things and that nurses are not there whenever they are needed. For example:

> "Here it is impossible for a nurse to treat patients rudely, and give orders. In a case where a cancer patient's temperature has to be taken in Turkey, the nurse calls the patient's name, shouts out loud and asks the relative to take the patient's temperature and report it to the nurse. What is the role of the nurse there… "UK.m.58

The participants from all research countries commonly voiced the observation that, due to financial reductions in health expenditure, a drop in the number of health care staff has been observed resulting in a diminished level of care over time since they first came to the host country. A Danish participant explained:

> " People were more valuable around the 1980s but nowadays it is difficult to see a nurse in hospitals. Older people are left alone; they send them home before even treating them..." DK.f.57

Diagnosis and Treatment

Accurate diagnosis is another important category in the participants' perception about physicians. The immigrants in all three countries think that the physicians in Turkey are better when it comes to accurate diagnosis. A distinction between the general practitioner (GP) or specialists hasn't been mentioned. The participants commonly tell stories of "late diagnosis" or "incorrect diagnosis" in their host countries.

> "Here he went to the hospital for over a year, and they could not diagnose the illness. It is not like that in Turkey. That is the good side, physicians diagnose the illness very fast in Turkey... " G.f.70

Such issues in terms of the effectiveness of physicians are related to the fact that the referral systems work slowly in the host countries and the differences in the medical training systems. Participants relate the fact that Turkish physicians are better in terms of diagnosis to the fact that medical training in Turkey provides more practice and that the Turkish physicians encounter a greater number of illnesses since the number of patients per physician in Turkey is higher than in the host countries.

All research countries have a strong referral system in health provided by social welfare state. In such systems, general practitioners serve as a barrier for advanced examination and referral to specialized physicians (Lee et al., 2010). Individuals await their turn for months for *appointments and referral* for advanced examination by a specialized physician.

> "…I had cataracts, received a letter from the hospital, I checked and guess when? Look, I applied in the fifth month (2011), and the appointment is on the 29th of the tenth month of 2012. I will not be able to see for one and a half years, and then the physician will make me see again!" DK.m.70

Problems related to referral systems are attributed to physicians and that creates negative perceptions about them. Although there is the general practice

system in primary care in Turkey, patients can still apply directly to hospitals. The participants frequently use paid private hospitals in Turkey. There, it is possible to have early contact with the desired physician and to have detailed examinations. This might increase the chance of an early diagnosis of the illness.

> "... but it is different in Turkey. You receive treatment on the same day or the next day in Turkey. But here, you wait for days, months, and people are almost left to die" UK.f.53

The participants generally consider non-referral or late referral to hospitals by family practitioners in Denmark, Britain and Germany as something negative. The easy access to specialized physicians in Turkey and requests by physicians for a detailed examination are considered positive factors in terms of early diagnosis.

Trust between the patient and the physician is highly important particularly at the stage of diagnosis and treatment (Scheppers et al., 2006). The participants who generally use private hospitals in Turkey complained about unnecessary investigations and treatment attempts by private hospitals for profit, and for that reason, some participants stated that they refrain from receiving healthcare services in Turkey.

> "If truth be told, I have no trust in Turkish physicians. It is all about money in Turkey, how can you trust such people? All they think is their profit" DK.m.62

In Turkey, the participants prefer to visit "familiar" physicians or they choose to seek the recommendations of their relatives or friends and select their physicians according to such recommendations. In this context, the participants refer to an "acquaintance" factor in respect to the trust of healthcare professionals in Turkey. According to the participants, having a friend or someone familiar at the hospital is something that facilitates the administration process and accelerates the appointments for investigations. This indicates that the participants preserve primary relationships with respect to medical issues. Participants have no such behavior in their host countries. However, "incidental friends" (e.g. a Turkish healthcare professional in the hospital they visit) seem to be important particularly at hospitals where there is a language barrier. This statement of a participant shows the wish to trust someone who is not even familiar, but who feels familiar because of the similar ethnic origin and the common language at hospitals which are considered to be "unfamiliar environments".

> "My uncle's son came to visit me at the hospital. He said that there is a Turkish nurse at this hospital. That gave me the world..." UK.f.65

Communication

Communication is an important issue in terms of the participants' thoughts and perceptions about healthcare professionals. There are two factors that stand out in respect to the communication between the patient and healthcare professional. The first factor is the language barrier that participants experience in host countries as they are immigrants. Many studies show that the language barrier is a significant factor in the use of healthcare services by immigrants (Lee et al., 2010; Papadopoulos, 2007; Martin, 2009; Nazroo et al., 2008; Campbell, 2002). In addition to the language barrier, social barriers such as being from a different culture, ethnic exclusion or status also have an impact on the perception about healthcare professionals with respect to the communication.

Most of the participants stated that they spoke the *language* of the host country only well enough to cope in their daily lives. While 11participants spoke the language of the host country fluent, there were participants who could not understand or speak the host language at all. Most of the participants suffer a language barrier intensely at hospitals. Hospitals require communication with more people and more detailed examinations are performed, therefore participants reported needing support mainly from their children in regard to language. In case the adult children cannot allocate time to their parents, the participants communicate to the best of their ability. Problems arising through language problems, however, were not found to affect the level of satisfaction with the physician, because they were not seen as the physician's responsibility.

> "I am old. When I apply to a General Practitioner, when he does not understand me he says,'mummy sorry'". What can I do when the physician says 'Sorry', we do our best to express ourselves. It is not the fault of the physician ".UK.f.65

Even though the language is not a barrier between Turkish health providers and Turkish immigrants, the immigrants experience communication problems with Turkish health providers. They have mentioned the Turkish health providers hierarchical behaviour as a reason for this. This attitude has been felt especially at health providers in state hospitals. An example ofe this has been mentioned by a respondent from Germany such as:

> " The doctors and nurses in Turkey don't even take you seriously, you can't even get an answer for your questions ." G.f.70

When the participants are asked if they particularly want to see a Turkish physician in the host country, they stated that they have no such special preference, but that they are pleased when, they incidentally, see a Turkish physician.

The participants pointed out that they did not face any negative behavior from healthcare professionals for being Turkish and Muslim. All participants stated their appreciation that they were informed that the meals did not include pork and that the hospital staff members were supportive in respect of religion and culture. However, *inter-cultural differences* between patients and healthcare professionals may affect the approach to diseases and treatments. Many participants think that Turkish people have a traditional health approach compared to western medical approach and are more emotional about illness, and this has a negative effect on treatment perceptions. A participant stated that she changed many psychologists due to cultural differences.

> "Psychologists need to know our culture well when they make decisions. For example, they (the Danish) just dismiss. If something is upsetting you, just leave it. It is so easy to say this… They can do this but we can never do it… They can't make a correct diagnosis as they don't understand us."Dk.f.50

Disease perceptions may also vary from one culture to another. Some participants stated that certain illnesses such as a slipped disk and rheumatism, which are regarded by Turkish immigrants as illnesses, were disregarded by the healthcare professionals in the host country. As a result of this distinction, they cannot receive the treatment they want. In such cases, participants try to see a physician or seek alternative treatment methods in Turkey.

4. DISCUSSION

Cross-border health care use turned out to be more common in recent years, which has also resulted in more attention to the current literature (Horton and Cole, 2011; Lee at al., 2010). A relation is created between health care provider and user which shapes the perceptions. This research aims to reveal the perceptions of Turkish immigrant health care user of their health care providers and aims to represent the way how their perceptions affect health care use. A literature search has shown that this research can be accepted as the first qualitative research about the perceptions of Turkish immigrants of their health care provider in their home and host countries.

The respondents use healthcare services both in their home and host countries. They consciously choose the services in Turkey with which they were not satisfied or which they think are more expensive in their host countries as reported in several studies on cross-border health for immigrants from different countries (Main 2014, Lokdam, 2016). In his study carried out in Holland Şekercan el al. (2014) found dissatisfaction with care in the residence country and seeking second opinions as the main motivations for cross-border health care use.

Several studies reveal language to be an important communication barrier for immigrants creating disadvantages in health access and patient satisfaction (Scheppers et al., 2006; Ferraro and Shippee, 2009; Poortinga, 2006; Davies et al., 2009). In our research, however, language has not been found to be a primary factor affecting the immigrants' perception of health care providers and health service preferences. This can be seen as a striking result of our study with respect to language. In terms of communication with healthcare professionals in Turkey, participants reported a different problem, however. According to them, in contrast to their host country, there is a sharp hierarchy between the healthcare professionals (physician-nurse-caregiver) and the patient in Turkey which negatively affects the communication between healthcare professionals and patients. Most of the participants complain that it is hard to communicate with the physicians in Turkey and that physicians do not share the diagnosis and treatment methods and options in

detail with the patients. Participants also think that the nurses and caregivers "look down on" the patients and their relatives and do not establish "humane" communication, which is not the case in their host countries. A humane relationship with health care providers in host countries neutralizes the language advantage of communication with Turkish health care providers.

According to a study carried out by Yıldız and Erdoğmuş (2004) in Turkey about satisfaction from healthcare provider reveals that communication with doctors, respect from health care providers, sharing of information and attitudes of nurses were the main factors affecting satisfaction.

Martin (2009) found that "care and interest" plays a significant role in immigrants' perception of the "good (ideal)" physician which is similar to our research findings. The respondents revealed that they were satisfied with the care and interest shown by the health care providers in their host countries. Familiarity with health systems and culture are found to be important factors in the research of immigrants healthcare use (Şekercan at al., 2014). On the contrary, our respondents indicated that the Turkish health system and health professionals were unfamiliar to them and a striking result of this study states that they were trying to search for an acquaintance in health professionals before receiving health care.

A feeling of trust towards the healthcare system among immigrants may turn into distrust in cases of dissatisfaction with the healthcare services. Incorrect diagnosis and treatment have been found to have a significant effect on trust (Perloff et al., 2006; Migge and Gilmartin, 2011; Van de Ven, 2014). Another striking result is that trust and distrust in this study were expressed in two different ways: physicians in the host countries were distrusted in terms of accurate and prompt diagnosis as referenced above, whereas the physicians in Turkey were found to be distrusted in terms of financial abuse of their patients.

5. CONCLUSION

It may be asserted that generally, immigrants' perception about healthcare professionals are two-dimensional. While Turkish physicians are considered to be more competent in terms of diagnosis and treatment, the healthcare professionals of the host country are found to be more humane and reliable in terms of interest and care-giving. The participants who were generally satisfied with the primary care services given in all of the host countries have complaints about advanced investigations and referral to specialized physicians. In order to bypass this situation, they self-referred to healthcare providers in Turkey when they believed their medical condition required advanced examinations. The migration incentive, literacy level and country of residence have been found not to have a significant role in their perception and practices for cross-border health care. The outcomes of this study indicate that immigrants' perceptions of healthcare professionals are more affected at the practical level, that is, from healthcare professional-patient experience and these perceptions are shaped pragmatically.

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