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OCCUPATIONAL RISKS IN HEALTH CARE WORKERS AND EMPLOYEE SAFETY CONCEPT

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Abstract

From the perspective of health sector, occupational risks encountered by employees and employee safety concepts are considered to be highly topical matters. This is mainly because health sector involves greater risks compared to many other sectors. Major occupational risk factors are classified as biological, physical, chemical, ergonomic and psycho-social. These risk factors recently have led to an increase in occupational diseases, work accidents, and health problems. As its direct consequence, planned activities have increased in number to prevent diseases and improve the health of employees. These activities originated from the ideas to determine occupational risks in health sector, take

necessary precautions, and adopt an effective risk management. In this way, it is believed that the employees would be kept away from work accidents or losing health or being injured due to an occupational disease; that employee safety would be ensured; and that health service would be presented at a higher level with more quality and safety. Protecting employees from occupational risks and giving importance to employee safety concept will not only enable prevention of work accidents and occupational diseases, but also will ensure a peaceful and comfortable working environment.

Based on these, this article will explain occupational risks in health sector and their potential effects, include some examples of the most frequent occupational risks in Turkish health sector, and refer to employee safety concept and some precautions to ensure it.

Introduction

The concepts of occupational risks and employee safety have gained an increasing significance as a result of various factors including the increasingly more complex structure of health services, the developments in health technologies, emergence of different disease groups, presence of risk factors that cause diseases by the very nature of the sector etc. [1]. The main reason for this is that health workers are under greater risks compared to other employees in other sectors [2]. While the health service aims to protect, cure, and avoid damages, it is also possible that the health of the employees may be adversely affected by the possible risks that may appear during this serving process. This results in adopting the concept of risk management, improving patient care quality while at the same time keeping employee safety at the highest level, increasing the awareness of the employees for occupational risks and taking the necessary precautions [1]. Because the employees in health sector do not only have the mission to treat in the presentation process of health service, but also responsible to protect and improve the health of society in the long run. This is only possible when the health of employees is protected, necessary precautions are taken against occupational risks, and a safe working environment is provided [3]. From this perspective, it becomes obvious that a safe working environment has uttermost importance for a safe and qualified presentation of health service, as well as to increase the productivity and performance of the employees [2].

A recent increase in the prevalence of particularly occupational diseases, occupational accidents and health problems connected to occupation among the health care workers has made hospital administrators interested in the employee safety and health and have more sensitive approaches to improve employee health and to prevent diseases [4]. The main reason for this is the decrease in the life quality of workers with higher occupational risks and the big damage of the labour loss because of occupational diseases and occupational accidents for not only the hospitals, but also national economy [5]. Another point of view states that it is only possible for the employees to work efficiently and to be satisfied when they work in a safe working atmosphere and when they are away from occupational risks. Besides, the interest in this subject has increased due to the fact that paying attention to employee health and eliminating occupational risks are considered as complementary to competitive atmosphere when striving to increase efficacy and productivity [6].

Accordingly, first of all, this article will address to occupational risks in health sector, which is a highly topical matter for modern world, and their possible effects on the employees. Then it will proceed to mention the most frequent occupational risks observed in health sector of Turkey within the context of literature review

conducted. This study is thought to contribute into other studies in the field and to be helpful for international comparisons.

Occupational Risks in Health Sector and their Potential Effects

It is observed that the employees encounter many risks such as occupational accidents and occupational diseases during their work life. Although it is stated that life itself includes some risks by its very nature, what is important at this stage is to protect the health of both the employees and society and to control all the risks encountered. It is thought that it is only possible in this way to avoid work accidents and occupational diseases. The reasons for occupational accidents are classified as human-related reasons such as personal characteristics leading to dangerous behaviors, age, seniority, family issues, sleeplessness, exhaustion, imprudence, carelessness etc. and physical and mechanical atmosphere driven reasons [7]. Apart from these reasons, it is reported that there are some other factors which increase the risks for the employees in health sector to have work accidents. These factors may be listed as professional working years, working duration, being informed about work accidents, having duty shifts, the department in which they work, the level of satisfaction with the work, using a device working against health (e.g. x-ray device) or a substance (e.g. anaesthetic substance), and, finally, the rate of accident reports (if it is less, then ignored) [8].

Occupational disease is defined as the deterioration of health of an employee because of the nature of an occupation and working conditions when conducting a job [5]. From this perspective, it is seen that employees at health sector are exposed to some occupational risks and consequently come down with occupational diseases [9]. The occupational risks which adversely affect the health of health workers and increase their incapacity is categorized as biological, ergonomic, physical, chemical, and psycho-social factors [2, 8, 10, 11].

Biological risks include stab wound [12], infections, bacteria, viruses, parasites, and diseases such as Hepatitis B or tuberculosis which appear in cases of contact with contagious body fluids [13]. In this respect, hospitals are especially seen as an environment which is rich in inflectional factors and it is observed that humid air at hospitals boosts bacteria reproduction, resulting in higher infection risks for the employees when presenting the health service. If the required and necessary precautions are not taken, it becomes inevitable that the infection transmits from patient to patient, patient to health staff, or from health staff to patient [7]. In this sense, when the risk areas for infections in health organisations and potentially risky activities are to be listed, what comes to mind first may be operation rooms, emergency and ambulance services, dialysis units, laboratories, intensive care units, departments of pathology, anatomy and forensics, clinical treatments, taking blood, bodily fluids and other clinical samples, surgical operations, treating injuries, using sharp and pointed devices or equipment [14].

Chemical Risks emerge as a result of exposure to chemicals such as formaldehyde or ethylene dioxide [12]. It is stated that such chemicals and medicines harm the body system or poison it [13]. Health staff may frequently be exposed to such chemical risks as a result of their occupational activities and these chemicals may be taken in the body through various ways such as skin, respiratory system, mouth, eyes, and being injected. Consequently, health employees may display some acute and chronical effects [7]. In particular, health employees working in laboratories and anesthesia activities and in chemotherapy departments are under risk and their health status are adversely affected [14]. What increases the risk of being exposed to chemical dangers are operation rooms in which numerous chemical agents are used and disinfectants used to clean hospital with sanitary purposes [7]. The staff working at radiology, radiation oncology, and nuclear medicine departments are also under the risk of radiation particularly as a result of occupational rays

being exposed. Being exposed to long-term influences of lower dose ionizing radiation adversely affects immune system [15].

Psycho-social risks include heavy working conditions and burn-out syndrome [12] and they cause stress related to job or working atmosphere, emotional strain in employees resulting from shift system and heavy work load, and interpersonal problems [13]. Psycho-social risks increase due to some factors as role ambiguity and conflicts experienced by health staff while conducting their work, poor physical conditions, necessity to constantly contact with patients, changes in medical technologies and adaptation problems, insufficient support from colleagues and top management, being responsible for the health and well-being of patients, and lack of proper dietary and relaxation opportunities [7]. In addition, there are some additional factors such as having duty shifts, working at night, working upon call which results in the impairment of health status of workers and problems with employee safety [2]. Depending on the level of stress, people may have some diseases such as migraine, hypertension, and coronary arterial diseases, or may have behavioural and psychological problems [7], and also there may have an increase in the instances of chronic insomnia, exhaustion, motor vehicle accidents, impairments in memory and concentration, family problems, malpractice, affective disorders, and cancer [2]. As a result, it results in some unfavourable consequences such as insufficient motivation, decrease in the efficiency and performance, withdrawal from work, increase in drug addiction etc. [7].

Ergonomic risks cover the injuries and malformations that may appear during such activities as carrying the patient and lifting the patient [12]. Ergonomics aims to improve the harmony between an individual and his environment and to maximize production. In this respect, it creates opportunities for employees to work in safety, decreases the events resulting in injuries, increases quality and production, and positively affects the morale and motivation of the employees. However, not regulating the working environment in accordance with ergonomic rules and ignoring air conditioning and lighting may lead to some unfavourable outcomes such as an increase in work accidents and musculoskeletal injuries, or a decrease in employee success and efficiency [7]. In view of developed countries, backaches which are stated as a significant musculoskeletal injury come first among the factors which, in particular, decrease production and lead to labour loss. The main reasons to increase the pain are listed as staying often standing up depending on the task and working conditions, and lifting or positioning patients [15]. Particularly physicians, nurses, dentists, physiotherapists, and nursemaids have complaints of backache [2].

Physical risks arise as a result of such practices as radiation or laser which may cause tissue trauma at work [13]. Being exposed to radioactive substances may harm cells with regard to the dose being exposed; it may lead to cataract, eye impairments, mutation and chromosomal disorders; tissue losses may happen; the skin may get drier and darker; capillaries on the skin may dilate; and painful injuries and skin cancers may occur as a result. Besides, it may result in some complaints such as an increase in blood and bone disorders or lung cancers, [7], headache, blurred vision, experiencing stinging, itchiness and dilution in eye, palpitation, hearing loss, feeling exhaustion and fatigue etc. [2]. Health care workers are subjected to violence is also a subtitle of physical risks [12]. Violence may appear in forms of physical and verbal attack or sexual abuse and negatively affect the health and safety of employees. Violence seen in health organisations is usually committed by patients or their relatives or anyone else and poses a great risk for health staff. When compared with other sectors, the employees in health staff are found to face more violence. When a health staff encounters with violence, the quality of care decreases, the morale and motivation of the staff declines, quitting job or absenteeism increase, and the staff may

feel some negative things such as stress, insomnia, fear, weakness etc. and may be physically injured [7], the level of anxiety and insecurity among staff increases [2]. As the staffs of emergency service in particular is considered as the group which suffers violence most, it becomes inevitable for them to work in an unpeaceful working environment and to feel insecure. Among the health staff professions, nurses are the first to face most violence and practician and expert physicians follows them [15].

As can be seen from the statements, many health problems caused by the work itself, working process and work accidents deeply affect the health of health staff and health sector is considered as one of the sectors which has such problems the most. Nevertheless, the likelihood of the health staff to encounter with such health problems depends on his or her work itself, department and profession [7, 151]. When we have a look at what are the most commonly seen occupational risks and job accidents, it is seen that the reasons for such problems are listed as the injuries or incisions resulting from any kind of pointed sharp-stinging equipment and broken tubes used for health services; health problems experienced when exposed to explosive and flammable chemicals; non-protective radiation sources, insufficient personal security precautions, musculoskeletal system injuries resulting from lifting and carrying patients unconsciously [14].

These risk factors and occupational diseases encountered by health staff not only have an influence on the health and performance of the staff, but also increase the job accidents and threaten the safety of patients [2]. Moreover, as a result of their occupational activities, health staff may both get injured frequently and may display indifferent approaches towards diseases in due course. Therefore, it is highly important to get health staff to have necessary check-ups in certain intervals and to have regular inspections, to immune them, to analyse their working environment, to inquire factors impairing their health, to take protective precautions, and to increase the awareness of the staff about these matters [7]. Apart from that, it is thought that it may yield helpful outcomes to conduct some activities to change the thought system of the society and top management leading to the perception that health staff should always self-sacrifice or they should think that they have no health problems and they will never have any in the future [2].

The Examples of the Mostly Seen Occupational Risks and Job Accidents in Turkish Health Sector

Based on the idea that all the employees have the right to work in a safe and secure environment [16,17], it is seen that there are some studies conducted with the aim of creating a secure working environment in health sector, to eliminate the reasons for job accidents and occupational diseases by identifying the reasons for them, and the study will include some results of various researches conducted with the aim of decreasing human and financial losses and increasing the efficiency and performance of the staff [16]. This part will include the results of various studies conducted in order to identify what are the most frequently seen occupational risks and work accidents in Turkish health sector. The results of these studies are thought to be used as a resource for and contribute into international comparisons.

One of the studies conducted with this aim in mind is a study done in order to evaluate work accidents encountered by the health staff employed in a state hospital in Isparta, Turkey. According to the results of the study, it is observed that the employees in the hospital are exposed to blood and body fluids, are injured by sharp and pointed objects (injections, ampule breaks, injury by a surgical instrument), are exposed to violence (verbal attack, physical violence, sexual abuse), have to contact with chemical staff and medicine, experience allergic reactions (to latex, food, medicine, urticarial or allergic asthma), have musculoskeletal injuries and poisoning (ingestive and respiratory) [18].

According to another study which aims to evaluate the activities conducted in order to create a safe working environment and ensure job safety for the physicians, nurses, and other health professionals employed at various state hospitals in Trabzon city centre and its provinces in Turkey, it is stated that some actions are taken in order to ensure job security in state hospitals on grounds of legislative regulations. However, other findings of the study indicate some unfavourable conditions such as problems with the occupational diseases suffered by the employees, the complaints about these problems, insufficient support from the management; though not very often, the instances of work accidents and occupational diseases; and more complaints from especially female nurses about the accidents and poisoning [6].

One more study conducted with the aim of identifying what are the occupational risks, health problems, and protective behaviours of the nurses employed in nephrology services and dialysis units in Erzurum reported that nurses have the most inflectional risks among all the occupational risks, and besides there are others other risks such as experiencing stress and psychological trauma, being exposed to verbal and physical violence, having problems resulting from allergic agents and noise. During their working hours nurses are exposed to some work accidents in the forms of contact with blood and body fluids through skin, eyes, and open wound and injury by sharp and pointed objects. Furthermore, when the most frequently observed health problem of the nurses is analysed, it is seen that they have to suffer from lower back pains, exhaustion, fatigue, arthralgia, improper sleep habits, headache, neck ache, and backache, and varicosity [19].

When the literature is reviewed, another study on the nurses employed in a university hospital in İzmir, Turkey by Ceylan [8] aimed to identify the number of accidents and the factors leading to these accidents experienced by the nurses in a month and in 6 months. According to the results of the study, 47 % of the nurses had a work accident during the last month while 60 % of them had a work accident during the last 6 months. These accidents of the nurses are listed as injuries through a sharp object, exposure to blood and body fluids, tissue trauma resulting from sliding and falling, and exposure to violence.

The results of another study on the health problems and occupational risks of the nurses employed in a university hospital in Erzurum show that the nurses mostly suffer from sleep problems and exhaustion and fatigue; and they have some health problems such as arthralgia, leg, back, and lower back pains, varicosity, headache and stress. The nurses also stated that their family life was adversely affected from their working conditions, they had sleep and dietary problems, and they had such problems as alienation to work and isolation from social life [3].

According to the results of another study on identifying occupational risks and individual and organisational precautions to eliminate these risks faced by the nurses employed in a university hospital located in Ankara in their own departments as reported by themselves, the nurses stated that the significant factors which adversely affect their health in their working environment are infections, contagious diseases, stress and fatigue resulting from overworking and working for long hours. Besides, it becomes obvious that the employee health is adversely affected by some other factors such as exposure to anaesthetic gases and radiation, chemotherapy, noise and insufficient ventilation [9].

Some important findings are recorded by a study conducted to identify the experiences of the health staff employed in health centers and hospitals (both state and university hospitals) in Mersin about injuries through sharp and pointed objects and their precautions to decrease occupational risks. According to this study, approximately 80 % of the health staff had at least one injury through a sharp and pointed object so far in their

working life. The main reason for this is injury through a blood contaminated object. Other practices which result in injuries through sharp and pointed objects in employees are listed as injury by a clean equipment before treatment, injury during treatment, injury when closing the cap of injectors, when opening the cap of injectors, and when throwing injectors to waste bins, accidentally get injured when a friend is holding the injector, getting injured when helping to a colleague, or getting injured when cleaning materials [20].

Another study on the subject was conducted to identify the perspectives of the students of educational organisations in İzmir to be appointed to 112 emergency health service ambulances (emergency medical technicians and paramedics programs) towards the occupational risks they will face during work. The study concluded that the students had lower levels of knowledge scores on the risks which are classified as ergonomic, biological, environmental, and psychological risks. On the other hand, when the results of other studies in literature on the same subject are analysed, it is seen that the ambulance staff face ergonomics-related risks mostly and they most commonly have musculoskeletal system diseases and sprains, traumatism, and pain in the upper back [21].

One more study which was conducted to identify the occupational risks and the level of awareness of the students at Akşehir Health Vocational school (second, third and fourth grade nursery students) reported that the students did not have the desired level of awareness about, occupational risks, the ways how inflectional diseases spread, and the precautions to get protected from inflectional diseases. Other findings of the study show that around 43% of the students did not have Hepatitis B vaccination, 23% of them had insufficient vaccination doses, and 32% of them experienced an injury due to a sharp and pointed object (while they are preparing medicine for injector, while using lancet and bistoury) [22].

As suggested by the findings of studies reported in the literature, the health staff employed in Turkey faces extremely high levels of occupational risks and work accidents. Because of these high risks and accidents, most of the employees have worse health conditions, display poor performance, and experience some unfavourable situations such as alienation to work, dissatisfaction, disability, and quitting the job etc. As a natural consequence of all these, the quality of health service decreases, the expectations of the society are not met, and all these unfavourable conditions get worse day by day and become a problematic subject which needs to be solved. All these developments caused the concept of job security to gain more importance and to take some precautions to ensure the security of employees in health sector, as it does in all the other sectors.

The Concept of Employee Safety and Precautions

In most general terms, working is defined as performing the production of goods and service using productive factors at a certain working environment. There is a bilateral relation between the employee health and working environment. Therefore, the health condition of an employee affects the life and performance of the employee and work life also has a significant influence on the health of an employee [15]. Individuals work for many reasons including to continue their lives, to have a career or to make a good service for the society etc. From this point of view, it is an incontestable right of an individual to wish a safe working atmosphere. Creating a safe working environment is physically, socially, psychologically and ergonomically highly important to increase the productivity and performance of the workers, as it causes to build organisational attachment and confidence in the organisation [7]. In order to protect health and to provide a healthy and safe working environment for employees, the factors threatening and impairing the health of employees need to be identified in the first place and the precautions to eliminate these risks need to be taken [23]. This has caused organisations to

undertake more and increasingly more activities related to employee safety [10].

The main aim of the studies on the health and safety of the employees is to protect employees from potential conditions which may hurt health and from potential dangers that arise when the work is being performed, to make regulations to maintain the health of employees, and to create a safer working environment [8]. To work in a safe and healthy environment has a great importance not only to maintain the health of an employee, but also to increase the life quality. In this way, it will be possible for an employee to prevent job related health problems, to lighten the burden of existing diseases, and to increase the efficiency and productivity of the employee [10].

Within the context of declarations from various organisations such as American Hospital Association (AHA), International Labour Organisation (ILO), National Institute for Occupational Safety and Health (NIOSH) and unions acting in health sector, it is stated that the health staff also deserves the right to be healthy and to work in a healthy and safe hospital environment, as do the employees of the other sectors [7].

The first step to give the due attention to the health of health employees and to show the necessity to make some regulations on this subject was taken when in 1956 German government took some precautions to prevent work accidents and had the employees have pre-job health examinations [18]. This development was followed by the joint declaration issued by American Medical Association (AMA) and American Hospital Association (AHA) in United States of America (USA) in 1958 [15,16]. Following this development, the works of National Institute for Occupational Safety and Health (NIOSH) conducted between 1974 and 1976 defined some criteria concerning the occupational health in hospitals. Accordingly, a healthy and safe hospital environment is defined as a place where there is not any kind of physical, chemical, biological and ergonomic danger and risk which results from the work conducted and which are harmful for health and where there is no work accidents and occupational diseases resulting from these risks and dangers. NIOSH and occupational Safety and Health Administration (OSHA) stressed that it is necessary to primarily identify the potential risks and dangers at work place and take some precautions to eliminate these risks and dangers in order to create such an atmosphere. In this way, the employees will be able to work in a safe and healthy environment, and the working conditions and relations will be regulated in favour of health staff [15].

In the early 1990s, Accreditation Commission of Health Organisations in USA stated the necessity of a health and safety committee in hospitals. NIOSH and OSHA figured the main purpose of this committee as elimination of all kinds of physical, chemical, psychological, biological and ergonomic risks and dangers that are harmful to health and creating a healthy and safe hospital atmosphere in which no occupational diseases or accidents occur [10]. In this respect, the committee is regarded as a primary care health service which provides outpatient services and aims to protect the health of health staff, to prevent diseases, and to improve health [2,18]. An effective hospital job health program is expected to cover pre-job health examination which includes a full medical anamnesis and periodical examinations, to provide health and safety trainings, to provide immunization, to give importance to such topics as health guidance and environmental control, to adopt a health and security recording system, and to include a planning to enable a coordination between all the departments of the hospital [2].

The services of this committee can be categorized under three subtitles: services for health care workers, services for hospital atmosphere and production process, and other services [10, 18].

The services for Health Care Workers are:

- creation of programs to improve health,

- informing the health care workers about occupational risks and dangers,
- provision of health training on health and safety matters,
- provision of consultancy service on health,
- monitoring the adaptation of the employees to the established health and safety standards,
- to have periodical examinations,
- immunization (e.g. Hepatitis B),
- paying attention to health care workers to have a healthy and balanced diet,
- increasing the usage of personal protective by health care workers,
- keeping the necessary records of occupational diseases and accidents and informing whom it may concern (health care worker, unions, administration etc.),
- caring and treating the health care workers when injured or sick.

Services for Hospital Atmosphere and Production Process:

- Involving the committee in constructing the hospital,
- drawing a workflow diagram for each occupational group and describing the production process,
- identifying and monitoring the risks for health and safety,
- monitoring the efficiency of the regulations on occupational risks and dangers.

Other Services are listed as

- Establishing a procedure and policy for health and safety in hospital,
- developing a recording system for health and safety,
- coordinating with hospital units,
- making preparatory plans for emergency cases,
- getting the support of the hospital management [10].

Following these developments, by 2007, World Health Assembly attempted to reinforce the health systems and to create protective programs special to health staff in order to protect the health of health staff [15]. International Occupational Health Commission (IOHC) suggested to evaluate regulations on the health of health care workers through labour health approach [7, 10].

At the end of a meeting held jointly by World Health Organisation (WHO) and ILO in 2010, to protect the health of health staff was determined to be a prioritized subject. In this respect, a guidance was prepared especially for services to get protected from, to treat and care some diseases such as HIV and tuberculosis [15]. Furthermore, ILO developed some national and international standards about how to record work accidents and occupational diseases and about how to evaluate them [18].

As for Turkey, the necessity to establish an employee safety committee is stated in the Guidelines for Hospital Service Quality Standards issued by the Directorate of Performance and Quality Improvement and Department of the Ministry of Health in 2011. In this way, it is expressed that it would be possible to protect the health of the employees and to enable them to work in a safe atmosphere [24]. The Code of Providing the Safety of Patients and Employees, which was issued by the Ministry of Health in the same year, included similar regulations. Accordingly, the Article 7 of the Code specified the regulations on preparing an employee safety program, conducting health check-ups for the employees, making necessary amendments for the disabled employees, enabling the employees to personally take protective precautions, and taking the necessary precautions to avoid physical harassments to employees.

Article 8 of the Code includes regulations on the control and prevention of infections, laboratory and radiation safety, conducting coloured coding practice, performing a safe reporting system, training on patient and employee safety, and establishing patient and employee safety committees. Besides, in order to protect the health of the employees, to prevent occupational diseases and accidents, to conduct planning, researching, and auditing services, and to take necessary precautions in collaboration, The Department of Patient-Employee Rights and Safety was established under Turkish State Hospitals Authority [7].

In the Article 19 of the Code of Job Health and Security Number 6331 enacted after being published on the Official Gazette issue number 28339 on 30 June 2012, it is stated that "The employee is obliged not to endanger the health and safety of other staff who are affected by the employee, his work or his behaviour, in line with the training he receives on job health and safety and the instructions of the employer concerning these" [25, 26]. When this article is analysed, health staff should

- Properly and correctly use all kinds of machine, device, equipment, tools, hazardous materials, carrying equipment and all other kinds of production tools and should not use them arbitrarily,
- Properly use and protect the personal protective gears provided for them,
- Inform the employer or employee representative if they ever see any failure of protective precautions or if they ever under any kind of danger in terms of security concerning the machines, devices, equipment, tools, or buildings they use,
- Cooperate with the employer or employee representative in order to make up any sort of deficiencies observed in their own working place,
- Cooperate with the employer or employee representative in order to ensure job health and safety in their own working place. Apart from these, other obligations of the health staff include to protect their own rights which are assured by legal regulations and which are natural consequences of being a human and an employee and to act properly in accordance with the security culture approach. When the "Regulation on the Usage of Personal Protective Equipment in Work Places" issued by the Ministry of Labour and Social Security is analysed, using personal protective gears for the work performed by the health staff is not only required by the legislation, but also it is important for the employee to protect his own health [25].

The precautions to be taken related to the occupational risks as frequently encountered in health sector are listed as follows: Sterilization should be emphasized to eliminate biological risks; sanitation standards should be identified, pointed tools should be placed in protective containers; hands should be washed after contacting with patients; gloves, masks, aprons, eyewear should be used; and periodic audits should be performed for health units [7]. The number of units at hospitals to wash hands should be increased, more attention should be given to control and properly dispose waste materials [2, 14], hygienically working conditions should be created and in-service trainings should be organized on these issues [2]. When we think that health staff is intensely exposed to infection, it is necessary for them to act according to three basic rules listed as not to stay close to the source more than necessary, to work from furthest possible distance, and to put a blocking shield between himself and the source [27]. When combating with chemical risks, high amounts of disinfectants should be avoided and ventilation should be done with care [7]. Through effective ventilation, some problems such as fatigue, headache, nausea which results from insufficient ventilation may be solved [23]. The precautions to eliminate ergonomic risks can be summarized as creating a suitable working atmosphere, establishing awareness for muscle-skeleton injuries among employees, or preferring to use ergonomic furniture [7]. It is thought that if the

health employee is given enough and proper relaxation time, it will contribute into the decrease of this risk [28]. For psycho-social risks, what would help is to use effective communication techniques, to encourage team mentality, to organize social activities and entertainments to decrease monotony, and to reinforce trust and solidarity feelings [7]. Apart from this, it is thought that to teach employees how to cope with stress is also an effective method [23]. It is also stated that to prevent violence towards employees (white code practice) to act in accordance with the Radiation Safety Code, to extend the use of appropriate safety eyeglasses and panels may help to eliminate the physical risks [7]. Among the other precautions to be taken are that monitoring the employees who are exposed to radiation by devices measuring radiation doses, to wear special outfits with respiratory devices and wearing masks in cases with internal radiation dangers (based on respiration, ingestion, and the scratches on the skin) [27].

It is highly significant to identify the risks and practice an effective risk management to cope with these risk factors each of which has a distinct nature and many negative effects [11, 12]. It is stated that, in this way, it would be possible to minimize occupational diseases and accidents, to create a healthy and safe working atmosphere, to enable employee safety, to increase the productivity, performance and satisfaction of the employees, to avoid labour and work day loss, and to eliminate financial losses in the organisation resulting from accidents [12].

As seen from the explanations made so far, several regulations have been made by ILO, OSHA, NIOSH, AHA and health unions under the context of constructional changes in health sector on employee health and safety. The major point stressed by all these regulations is that the health staff has the right to be healthy and to work in a safe environment, as do all other employees of other sectors. In line with the improvement in the world in general, Turkey has also signed some regulations on employee health and patient safety and emphasized the significance of employee health and security. It is extremely important to evaluate both the working conditions and working environments and it is necessary to identify the factor which endangers health. In this way, it will be possible to take the required protective precautions and to increase the awareness of employees about the risk factors and thus to lower the number of work accidents and occupational disease prevalence [15].

Conclusions

Based on the peculiar characteristics of health sector, the health staff who aims to provide health service for public is exposed to a great number of occupational risks and work accidents when performing his or her work. In our country, from the perspective of health care workers in particular, it is observed that there is a dramatic increase in the number of occupational accidents and diseases resulting from the working atmosphere and relationships in that atmosphere. The most commonly observed risk factor in health sector are classified as physical, chemical, biological, ergonomically, and psycho-social risk factors. These risk factors faced and the work accidents that take place adversely affect the health of employee, and injuries or frequent disablements occur; the performance of employee decrease, and some problems arise such as alienation to work, lack of motivation, loss of labour, stress, decrease in organisational commitment, low levels of satisfaction, loss of income, and burnout syndrome etc. Consequent to these, a health service that is in line with the expectations of public may not be provided and in the long run, highly significant and sometimes irreversible losses in economy and health status of the society, as well as of the employee may be observed.

The possibility of a health employee to face occupational risks and have work accidents depend on the profession of the health employee, the work he or she performs, and the department he or she is working for. Besides these factors, personal traits of an employee also

directly affect occupational risks and work accidents. When the right of each employee to work in a healthy and safe environment is considered, the significance of the issue becomes more profound and it becomes inevitable to make some regulations. Therefore, the working conditions of the health sector should be analysed, the factors impairing the health of staff should be identified, these factors should be researched for their frequency and for especially which group is affected by them, detailed analysis should be done on occupational risks and after fixing all these, then we should head for some protective precautions. As seen above, to decrease occupational risks and to ensure employee safety, it is highly important to act with plans. Detailed programs should be organized for employee safety, health check-ups for employees should be done with certain intervals, sustainability should be ensured for the precautions taken to provide the safety of both patients and employees, and through occasional in-service trainings, the deficiencies should be remedied.

The regulations made and the precautions taken in order to make working environment a healthier and safer place will not only contribute into the health and safety of the employee, but also it closely concerns their performance. The employees in a safe working environment have more potential to provide a qualified and effective health service which is in line the expectations of public. Based on these ideas, the precaution to be taken to provide a safe working environment, to decrease occupational risks, and to prevent work accidents should cover especially some certain points. According to the regulations to be made;

- A culture of patient and staff safety in hospitals should be created and both the top management and all the staff should adopt this policy, and orientation programs should be held,
- To ensure a safe working environment, employee safety committee should be made to perform actively,
- Actions should be taken in accordance with national and international statute on patient and employee safety,
- When the employees are in need of guidance to cope with the problems they have, they should be guided and consultation services should be provided for them,
- The employees should receive trainings on job health and safety, their rights, occupational risks, work accidents, and how to avoid them and in this way they should gain awareness,
- The employees should be encouraged to actively participate in the works on patient and employee safety and their expectations should be found out,
- The employees should be urged to report work accidents,
- Hospital infections should be combated,
- The use of protective equipment should be encouraged,
- Personal information of the employees who are required to have regular check-ups should be recorded,
- Immunisation for infections should be made,
- Ergonomic working conditions should be created and instructions should be prepared about how to lift and carry,
- In order to decrease the hazardous effects of radiation and anaesthetic gases, the staff in the concerned departments should work in shifts,
- Working hours should be regulated in order to decrease the problems accompanying the busy, long and nonstop working pace,
- Sufficient security precautions should be taken for violence and the white code practice should be extended,
- All kinds of equipment, tools and devices used for work should be checked regularly,

- The employee who get the occupational disease should not be left alone, but given the necessary support,
- Protective precautions for employee safety should be given priority,

It would only be possible in this way to enable the consistency in health services and to present a high quality, effective, and accessible health service. The precautions have distinctly positive effects not only on the employees in an organisation, but also on the national economy and society.

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HISTORICAL DEVELOPMENT OF HEALTH MANAGEMENT TRAINING IN TURKEY

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ABSTRACT

Today, health management training, with its increasing interest and importance, has had an important part in training programs in developed countries. Global competition, the purpose of profit and management challenges arising from the structure of health institutions entailed delivery of health institutions to professional health administrators. The aim of this study is to study the historical process of health management training in Turkey. In view of the literature, it is seen that the first health management began in the area of hospital administration. During the Ottoman era, hospital managers were selected from non-physician people.

During that period, all the administrative and financial affairs of a hospital were conducted by "Müdir-i hastane" i.e. a hospital manager. The chief physician of a hospital had a position dealing with patient care and coordination of subordinate physicians. After the proclamation of the Republic, the first school established to train students in the field of management of health institutions was Health Administration High School, which was established within the Ministry of Health, General Directorate of Vocational Education on December 19, 1963. Then, this school was assigned to Hacettepe University in 1982, and it has graduated students under the Faculty of Economics and Administrative Sciences ever since. Now, there are a total of 55 universities providing education at undergraduate level in the field of health management in Turkey. Because of the great importance of health management training for the sector, this study is expected to make a significant contribution to the literature.

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1. INTRODUCTION

There are two most important problems underlying the problems related to health, which have built up over years: firstly, "lack of finance", and secondly, "lack of trained managerial staff" are the problems expressed on every occasion. Although therapeutic health services are concentrated on in health policies, it is a known fact that these systems do not have sufficient efficiency, that they not satisfy the service providers and service receivers. One means for overcoming these problems is based on raising managers who have modern management understanding and who are in command of management methods [Cit: 1].

Influences of well-trained professional health managers on health institutions are substantial. Efficient use of the resources, prevention of unnecessary drug use, increase and follow-up of performance of the institution may be listed among these. Therefore, professional training is the most important characteristic that should be possessed by the managers serving at all levels in the hospitals [2].

The fact that countries with any level of development from America to India, from Africa to England have similar training programs in their university curriculums, and that management training is given on several special fields reveals as a universal reality that there is a need for field-specific manager training such as "sports management, disaster management, training management, health management" [3].

2. CONCEPTUAL FRAMEWORK

2.1. Training

One of the most important of issues of our era is training. In the rapidly developing world, available information is increasing and changing as never seen in the previous years. In addition, the substantial and rapid developments in the industry have developed the efforts to make the human factor more useful and stronger. Training expenditures are now regarded as investment in the future. Now the researches include the expenditures made for human force training in their field of examination [4].

Training is a very broad concept in terms of scope. It can be defined as an individual's activities of making changes in his/her knowledge, talents and skills through formal programs, or by himself or though gaining experience, within or outside the establishment. In a sense, training may be defined as a change process [5]. According to another definition, training is defined as "In order to enable that the

individuals or the groups constituted by them to carry out the tasks they have undertaken or will undertake in the establishment more effectively and more successfully, all of the instructional actions, which broaden their professional knowledge horizon, which enhance the knowledge, experiences and skills aimed at making positive developments in their thoughts, behaviors, attitudes, habits and understanding" [6]. In addition to the training definitions made above in individual terms, the definition "all the managerial purposes aimed at developing current success of the organization from the aspect of effectiveness, freedom and efficiency" is made in organizational terms [7].

The organizations are aware of importance of training and its contribution to performance, and are increasingly making effort for employer training. In order to be able to get result in training, it is compulsory to be fast and to use the time effectively in today's information age. The main goal in training of health professionals is to realize quality of the health services, i.e. to ensure that the personnel is equipped in accordance with the requirements of the age in respect of the issues such as knowledge, skills, ethic values and social approaches, and as a result of this, to increase healthiness level of the society [8].

2.2. Health Management Training

Today, health institution management is considered as one of the special management fields, and it is stated that professional health managers are indispensible for the establishments to reach the desired effectiveness and efficiency level. In Turkey, health management training is given at the associate degree, undergraduate, graduate and doctorate levels. However, since professional health management is not recognized as required in the health establishments, the institutions cannot make use of these professionals sufficiently [9].

The fact that a special training was required for managing the health institutions was realized in the USA in the 1910s, and graduate hospital management programs were started to be opened in various universities beginning from 1934. In the historical process, the changes seen in USA in the health management training have entailed a series of changes in role, title, duty and functions of hospital or health services manager. Fifty years ago, a hospital manager would not receive any special training for the management role, whereas today, that person is designated as chairman of board of directors, CEO, can become the member of a professional association, and carries out all activities of the organization he/she takes part in [10].

From the past to present, it is seen that the new approaches manifest themselves in the management training, and that importance is placed on accreditation [11]. The requirement of giving the Health Institutions Management training within certain standards is among the issues of debate in America and Europe. For example, while it is known that the programs providing training in this field are present within different faculties, recently, these departments are seen to be providing training under the faculties of business management. This is encountered in Turkey, too. In the USA, these programs are accredited by an autonomous agency (ACEHSA). A program approved by this agency gives to a potential student the warranty that it will meet the minimum standards developed by that profession or health system. The main goal of ACEHSA is to establish standards for planning and policy of the graduate training in the health management field, to carry out the studies that will stimulate the universities for the development of the programs. Another agency establishes by all the university programs in the health services management field is AUPHA (The Assocation of University Programs in Health Administration). According to the statistics of 2008, 160 programs have become member of this program so far. Two agencies that have ensured formation of this agency are AHA (American Hospital Association) and ACHA (American College of Hospital Administrations). While all profession groups can become member to AHA, ACHA is an agency that

has been established to elevate the profession standards and that accepts only selected professionals to membership. In Europe, EHMA (The European Health Management Association) acts as the superior body of the European health management. In Turkey, organizations at association level (Association of Health Administrators, Association of Health Managers) are present [12].

2.3. Historical Development of Health Management Training in Turkey

In this section, emergence and development of health management in Turkey and the universities currently providing training in this field were examined.

2.3.1. Emergence and Development of Health Management Training in Turkey

The profession of health management is a fairly new profession throughout the world, and the most developed branch of this profession is hospital management. The first training programs in the health management field have been started with the name of "Hospital Management". Today, hospital managers assume the responsibility for a very big budget under the pressure of scarce resources and the too rapidly advancing technology and consumer movements, and are supposed to operate a very complex institution so as to ensure the harmony of the professional, semi-professional and assistant service class personnel from a wide range of fields. The adventure of health management training that has started in 1910 in the USA have been redesigned particularly in the last two decades, and have become aligned with the needs [13].

When we go a little back in the history, hospitals are the most ancient ones among the examples that can be given for the social organizations. Hospital management is an ancient profession. The great Turkish physician Mehmet Razi (850-923) is known to have served as Head Manager at Baghdad Hospital [14]. In the Ottoman Empire, hospital management was regarded as a specialty field of occupation. The person who is responsible for management of the medical services in the hospital management was the head physician, and "Tımarhane Ağası", ""Bimarhane Ağası" (chief of the institution), the person who was not a physician, was responsible for administration of the affairs other than the medical services [15].

Following the 1840s, hospital managers were given the title of "Hastane Nazırı" [15], or "Müdür-i Hastane". The person with the title of Müdür-i Hastane was not a physician. All administrative, financial and operation services of the hospital were being carried out by the Müdür-i Hastane. At that time, the chief physicians were responsible only for carrying out the professional services regarding patient treatment [14].

In the Republic period, first training in the field of health management has started with the Higher School of Health Administration founded on December 19, 1963 as affiliated to the Ministry of Health, General Directorate of Vocational Education, as prescribed in the first five-year development plan [14]. In 1970, the Higher School of Hospital Management was opened in Hacettepe University, and that school gave graduate training until 1975. At that date, name of the program was changed into Higher School of Health Administration, and these schools that gave training between 1975 and 1982 were joined by virtue of the Decree Law no. 20 July 1982/41, and made affiliated to the Rectorate of Hacettepe University [cit: 12]. With the requirement that the management phenomenon, which is certainly known to have a great contribution to make the health system effective, and the recent acceleration in the efforts to ensure establishment of and to develop this new profession, new departments have started to be opened [16].

2.3.2. The Universities giving Health Management Training

The adventure of health management training that has started with the Higher School of Health Administration in Turkey continues very fast. The health management departments in the public, private and foundation universities in Turkey are examined

below. Websites of the universities were examined to create tables.

Table 1. Health Management Departments in Public Universities

UNIVERSITY	Under graduate (4 Years) (F.T.)	Under graduate (4 Years) (E.T.)	Associate degree (2 Years) (F.T.)	Associate degree (2 Years) (E.T.)
AFYON KOCATEPE UNIVERSITY	X	X	X	-
AĞRI İBRAHİM ÇEÇEN UNIVERSITY	X	-	-	-
AKSARAY UNIVERSITY	X	-	-	-
ANKARA UNIVERSITY	X	-	-	-
ATATÜRK UNIVERSITY	-	-	X	-
BALIKESİR UNIVERSITY	-	-	X	X
BATMAN UNIVERSITY	-	-	X	X
BİLECİK ŞEYH EDEBALİ UNIVERSITY	-	-	X	-
BİNGÖL UNIVERSITY	X	-	X	-
BİTLİS EREN UNIVERSITY	-	-	X	-
BOZOK UNIVERSITY	X	-	-	-
CUMHURİYET UNIVERSITY	X	X	-	-
Ç.KALE ONSEKİZ MART UNIVERSITY	X	-	-	-
ÇANKIRI KARATEKİN UNIVERSITY	X	-	-	-
DİCLE UNIVERSITY	X	-	-	-
DOKUZ EYLÜL UNIVERSITY	-	-	X	-
DUMLUPINAR UNIVERSITY	-	-	X	X
DÜZCE UNIVERSITY	X	X	-	-
ESKİŞEHİR OSMANGAZİ UNIVERSITY	X	-	-	-
GAZİ UNIVERSITY	X	-	-	-
GAZİANTEP UNIVERSITY	X	-	-	-
GAZİOSMANPAŞA UNIVERSITY	X	-	X	X
GÜMÜŞHANE UNIVERSITY	X	X	-	-
HACETTEPE UNIVERSITY	X	-	-	-
HAKKARİ UNIVERSITY	-	-	X	-
İSTANBUL MEDENİYET UNIVERSITY	X	-	-	-
İSTANBUL UNIVERSITY	X	-	-	-
İZMİR YÜKSEK TEKNOLOJİ UNIVERSITY	-	-	-	-
KAFKAS UNIVERSITY	-	-	X	X
K.MARAŞ SÜTÇÜ İMAM UNIVERSITY	X	X	-	-
KARABÜK UNIVERSITY	-	-	X	-
KARADENİZ TEKNİK UNIVERSITY	X	-	-	-
KARAMANOĞLU MEHMETBEY UNIVERSITY	-	-	X	X
KIRIKKALE UNIVERSITY	X	-	-	-
KIRKLARELİ UNIVERSITY	X	X	X	X
MARMARA UNIVERSITY	X	-	-	-
MEHMET AKİF ERSOY UNIVERSITY	X	-	-	-
MERSİN UNIVERSITY	X	-	-	-
MUĞLA SITKI KOÇMAN UNIVERSITY	X	-	-	-
MUŞ ALPARSLAN UNIVERSITY	X	-	X	X
NAMIK KEMAL UNIVERSITY	X	-	-	-
NECMETTİN ERBAKAN UNIVERSITY	X	-	-	-
NEVŞEHİR HACI BEKTAŞ VELİ UNIVERSITY	-	-	X	-
ONDOKUZ MAYIS UNIVERSITY	X	-	-	-
PAMUKKALE UNIVERSITY	-	-	X	-
SAKARYA UNIVERSITY	X	-	-	-
SELÇUK UNIVERSITY	X	X	-	-
SİNOP UNIVERSITY	-	-	X	-
SÜLEYMAN DEMİREL UNIVERSITY	X	X	X	X
TRAKYA UNIVERSITY	X	X	-	-
UŞAK UNIVERSITY	X	-	X	X
YALOVA UNIVERSITY	-	-	X	-

Health management departments in public universities are given in Table 1. Information on the departments of undergraduate degree formal training, undergraduate degree evening training, and associate degree formal and evening training. Accordingly, 36 undergraduate programs are available in formal training and 9 in evening training in the public universities. Again, according to the same table, number of formal training

programs is 22 and number of evening training programs is 10 at the associate degree level.

Table 2. Health Management Departments in Private & Foundation Universities

UNIVERSITY	Under graduate (4 Years) (F.T.)	Under graduate (4 Years) (E.T.)	Associate degree (2 Years) (F.T.)	Associate degree (2 Years) (E.T.)
ACIBADEM UNIVERSITY	X	-	-	-
AVRASYA UNIVERSITY	-	-	X	X
BAHÇEŞEHİR UNIVERSITY	X	-	-	-
BAŞKENT UNIVERSITY	X	-	-	-
BEYKENT UNIVERSITY	X	-	X	-
BEZM-İ ALEM VAKIF UNIVERSITY	X	-	-	-
BİRUNİ UNIVERSITY	X	-	-	-
ÇAĞ UNIVERSITY	-	-	X	-
İSTANBUL AREL UNIVERSITY	X	-	X	X
İSTANBUL AYDIN UNIVERSITY	X	-	X	X
İSTANBUL BİLGİ UNIVERSITY	X	-	-	-
İSTANBUL BİLİM UNIVERSITY	X	-	X	X
İSTANBUL ESENYURT UNIVERSITY	-	-	-	-
İSTANBUL GELİŞİM UNIVERSITY	X	-	X	X
İSTANBUL MEDİPOL UNIVERSITY	X	-	X	-
İZMİR EKONOMİ UNIVERSITY	X	-	-	-
NİŞANTAŞI UNIVERSITY	X	-	X	X
OKAN UNIVERSITY	X	-	X	-
SELAHADDİN EYYUBİ UNIVERSITY	X	-	-	-
TOROS UNIVERSITY	X	-	-	-
ÜSKÜDAR UNIVERSITY	X	-	X	X
YENİ YÜZYIL UNIVERSITY	X	-	-	-
ATAŞEHİR ADIGÜZEL MYO	-	-	X	-
İSTANBUL KAVRAM MYO	-	-	X	X
İSTANBUL ŞİŞLİ MYO	-	-	X	X
PLATO MYO	-	-	X	-

Distribution of health management departments in private-foundation universities is given in Table 2. Accordingly, number of programs at undergraduate level is 19, and number of programs at associate degree level is 15. There are no evening training programs at undergraduate level.

When examined in terms of graduate and doctorate training, number of universities giving graduate training in the field of Health Management in Turkey is 39 (Including Ahmet Yesevi University and GATA). The number of universities giving doctorate training in the field of Health Management in Turkey is 10 [12].

3. CONCLUSION

Once the schools training health managers, which have a history of around 50 years in Turkey, provide a really efficient training, the graduates, who are the output, will accomplish quality works in the field. Major tasks fall to the instructors in provision of this training.

However, the non-area academicians and the fewness of academicians are among the main problems hindering this.

Well-trained health administrators who are professionalized in their field will achieve success in the environments where there is intensive uncertainty and variability. It is considered that there will be a linear relationship between placing the necessary importance on health services management and success of the national health system [16].

In Turkey, the need for professional managers equipped with the operation and management knowledge in health institutions of every level, who can assume duty in different managerial positions, is increasing day by day [12]. Similarly, the number of health management departments are increasing in number day by day in Turkey Here, the essential objective desired to be achieved is, rather than numeric increase, to manifest actual quality of these departments by transferring the output, i.e. the graduates who are enterprising, knowledgeable, self-confident and open to innovation, who will represent the profession of health management.

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IN HEALTH WORKERS LEADERSHIP AND ORGANIZATIONAL COMMITMENT

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A R T İ C L E I N F O

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Abstract

The purpose of this study, the confidence of employees and managers of the organization's policies and procedures within the organization as a volunteer in a constructive manner and behavior is to examine the ongoing effort to change. For this purpose, field research and review of the literature was conducted. Confidence in the center of the social exchange to take place, taking into account confidence in the organization as a whole workers' organizations and employee organizations in expressing confidence shows social exchange. Managers rely on the employee's immediate supervisor represents social exchange

Relevant literature and field research performed using SPSS 19.0 software Microsoft Office Word program and directly benefiting from the transfer , interpret and summarize in health organizations with

leadership and organizational commitment are described

Health care workers at the hospital tasks to a large extent they do with financial concerns and the resulting income was found to affect the organizational commitment.

This research organizations rely on the manager's commitment has been constructed in order to exert their influence on the lens. One of the variables of organizational culture, organizational commitment is affected. Research the organization, management and examining the concept of organizational commitment; confidence in organizations to manage the impact on employee commitment towards finding a literature study was conducted. Organizations rely on the manager's impact on employee engagement in the organization, in terms of continuity and employee productivity are essential.

This research, the manager of the trust, organizational commitment contributed significantly to the assumption that it is organized.

INTRODUCTION

There have been a variety of definitions of leadership in the literature. In examining the definition made by the leaders of the community are bound to their world view, which is in the field and that leadership is defined by the fact that depending on what mindset. The developments in world leaders who have demonstrated the fastest way to implementation features that are valued community leaders. These people intuition, intelligence, information-based decision-making and the decisions taken are handling characteristics of this society. Power in the hands have the ability to use. Through this power can influence people around them. They get through difficult decisions and decision-making techniques has always defended the confidence of knowing to stand behind their decisions. They argue that people should be regularly trained. Because they know that people received information through behavioral changes provided they appeal to wisdom. In addition to guiding people in order to ensure organizational commitment and they train. They want to gain people's confidence in them. Make the people around constantly sharing ideas and these ideas, they give themselves the final decision, combined with their own thoughts. Hesitation in taking responsibility not suffer.

In this study, leadership and leadership qualities, organizational commitment were treated topics. The leadership in the field of health care workers with work carried out in a hospital and examined how it is perceived in organizational commitment.

LEADERSHIP

Leadership has been an issue for centuries attracted people's attention as it is known. Overall leadership; faith, confidence, dynamism, courage, knowledge, and intelligence has been used in expressing the meaning. Multidimensional and dynamic concept of interest is attractive and there is the need for leadership with a growing research about it, the mystery of this concept and reserves attributable to the strength in this mystery [12].

Traditional (Classic) Leadership Approaches

Especially in the early part of this century, there have been several studies to determine the characteristics of a leader in this approach. As a leader, age, gender, height, race, physical appearance, knowledge, intelligence, the ability to establish relationships, farsightedness, integrity, sincerity, candor, emotional stability, maturity, self-confidence, determination, initiative, such as motivation, physical and psychological It is examined [11].

Leadership of the Great Man

Leader features that make it the leading event according to this theory, which considered the most important factor in determining; It is different from the followers of the leader in terms of physical and personality traits [15].

Personal Property Source Leadership

LL Barnard, Bingham, Kilbourne, Kirkpatrick & Locke, Kohsar & Irla, Page, according to researchers such as TAED leaders, has superior characteristics and temperament that separates them from other people. The concept of executive leadership with the concept used by these investigators is almost the same meaning. Led by TAED, which is a set of features necessary to convince others in achieving a specific job [10].

Mc Gregor Theory X and Y

The work of the X Theory developed by Douglas McGregor, who fled to manage and responsibility, showing more interest in economic incentives, which requires monitoring and punishment, an unreliable business who described while Theory Y work, taking responsibility and loving to manage, the motivation for prestige, a creative business saw profile It has drawn. McGregor argued that the need for more emphasis on Theory Y managers announced after these two theory. This theory raises an important clue to the generalized trust by different properties attributed to employees. Despite the relative sense of security deficiencies in the classical approach, neo-classical approach to the notion that there is a higher degree of confidence, led to no difference between the two periods of the motivational tools used [1].

Situational Leadership Approaches

Contingency theory of general assumption is that the most appropriate leadership behavior will change according to the situation of the different conditions and different leadership styles. Although the theory of this thesis, under what conditions the number of studies showing what would be the appropriate type of leadership behavior is not much. Best known for his work on this issue, Fred Fiedler is a situational leader effectiveness model [16].

Path-goal theory

Road Purpose Theory, developed by House and Evans. This theory adopts the task and relationship behavior shown leadership and to reach the goal of following the leaders aim is to stimulate them to add the third dimension. Leaders to reach organizational goals, achieve job satisfaction and subordinates in the workplace (the audience) is to motivate action in terms of the basic assumption that the persons who are events [11].

Life Cycle Theory

According to this theory, the most effective leadership style depends on the maturity level of the subordinates. Hersey and Blanchard maturity, not by age or emotional stability, people's desire for success, explain the desire to take responsibility and work-related skills and experience. The relationship between subordinates and managers, subordinates go through four stages of maturation and development in line. Managers must differentiate leadership behaviors at each stage [8].

Astor is now much more experienced increased levels of self-esteem and to find their own way. Managers can reduce supportive and encouraging the behavior at this stage; subordinates are no longer needed to be self-sufficient and guiding behavior [15].

Modern Theories of Leadership

Despite the current contingency approach may not have the same approach envisioning In any case, it is not possible to argue that in the end of the research on leadership. In this context, to mention several theories developed in recent years regarding leadership seems useful. The charismatic leadership of recently developed approach (transactional) and transformational leadership (transformational) leadership, which is indexed with leadership and leader-member exchange quality award will be announced in this section.

Transformational (transformational) leadership

Many transformational leadership in leadership theories, particularly about understanding the rapid change in leadership within the company. When the leadership literature is examined, it is seen to various examples of the leader with foresight in action in the work environment; (In the new industrial sector it has been faced with a similar situation in the same way for profit.) [15].

Emotional Intelligence and Transformational Leadership

110 middle managers who work on Gardner and that the existence of a strong correlation between emotional intelligence and transformational approaches; You never leave the leaders in terms of style, it appears that they do not have high emotional intelligence level

Charismatic Leadership

Authority on the Web is a classic triple typology; charismatic, traditional and legally divided into three. Charismatic authority, attributing superhuman as the audience leader in the emerging instability and chaos are exclusive features. The continuity of this relationship depends on the show these characteristics attributed to the leader [12].

With indexed Behavior Leadership Award

The size of the business in very different ways, create potential sources of awards will be given to the employees. When assessing specific business characteristics, (in certain cases), it may need to have the equivalent of the availability of this character. Giving these characters related work is to determine the individual independent connection. Deployment of the business value of an export point in time may not match the distribution opportunities related to the satisfaction of these values. To understand the diversity of employees' job satisfaction not only to focus on value is also necessary to have individuals working approach. However, the types of prizes are available [12].

Leader-Member Exchange Quality

Leader-Member Exchange Quality, delegating decisions leading to its simplest form refers to the authority and power to provide them with subordinates autonomy. In such a context of

leadership behavior; The leader takes his followers that each can decide on its own as well as her role models by recognizing these opportunities; It can feel like a leader.

THE CONCEPT OF ORGANIZATIONAL COMMITMENT

Commitment to organizational goals, not only in terms of absenteeism, raising the quality and quantity of a certain degree of success and the role of not only contribute to the reduction of labor turnover; at the same time the individual is led many voluntary action necessary for organizational survival and success of the system at the highest level [12].

History of Organizational Commitment

One of the positions on the business process and organizational commitment who, although not particularly on an issue discussed much later in the 1970s, has not yet reached a consensus on the definition of this concept. The most important reason, sociology, psychology, said researchers from different disciplines such as social psychology, organizational behavior and handling are the basis of their expertise. Therefore it is possible to come across many different definitions from each other commitment Considering the organizational commitment literature. For example Morrow literature implies that there are around 30 different definitions related to organizational commitment [4].

Factors Affecting Organizational Commitment

Organizational commitment is affected by two main factors, namely personal and organizational.

Personal Factors

Organizational commitment; age, gender, education level and working time (severance) are affected by factors such as personal. These factors are described below.

Age

The age of the person, their attitudes to work, perceptions may affect their wishes and expectations. Individuals with the beginning of the career, for the first time to experience the problem of job search and job placement, employment and training appropriate to the characteristics of demand will be high. Individuals, businesses and business environments to recognize and connect to work, settle in, see the existence of a positive mood for themselves and must be passed within a period of time it [7].

Sex

Women's traditional household chores, children have been undertaking activities for families to care for and identification with a role in providing livelihood outside working family men, has led to a social mission distribution of time between men and women [19]

Education Level

Employees' level of education, is an important factor affecting the outlook for the business of life and life expectancy of business. The higher the education level, expectations differ loaded with meaning to work and work. Social and economic conditions have continued to significantly higher training as soon as practicable and trained individuals, educational level than those with low job perspectives are very different. Rather than enter working life at an early age, folded a longer cost of studying, those who sacrifice to achieve more than income, education and working life are located at the end of the qualified workforce.

Run Time (Severance)

Seniority, how long they have been working in a job. Remaining in the same job for a long time, so can be expected to be higher than the cohesion of an individual with high seniority. Can not get used to the job, while providing satisfaction from work, not an individual identified as psychological, if accepted will tend to leave the business, employee commitment to the organization's relationship is clearly visible. However, if another job options here and thought that the economic problems that complicate the employment of the individual, may prove to be an employee of the organization is less important relationship commitment. For this reason, it is considered as a factor affecting organizational commitment seniority alone can be misleading [7].

Organizational Factors

Organizational commitment; The size and structure of the organization, organizational culture, compensation, organizational rewards, management style and participation possibilities, are influenced by organizational factors such as organizational justice and teamwork. These factors are described below.

Size and Structure of the organization

The number of people working in the organization grows, so grows, organizations are increasing bureaucratic practices. The best way to handle a large organization in the management and control mechanisms, a well-defined hierarchical structure, there are certain powers and responsibilities of the position taken by everyone found. There are detailed and concrete guidelines on how to do each step in the job. In interpersonal relationships, it will continue in accordance with the position of principle made [16].

Organizational Culture

Organizational culture, Eliot Joques (1952) by "the general thinking of the organization and the way to do things in an organization." and it has been defined. According to another definition of

organizational culture, norms that guide the behavior of individuals and groups within an organization, behavior patterns, beliefs, attitudes and habits of the system (Turner, 2007).

Org consist of individuals from different cultures. These individuals have met in functional and professional standards and criteria, as a result of creating together a group, but different from other organizations have formed a small, though common beliefs and value systems themselves [9].

The positive aspects of the organizational culture is to create a common sense of identity in people. Besides, it helps to build organizational commitment to organizational goals through participation [2].

Wages

An employee's, select a specific workplace, stay there and work with high motivation, it is closely linked to the wage level and reward employees, especially for those living in economic hardship, pay satisfaction; business, colleagues, may be more important than other factors, such as management satisfaction. The formation of opinions about the fee, although the effective livelihood and standard of living, is an important factor in people's wages. A behavior common in people who work, pay levels are not comparable with other people their own fees. In the research on income distribution, a conviction that they receive the wages they deserve the employees are determined to get their results compare with those similar to their own employees [3].

Organizational Awards

All employees who are recognized in the same way or with the same kind of likes and unimaginable rewards they want them. Such a thought, considered an important error in managing people. But regardless of individual differences, all employers, how they are valuable to the organization, what their work is so important and how great a job they did, they'd like to hear from the manager. The retaining talented employees with the most important tool is only a fact accepted today that there is no money anymore. Money is not enough to secure the retention of talent held. Employers, they do good things to be aware of and want to be appreciated. This can make managers, employees will further increase the chances of keeping their side [3].

Facilities management style and Participation

Loyalty to the organization, work and study to determine the relationship between variables related to the business environment, the perception of employees to managers was found to be very important. Reliable, innovative, open, seen as compatible with the manager, to enhance the performance of employees, these managers have been found to make a significant contribution to high psychological atmosphere necessary for the development of organizational commitment [7].

Organizational Justice

Employees compare themselves with others in their organization. The rules applied equally to everyone, equal pay for equal work, the have equal rights in permitting, he expects the team to benefit from social opportunities equally with others. However, the focus of the justice perception is not only to compare these outcomes and outputs. Rules of the organization, the interaction between these rules and the application forms are also the focal point of justice perception individuals [11].

Team Work

The team examined the definition highlights three important elements. First, two or more people is required to form the tool. Secondly, the person who creates the team is dependent on each other. So team members are obliged to constantly interact with each other. Third, it is working to achieve a particular purpose of the creator of the team. The advantage of an important team work of different disciplines within the organization; knowledge, skills and experience to bring together. Teams, an organization beyond the strict hierarchical structure and unnecessary restrictions are gathered around a common goal [3].

The Importance of Organizational Commitment

Up to the present from the past, there have been several studies on organizational commitment. These studies; dismissing, work late, the important personal and organizational issues such as performance and absenteeism shows that continued today. Organizational commitment in solving these problems is emerging as a very important factor [6].

Organizational commitment has become a vital issue for organizations because of five reasons. These are [2]:

- Work to leave, absences, withdrawal and job search activities,
- Job satisfaction, work hugging, such as morale and performance attitudinal, emotional and cognitive structures,
- Autonomy, accountability, participation, such as the employee's job duties and role of the characteristics of understanding,
- Age, gender, length of service and employees' personal characteristics such as education,
- Owned by the individual predictor of organizational commitment

Organizational Commitment and Related Concepts

This section is concerned with concepts similar characteristics with organizational commitment. Because these concepts are often being experienced

with ambiguity between organizational commitment, even used one instead of another. Some of these concepts professional dedication, loyalty to colleagues, loyalty and obedience.

Professional Commitment

Professional commitment with the result that the skills and expertise of the individual's life is related to the understanding of the importance of the profession. More clearly, the professional commitment of individuals in a certain field of skills and expertise importance in the life of the profession as a result of his work in order to earn and how central is the perception that it has a place [4].

Commitment to the Business Friends

Loyalty incentive gives too much importance to the friendly relations and friendship ties with high individuals. They are a team with people rather than deal with plans for the future, they share something with them and prefer to work in an environment they help them. For individuals with this type of attachment to friends is a double purpose. In such cases, to leave the organization, commitment of individuals to break away from organizations that also mean to leave his friends heard it is more difficult.

Loyalty

Similarly another definition by Lee. According to this definition, which is only one dimension of organizational loyalty, organizational commitment is related to the desire to maintain membership in the organization. In addition, the pride of being a member of the organization, including the hearing is a pleasure to speak in favor of attitudes defense organization and with other organizations towards the environment. As a result, although a more comprehensive concept compared to an overall organizational commitment and loyalty is a much stronger sense of loyalty than loyalty [13].

Obedience

Individuals outside the field is a sense of duty and obedience is based on a single source supply order issued by an authority. Individuals often demonstrate obedience for fear they will face sanctions and penalties as a result disobeying orders. Yet that was not caused by the external environment, organizational commitment, an inner sense of duty. Because it is internal, it is not possible to establish with external orders.

Relationships Between Organizational Commitment Leadership

Manager behavior and practices, there is evidence that it affects the employees' level of organizational commitment. Who is supported by organizations, individuals who decide to get involved and limited feedback about the job role and performance in procurement generally show low commitment. The leadership style is applied mainly in the organization can impact positively or negatively on organizational commitment [14].

Effective managers, strong positive beliefs and attitudes with positive behavior on other people in the organization to which they combine in an appropriate manner, and leave a positive impression. These beliefs and actions, embodies the commitment levels [5].

APPLICATION OF A STATE HOSPITAL AFFILIATION AND ORGANIZATIONAL LEADERSHIP INTERACTION

Project Title This research, health care staff of the hospital medical staff leadership style of managers perceive in was conducted as a descriptive commitment to demonstrate their impact on the organization.

Project Problem

The State Hospital health professionals studying leadership and organizational commitment will attempt to interpret perceptions. Of the patients in our study on current practices, ideas and attitudes will investigate what is happening.

Project Purpose

One of the sectors in which it operates is the leadership approaches of managers who adopt health sector. The health sector is one of the fastest growing and progressive industry in the world economy in the last century. Most of the time, the health sector plays a driving force for regional or national development. This is the reason the health sector has a privileged place among other industries. Whether employment, also allowing them to maintain a healthy position in terms of the right of people of the country. The importance of the health sector giants this extent, the presence of a competitive environment in the institutions operating in the health sector are inevitable. This competition is expected to be the leader in the health care market with specific competences. The aim of this study was to evaluate the perceptions of leadership approaches and health care issues in organizational commitment.

One of the main system of health institutions to enable them to differentiate themselves in a highly competitive environment is the leadership approach. The introduction of the business-led approach to life is based on the 1980s. Learning organizations develop leadership approach in the development of consciousness and began to find a place for itself in business. Leadership system, the human resources which aims to evaluate intellectual capital more efficiently. Improving the performance of employees, their personal satisfaction of helping both the company and employees. Leadership, as a

dimension of management, leadership process that can be used within the organization can also be offered as a service that appeals to all segments by consultants. Leadership approach to training and development is the most effective method of technical development between managers. For this reason, the implementation of health management and leadership development approach is extremely important in terms of increasing the organization's effectiveness and efficiency.

Project Importance

In this study, health care institutions that are important for leadership approach, by hospital management to implement without hesitations and thus required to determine the factors that are important in solving the problem of health care workers. In addition to resolving the negative administrative conditions faced by health workers to provide organizational benefits just as increasing employee satisfaction and loyalty by not only the people contributing to the reduction of employee discontent get a little bit to be happier and live a prosperous life in terms of contributing it is important.

The research conducted on the other hand, the leadership approaches are generally tends to focus on the impact of individual factors on leadership, organizational factors, but it is ignored. This work led the trend observed in addition to the personal factors affecting the organizational and leadership literature by examining the situational factors and draw attention to the gap in terms of contributing has a different significance.

Due to a communication process that occurs between health workers and hospital management leadership, this behavior is simply inadequate to explain the patient's individual characteristics. This approach, instead of leadership, a significant portion of which constitutes health professionals and hospitals of various properties of the specified communication process (corporate safety, corporate image, perceived the hospital's compensation policy, the features of the complaints system, etc.) To be the relationship is considered.

Project Research Method

Research, research is the model. State Hospital for the purpose of assessing the perception of literature on leadership and organizational commitment will be made subject of health care workers. As data collection methods in the study, a questionnaire will be used.

The research universe and sample

The total population of the research staff at the hospital (n = 100) constitutes employees. Due to the small number of employees will be taken as the number of sample universe.

Data Collection Tools

The data collection tools, consisting of 27 phrases and Organizational Commitment Questionnaire consisting of 30 phrases leadership questionnaire will be used. A questionnaire will be applied to healthcare professionals; Afyon Kocatepe University Institute of Social Sciences Department of Business Kızıltay Assist by students of Emine written in 2010. Assoc. Dr. Süleyman Dündar 's he worked as consultant "Investigation of entrepreneurship Features According to Director of Leadership Styles: Tourism Sector Research" on the master's thesis from Gazi University Institute of Social Sciences Business Administration Department of Management and Organization Science students from Renginar Yusei by post in 2013. Prof. Dr. Rasih he worked as consultant forge "Motivation Relationship Between Organizational Commitment: An enterprise application" it is cited on the Master's thesis.

Ethical Aspects of Research

For the implementation of the study, the Ethics Committee of the State Hospital 'na, submitted in writing to the relevant procedures ensuring compliance and ethical decision will be taken. After obtaining written consent for the study, a questionnaire will be distributed to health workers who agreed to participate in the study.

Limitations

1. Research the hospital is limited to health workers.

2. The emergence of the hospital's ethics committee late response can delay the start of the study.

3. Reduce the universe of the study to allow partial research at the hospital.

4. birth to the hospital, health workers, etc. allowed. It may be impossible to achieve because of such circumstances. This will lead to shrinkage of the research universe.

5. dealt with the variable in this study is limited by the size of the applied reliability survey.

6. unwillingness to participate in a survey of a portion of health care workers in hospitals will lead to shrinkage of the research sample universe.

Evaluation of data

All survey questions SSPS 19 (Statistical Package for Social Science) statistical data transmitted to the environment will be created. Data on identifying characteristics of health workers; number, percentage, will be evaluated by the average. To examine the relationship between these characteristics and scale dimensions scores; analysis of variance, Pearson correlation, statistical methods will be used. The reliability of the survey

to assess Coffient Croncbach alpha coefficient, the substance will be used for total score correlation tests. p <0.05 will be considered.

Dependent variables: will form part of their views regarding the determination of health professionals edited questionnaire

Independent variables: socio-demographic characteristics of the health workers involved in the study (age, sex, education, marital status) is the related question.

Results

Table 1: Distribution of Participants Demographic Situation

		n	%
Gender	Woman	65	63,7
	Male	37	36,3
	Total	102	100,0
Age	17-24 years	11	10,8
	25-34 years	39	38,2
	35 age and older	51	50,0
	Total	101	99,0
	Missing	1	1,0
	Total	102	100,0
Marital status	Married	70	68,6
	Single	32	31,4
	Total	102	100,0
Education level	Health Vocational High School	26	25,5
	Associate Degree	34	33,3
	License	28	27,5
	Graduate	7	6,9
	Doctorate	3	2,9
	Total	98	96,1
	Missing	4	3,9
	Total	102	100,0

The distribution of those surveyed in the study of the demographic situation;
63.7% of the proportion of women according to gender (n = 65), while the proportion of men and 36.3% n = 37,
10.8% of those between 17-24 years of age according to age (n = 11), 38.2% of those aged 25-34 (n = 39), 50% of those 35 and older (n = 51), loss of data% 1 (n = 1)

According to the marital status of married 68.6% (n = 70), 31.4% of the single (n = 32),
According to the Health Professions High School education level of 25.5% (n = 26), Associate 33.3% (n = 34), Bachelor of 27.5% (n = 28), M.Sc. 6.9% (n = 7), 2.9% of doctoral (n = 3), 3.9% missing data (n = 4) is seen that.
The women in the study, and those above 35 years of age, were found to be more than the proportion of married and is a graduate associate (Table 1).

Table 2: Breakdown of Participants and Time of Duty

		n	%
Task	Doctor (Specialist Doctor - GP)	7	6,9
	Dentist	1	1,0
	Pharmacist	1	1,0

	Executives of Health	3	2,9
	Nurse	7	6,9
	Nurse - midwives	36	35,3
	Health officer	9	8,8
	Technician	13	12,7
	Other medical staff (Dieticians, Physiotherapists, Social Ser. Exp.)	20	19,6
	Total	97	95,1
	Missing	5	4,9
	Total	102	100,0
Run time position where	0-5 years between	47	46,1
	6-10 years between	26	25,5
	11-15 years between	12	11,8
	16-20 years between	11	10,8
	21 years and over	6	5,9
	Total	102	100,0
The total length of professional experience	0-5 years between	28	27,5
	6-10 years between	20	19,6
	11-15 years between	20	19,6
	16-20 years between	13	12,7
	21 years and over	21	20,6
	Total	102	100,0

The task of those surveyed, the study period and the total length of professional experience working in the position where;
Duties, Dr. (Specialist Doctor - General Practitioner) 6.9% (n = 7), Dentist 1% (n = 1), Pharmacist 1% (n = 1), Health Administrators 2.9% (n = 3) High Nursing 6.9% (n = 7), Nurse - midwives 35.3% (n = 36), Medical Officer of 8.8% (n = 9), Technician 12.7% (n = 13), Other Health Personnel (Dieticians, Physiotherapists, Social Ser. Exp.) 19.6% (n = 20), 4.9% missing data (n = 5),
Working time between 0-5 years in the position where 46.1% (n = 47), 25.5% between 6-10 years (n = 26), 11.8% between 11-15 years (n = 12), 16 - 20 year from 10.8% (n = 11), 21 years and over 5.9% (n = 6),
The total length of professional experience between 0-5 years 27.5% (n = 28), 19.6% between 6-10 years (n = 20), 19.6% between 11-15 years (n = 20), 16 -20 year from 12.7% (n = 13), 21 years and over 20.6% (n = 21), respectively.
Nurses and midwives in research, working hours in the position where it was found that more than 0-5 years, and the proportion of the total length of professional experience (Table 2).

Table 3: I'm doing my duty in the Hospital Anxiety with Substantial monetary Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Forecast Error
1	,492[a]	,242	,235	1,07461
a. Predictors: (Constant), I am doing my duty in the hospital with largely financial concerns.				

Model summary of the case the argument of value in the R-square column in the statement, "I am doing my duty in the hospital with largely financial concerns." In the case of the dependent variable "I think I made a mistake but decided to work from the hospital," the variance of variables explained 24%, in other words, the hospital incorrectly to work 24% of the decided opinion that it is understood that the mission of this hospital largely thought to be due to monetary concerns.

Table 4: I think I made a mistake but decided to work from the hospital Table Expression Anova

ANOVA[b]						
Model		Sum of squares	df	Mean Square	F	Sig.
1	Rotation	36,587	1	36,587	31,682	,000[a]
	Ruins	114,324	99	1,155		
	Total	150,911	100			
a. Predictors: (Constant), I am doing my duty in the hospital with largely financial concerns.						
b. Dependent Variable: I think I made a mistake but decided to work from the hospital						

The values in the ANOVA table column of the relationship between the variables of significance at p <0.01 level shows that significant. If the relationship were meaningless in this column over 0.05 (random) would do that review. If the relationship in the table to be formulated;

F (1,99) = 31.682; p <0.01 equations can be created.

Table 5: I'm doing my duty in the hospital with monetary concerns Substantial Factor Table

coefficient[a]						
Model		Standard Non-Coefficient		Standard Coefficient	t	Sig.
		B	Std. Error	Beta		
1	(Dependent)	,457	,289		1,580	,117
	I am doing my duty in the hospital with largely financial concerns.	,493	,088	,492	5,629	,000
a. Dependent Variable: I think I made a mistake but decided to work from the hospital						

Coefficient (Coefficient) The table, the regression coefficients used for the regression equation and give their significance. In our example, the coefficient of the variable is done with the hospital's mission largely concerns monetary 0.493, while the fixed value of the equation is 457.

When we encounter these values into the equation Y = a + bX; Y = 0,493X + 0.457

We will achieve equality. This equation shows us that the mission of the hospital is done largely with the monetary value of that care will be a mistake to consider how it affects you decide to work at the hospital.

Table 6: I'm doing my duty in the Hospital Anxiety with Substantial monetary Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Forecast Error
1	,386[a]	,149	,141	1,18312
a. Predictors: (Constant), I am doing my duty in the hospital with largely financial concerns.				

Model summary of the case the argument of value in the R-square column in the statement, "I am doing my duty in the hospital with largely financial concerns." In the case of the dependent variable "labor and knowledge prevents me from leaving the hospital." The variance of variables explained 14%, in other words, the hospital incorrectly to work 14'n% of the decided opinion that their efforts and experience in this hospital are understood to be due to leave this hospital.

Table 7: Labor and knowledge I leave this hospital Hampers Anova Table Expression

ANOVA[b]						
Model		Sum of squares	df	Mean Square	F	Sig.
1	Rotation	24,062	1	24,062	17,190	,000[a]
	Ruins	137,178	98	1,400		
	Total	161,240	99			

a. Predictors: (Constant), I am doing my duty in the hospital with largely financial concerns.

b. Dependent Variable: I think I made a mistake but decided to work from the hospital

The values in the ANOVA table column of the relationship between the variables of significance at p <0.01 level shows that significant. If the relationship were meaningless in this column over 0.05 (random) would do that review. If the relationship in the table to be formulated;
F (1,98) = 17.190; p <0.01 equations can be created.

Table 8: Labor and knowledge I leave this hospital Hampers Factor Table Expressions

coefficient[a]						
Model		Standard Non-Coefficient		Standard Coefficient	t	Sig.
		B	Std. Error	Beta		
1	(Dependent)	1,032	,319		3,238	,002
	I am doing my duty in the hospital with largely financial concerns.	,400	,096	,386	4,146	,000

a. Dependent Variable: I think I made a mistake but decided to work from the hospital

Coefficient (Coefficient) The table, the regression coefficients used for the regression equation and give their significance. In our example, the coefficient of the variable is done with the hospital's mission largely concerns monetary 0,400, while the steady value of the equation is 1.032.

When we encounter these values into the equation Y = a + bX;

Y = 0,400X + 1,032

We will achieve equality. This equation shows us that the work will be done to a large extent the value of financial concerns at the hospital's mission and how it affects the accumulation of leaving hospital.

CONCLUSIONS AND RECOMMENDATIONS

The duration of their position in the study of the demography of the health workers who participated in the survey and the total duration of 0-5 years of professional experience, has been found to be more involvement of nurses and midwives. Areas of work has been done by the hospital's staff is comprised of employees with less service time, it is thought that in this case the hospital's performance showed an employee profile of the amplifier elements considered appropriate training of human resources. State Hospital in providing services to the health care provision for health services, occupational health services to demanding patients and their relatives is an important factor in the health managers of the leadership characteristics of the carries and also health professionals concluded that usually the desired level of organizational commitment has been reached.

Today, the development of technology and the rapid development of countries in the health sector put into practice one of the most important features of the income they provide to health workers, especially the effect of organizational commitment was investigated in this study. In deciding to work in hospitals they work for health workers is a decisive factor in the amount of income to be obtained. That request usually consists of separation negatives occurring in the workplace. This case raises the particular employee turnover and leads to an increase in hospital costs. Knowledge of which is spent after being hired labor and achieve is a factor preventing the employment of workers. Revenue amounts are low, even if employees choose to depart from this case is circumstantial seeing things. State health agencies are the Ministry of Health hospitals, government health workers are determined to make the normal hours of work in tasks. However, given the continuous shift of health care in the period outside normal working hours are determined by the Constitution operating system is conducted. As a result of this study consists in a certain increase in income it is composed of health professionals and increase their quality of life. The idea of the health service delivery to patients is not limited by the necessity of working hours are not available in all health care workers.

Health care workers who work with beginners applied given a certain period of orientation training are working to ensure compliance with diagnostic and treatment services. Adapt to the challenges of attracting health professionals, and is generally thought to cause inability to adapt to their environment due to the negativity. Hospitals are

areas where patients and caregivers because they are constantly dealing with health care organizations to human health. Patients and their relatives of the disease in question is able to reflect stress situations in which they live every moment because health workers. This situation raises the issue of violence against health workers often on the agenda. Inability to adapt to some of the issues that can be considered as a cause in this way. Income level also one of the factors causing disharmony. In our research, health care workers in this way they think. With a negative impact on organizational commitment in this case leadership qualities that should be solved by health managers.

As in all health care facilities in workplaces there are rules that must be followed. Health care workers are obliged to comply with these rules. The implementation of organizational commitment in a way that caused by health managers should be the main target of these rules. Fees are eligible if they are obtained by ensuring compliance with the rules work. The environment is very stressful working environments, especially in today's violence and the increase in health workers' health study applied psychological pressure is thought to block requests. Employees who choose to take this case they are separated from whatever income jobs.

One of the most important indicators of the health workers of leadership and organizational commitment is to provide health managers. They are working to ensure that the performance of the system started running this commitment into practice in recent years in this regard. This system allows health workers are increasing their income, organizational commitment and redundancy is provided is prevented. In our research, health workers, increase the enthusiasm of the opinion that it was seen that work proceeds. Arranging the physical structure of the working environment of the employees working will also increase.

People receive power from being a member of a group or a community. Health workers have income if the good is in the group will be always happy and commitment will increase. Be transferred to the employees of the changes occurring in the field of medicine, requirement of showing the highest performance and motivation of employees for this, the creation of a suitable environment in health activities, also to be together often outside working hours is one of the crucial factors that organizational commitment. Health care managers who are leaders property must pay attention to these issues. This issue is triggered by income level again.

As a result of the elimination of monetary concerns of healthcare professionals in the provision of health care workers, or at least the removal of organizational commitment and leadership to the downloading feature it is among the tasks of health managers carrying. Organizational commitment will be achieved through the provision of required performance.

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EFFECT OF PER CAPITA INCOME ON THE REGIONAL DISTRIBUTION OF PHYSICIANS: GROWTH CURVE MODEL

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ABSTRACT

Aim: The economic basis of the imbalance of the regional distribution of physicians is the imbalance of per capita income among residential areas. As per capita income raises the demand for health services increases. On the other hand, doctors prefer high-income cities in order to generate more revenue. Turkey has a wide range of differences in inter-provincial income levels. In this study, the relationship between the distribution of doctors and per capita income in 70 cities between 1991 and 2000 in Turkey has been examined. Thus, it is aimed to point out the importance of the economic basis of the imbalance in the distribution of physicians.

Method: The survey data of the Income Distribution by Provinces between 1991-2000 provided by Turkish Statistical Institute and the total number of specialists, GPs and total physicians in these provinces, gross domestic product per capita, and population data have been used. Multilevel regression analysis has

been used in order to find out whether doctors prefer high-income cities, and how this preference changes as the income level changes, and whether this trend is higher among the specialists compared to the GPs.

Results and Conclusion: There is a statistically significant positive relationship between domestic product per capita and the total number of specialists, GPs and total psychians per 10000 people. It is determined that doctors prefer the provinces where per capita income levels are high. A statistically significant difference is determined in the changes of the medium of the total number of specialists, GPs and total psychians per 10000 people and domestic product per capita in time. It is seen that as the provincial income levels per capita increase the number of physicians in the provinces also increase. This relationship is stronger among specialists compared to GPs. The importance of economic development in providing equality of the accessibility to health services is an obvious reality.

1. INTRODUCTION

In order to provide adequate healthcare to everybody in need, well balanced management and recruitment is essential countrywide besides health workforce that is equipped with necessary knowledge and required skills [1].

Accessibility within the healthcare sector is closely related to the available health facilities and geographical distribution of health care professionals. The distributions of physicians across the countries affect the maternal mortality, infant mortality, and children under the age of five years mortality [2,3]. Primary care and income inequality exerted a strong and significant direct influence on life expectancy and total mortality [4].

In all countries, including Turkey, the main issue is the distribution of health care workers, especially physicians. Physicians are one of the most essential human resources for maintaining health. Equal distribution of physicians in consideration of health care needs is a crucial part of health policy. The unequal distribution of physicians is a worldwide, longstanding and serious problem [5-9].

The number of physicians working within big cities is disproportionately condensed compared to rural areas [10, 11]. Generally within all countries, rich or poor, health workers are prevalent within socio-economically developed and prosperous urban areas [6, 12]. This issue is greater in poorer countries; for example there is more than a fivefold difference in Tanzania which is one of the poorest countries in the world with the least number of doctors and lowest per capita income between the urban districts with the lowest and highest number of health workers per capita [13]

Comparing Turkey with Europe/OECD countries, manpower supply for healthcare is found to be limited. Especially, the density of practitioners and the ratio of physicians to nurses are half of the average rate in those countries [9, 14]. In addition to this, the number of expert physicians is greater than the number of practitioner physicians, and the number of midwives and nurses is less than the number of physicians which shows another dimension of the overall problem [1, 9, 15].

Macroeconomic trends, such as gross domestic product (GDP) and personal income, are good predictors of physician utilization. Growth in the utilization of health care workers generally, and of physicians in particular, might correlate with economic expansion. Health employment and health expenditures behaved similarly with respect to GDP [16].

In this study, we examined the relationship between the number of practitioners and specialists per 10.000, and the income per capita in various cities for the period of 1991-2000. The change in the distribution of physicians with respect to the change in the level of income during the 10-year period was analyzed.

2. INCOME LEVEL AND DISTRUBUTION OF PHYSICIANS

In the health sector, cost and demand is rapidly outgrowing the available funding. In countries, where

the general public shapes governments, they are under pressure to increase health spending to meet their expectations. In addition, healthcare workers are trying to maintain or increase their incomes [14].

The physician distribution imbalance indicates some kind of social and economic reason especially within cities and city centers. In economic literature, the most widely accepted measure of total economic performance is the per capita income (GDP). Therefore, the relationship between the 'per capita income' and the density of physicians has been the focus of attention for researchers in this area. Analysis from OECD countries, including the United States has been identified the relationship between physician distribution and per capita income multiple times [16].

According to Newhouse et al. [17] geographic concentration of income is an important factor in distribution of physicians; size of towns is the second factor. "Standard economic theory, (neoclassical) assumes that physicians seek to maximize their profit and therefore tend to practice in regions with high income. The existence of a positive relationship between the number of physicians and the level of income has been proven empirically [18].

As long as physicians provide services without being subject to public intervention, their location is decided by the GDP in the region. "Increase in per capita income, a measure of community wealth, was significantly associated with an increase in the number of physicians… residential population size and community wealth were still strong determinants of change in local physician supply" [19].

The market demand for physicians increases with the level of GDP. The increase in GDP also affects the demand for specialist physicians. This also increases the overall demand for general healthcare. When comparing specialist physicians with practitioners, special physicians work with market demands with higher GDP communities; therefore, higher GDP cities have a larger number of specialist physicians than the lower GDP areas. When we observe an increase in an area's GDP, we also observe an increase in specialist physicians.

''In normal competitive markets, an increase in supply results in price reductions that, in turn, may induce increased consumption. Empirical studies of the medical care system, however, sometimes contradict these two basic behavioral patterns. Fees were sometimes positively, rather than negatively, related to physician supply; even without price declines, the per capita consumption of medical care also seemed positively related to supply. To explain this anomalous behavior, two related target-income theories were proposed: the fee control model and the physician-induced demand model. The first suggests that as physicians find themselves with fewer patients, they raise their fees to maintain a desired level of income'' [20]. In other words, the service providers in the health care service system struggle to maintain their income [14].

Medical practice in Japan is financially based on a fee-for-service reimbursement system. There is no restriction on practice location. Physician distribution is determined largely by the market and by physicians' individual preferences. Physicians prefer geographically attractive urban areas with high income. These lead to geographic maldistribution of physicians [7]. This can lead to the concentration of primary care physicians in urban areas resulting in a shortage in rural areas [21].

Therefore, societal perspective market mechanisms alone do not allow and adequate supply of health personnel to be reached, public interventions such as human recourses planning are a means to correct for market failures [22].

Health authorities are carrying out necessary practices to increase the number of physicians almost all over the world. However, increasing the number of physicians is not a solution for the distribution problem. Despite the increase in the number of physicians, the distribution imbalance continues to exist [10, 21, 23].

3. MATERIAL AND METHOD

In this study between 1991 and 2000, the number of physicians to population data by province and GDP were used. For GDP analysis, Turkish Statistical Institutes' between the years 1987 to 2000 data was used [24]. In particular, our reason to choose this period is due to the presence of provincial GDP data for this period in Turkey.

Number of specialists and general practitioners (GPs) per 10,000 population and, per capita income[1] constituted the input for our analysis. We decided to include the data of 70 cities (out of 81) and 1991 to 2000 (10 years) period to obtain a complete data set with maximum number of years and maximum number of cities.

In our original plan we were supposed to investigate the 1987 to 2000 period with 81 cities, but during the aforementioned period (at different years) the government restructured the boundaries of some of the cities and created "new" cities. It was not possible to trace back some of the "new" cities' data. Therefore for the sake of balanced and widest data we decided to drop data of some of the cities and the periods. The city, "Kırıkkale" was also dropped from the data (even though it has a complete data set) because, in our preliminary analysis it was detected as outlier.

Multilevel Regression Analysis (a growth model) has been utilized in order to determine if specialists and GPs prefer higher income cities and the preference is more among specialists compared to GPs. We set up two regression analyses: In one of them, "number of specialists per 10,000" is the dependent variable and in the other, "number of general practitioners per 10,000" is the dependent variable. We started with the null model and finalise it with a two level random coefficient model where "per capita income" and "year" are the explanatory variables. We specified random effects at the city-level. Besides random intercept we allowed random slope on "year". In order to let both the intercept and the "year" slope depend on "per capita income", the interaction term "per capita income x year" has been added to the regression equation for a cross-level interaction. The analyses were performed by STATA 10.0.

4. RESULTS

Null Model (the Intercept-Only Model)

The intercept-only model (the intercept vary across cities) is useful that serves as a bechmark with which other models are compared [25]. For our data, the intercept-only model is written as:

$$Specialist_{ij} = b_0 + u_{0j} + e_{ij} \quad i = 1, \ldots, 70 \text{ and } j = 0, \ldots, 9$$

$$GP_{ij} = b_0 + u_{0j} + e_{ij}$$

The regression coefficient (b_0) estimates the grand mean of the dependent variable (average number of specialists or general practitioners per 10,000 across all cities), and the residuals (e_{ij}) are the individual deviations from the mean. The term, u_{0j} represents the deviations of the city means from the grand mean.

[1] Input as x1,000 TL. Each year's PCI has been divided by the GDP deflator (1998=100) of that year in order to reflect real income variations.

Table.1

The Null Model	Specialists		G. Practitioners	
Fixed Part	*Coefficient*	Standard Err.	*Coefficient*	Standard Err.
Intercept	2.93	0.27	5.12	0.26
Random Part				
σ_e	0.52	0.01	0.85	0.02
σ_{u0}	2.29	0.19	2.12	0.18
(ICC)	0.95	0.01	0.86	0.02
Deviance	**1431.23**		**2043.47**	

Average number of "specialists per 10,000" (b_0) is 2.93 (Table.1). Between city variation (σ_{u0}) is 2.29 which points to a high variation. Within city variation (σ_e) is 0.52. ICC (Intraclass Correlation - the proportion of the variance explained by the grouping structure in the population) equals to 95% indicating clearly that a multilevel model is required [26].

For general practitioners, the average number of "GPs per 10,000" is 5.12. σ_{u0} is 2.12, again pointing to a high variation. The high level of ICC 86% , warns us to conduct multilevel model.

Indeed, the graphs of number of specialists and GPs per 10,000 versus time (each line presents one city) suggests a linear growth, city-specific random intercepts and city-specific linear trends (Fig.1 and 2).

Fig.1

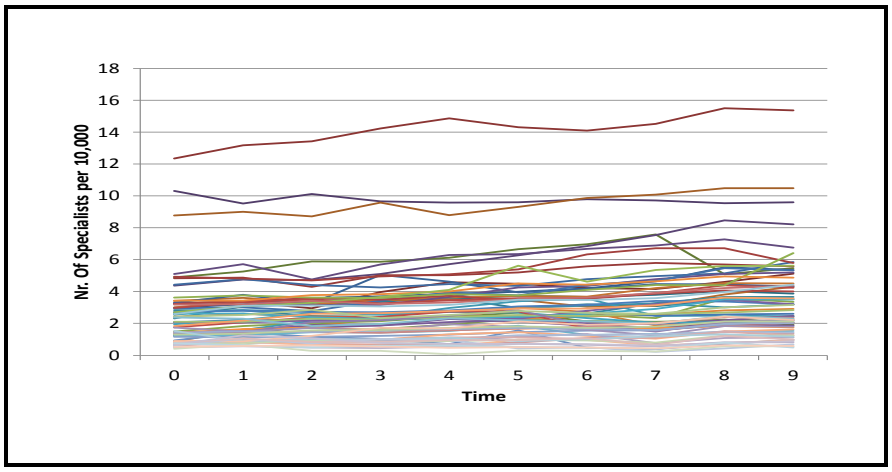
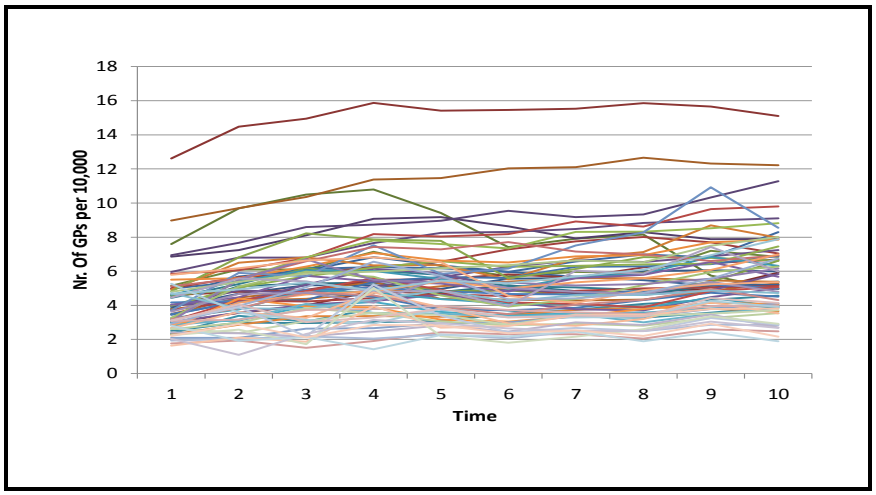


Fig.2



Random Coefficient Model with One Explanatory Variable – "Year"

Since number of specialists and GPs growth per 10,000 vary from city to city through the years, we included "year" as an explanatory variable allowing for a random intercept and random slope on "year":

$Specialist_{ij} = b_0 + b_1*year_{ij} + u_{0j} + u_{1j}*year + e_{ij}$

$GP_{ij} = b_0 + b_1*year_{ij} + u_{0j} + u_{1j}*year + e_{ij}$

Table.2

Random Coefficient Model	Specialists		G. Practitioners	
Fixed Part	*Coefficient*	Standard Err.	*Coefficient*	Standard Err.
Intercept (b_0)	2.47	0.25	4.48	0.24
year (b_1)	0.10	0.01	0.14	0.02
Random Part				
σ_e	0.30	0.009	0.59	0.02
σ_{u0}	2.08	0.18	1.97	0.17
σ_{u1}	0.09	0.009	0.14	0.01
σ_{u01}	0.43	0.11	0.11*	0.13
Deviance	871.82		1707.69	
*: Not significant				

As for Specialists; average number of specialists per 10,000 is 2.47 across cities at the beginning of the 10-year period, and the standart deviation of the constant (σ_{u0}) is 2.08 (SE= 0.18) indicating a high variation of the constant (Table.2). The regression coefficient of "year" is 0.10 (which is significant at 95% confidence level - 95% confidence interval is 0.08 and 0.13) meaning that average number of specialists per 10,000 increases by 0.10 each year. The SD of the coefficient of the "year" variable (σ_{u1}) is 0.094 (SE=0.009) also pointing to a significant deviation. The random intercept and slope have a positive correlation (σ_{u01}) of 0.43. This means that cities that tend to show higher number of specialists per 10,000 for average cities also tend to show higher gains in number of specialists per 10,000 per year.

As for GPs; average number of GPs per 10,000 is 4.48 (SE=0.24) and increases by 0.14 (SE=0.02) each year. The SD of the intercept (σ_{u0}) is high (1.97; SE=0.17) but not as high as compared to the specialist's situation. The variation of the coefficient of the "year" variable (σ_{u1}) is 0.14 (SE= 0.01) pointing to a high deviation at city level. We can also use the standard normal distribution to estimate the percentage of regression coefficients that are negative: 15% of the cities are expected to have a regression coefficient that is actually negative[2] (for specialists it is 14%).

[2] Mean regression coefficient (b1) is 0.14 with sd (σu1) of 0.14.

Given the large and siginificant variance of the regression coefficient of "year" across cities it is attractive to attemp to predict its variation using city level variables (i.e. per income capita).

Random Intercept and Slope with One Explanatory Variable – "year" and by Introducing One Explanatory Variable – "per capita income" at the City Level (2-Level Regression Model)

Taking up from our last premise we added "per capita income (PCI)" as level-2 explanatory variable. However we grouped cities into two, with respect to their 10 year average PCI, as high income and low income cities. The dividing line between the two groups is the median 50 (cities were listed from high to low income and upper median 50 is labeled as "high income - SES_1" and lower median 50 as "low income - SES_2").

The regression equation (for the specialists) was constructed as follows :

$$Specialist_{ij} = b_{0(SES\_1)}\, SES\_1_{ij} + b_{0(SES\_2)}\, SES\_2_{ij} + b_{1(SES\_1)}\,(year_{ij} * SES\_1_{ij}) + b_{1(SES\_2)}\,(year_{ij} * SES\_2_{ij}) +$$

Fixed part

$$u_{i0(SES\_1)}\, SES\_1_{ij} + u_{i1(SES\_1)}(year_{ij} * SES\_1_{ij}) + u_{i0(SES\_2)}\, SES\_2_{ij} + u_{i1(SES\_2)}(year_{ij} * SES\_2_{ij})$$

Random part

Table.3

Random Coefficient Model Adding Level-2 Explanatory Variable (per capita inc.)	**Specialists**		**G. Practitioners**	
Fixed Part	*Coefficient*	Standard Err.	*Coefficient*	Standard Err.
Intercept ($b_{0(SES\_1)}$)	3.58	0.41	5.37	0.38
Intercept ($b_{0(SES\_2)}$)	1.36	0.13	3.59	0.20
Year*SES_1$_{ij}$ ($b_{1(SES\_1)}$)	0.14	0.02	0.16	0.03
Year*SES_2$_{ij}$ ($b_{1(SES\_2)}$)	0.06	0.01	0.12	0.07
Random Part				
$\sigma_{(SES\_1)}$	2.40	0.29	2.21	0.27
$\sigma_{(year * SES\_1)}$	0.10	0.01	0.15	0.02
$\sigma_{(SES\_2)}$	0.73	0.09	1.14	0.15
$\sigma_{(year * SES\_2)}$	0.08	0.01	0.13	0.02
Deviance	**806.43**		**1677.59**	

Specialists

The regression coefficient of SES_1 (3.58; 2.78 – 4.37) is significantly higher than that of SES_2 (1.36; 1.11 – 1.61) meaning that SES_1 is on the average 2.22 points higher on number of specialists per 10,000 (Table.3).

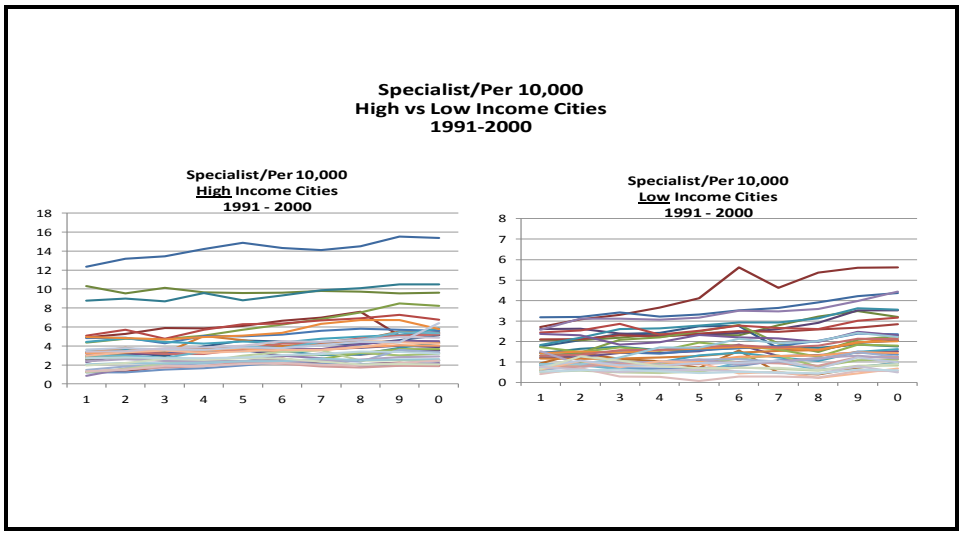
The difference between SES_1 and SES_2 grows wider as years pass by (the growth of number of specialists per 10.000 per year is significantly higher in SES_1 than that of SES_2).
year * SES_1= 0.14 (0.11 – 0.18)
year * SES_2= 0.06 (0.035 – 0.09)

This concludes that there is a systematic difference in the overall population mean line between SES_1 and SES_2.

SD (SES_1) is 2.40 (1.90- 3.04) and it clearly shows that regression slopes for SES_1 vary across cities significantly. SD (SES_2) is 0.73 (0.57 – 0.93), it means that regression slopes for SES_2 vary across cities significantly,too, however the variation in SES_2 is far below than that of SES_1 (i.e. SES_1 and SES_2 demonstrate different variability about their respective average lines) (Fig.3).

SD (year * SES_1) and SD (year * SES_2) are significant but are very low to have a significant impact.

Fig.3



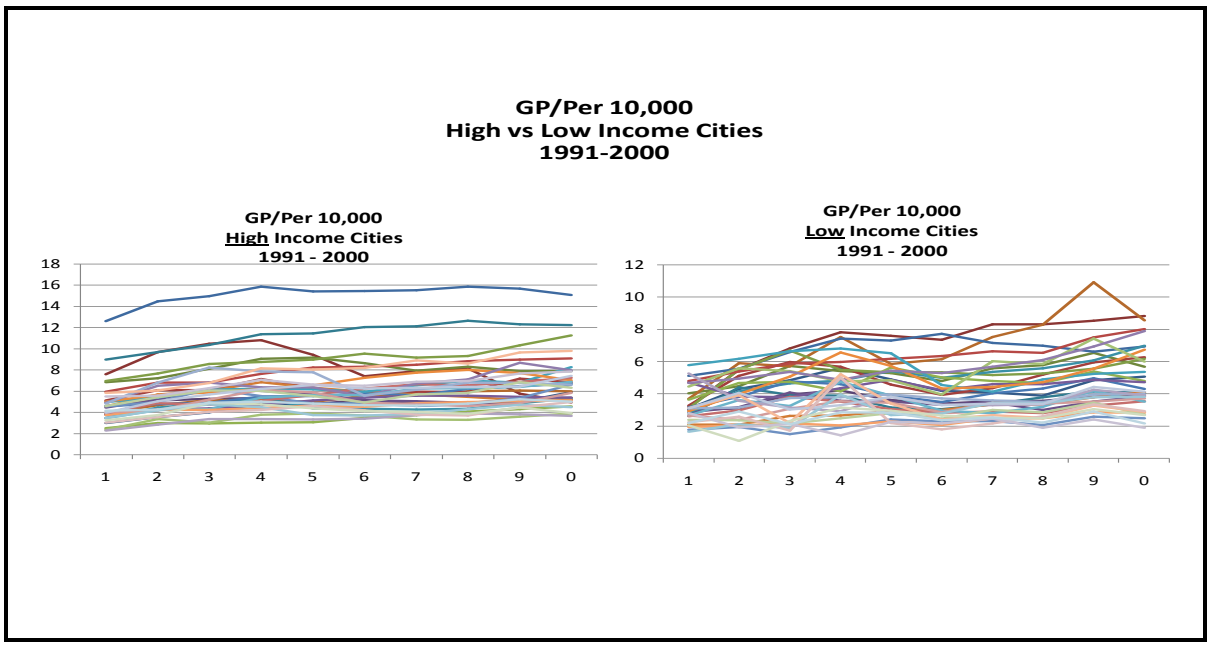
GPs

The regression coefficient of SES_1 (5.37; 2.63 – 6.12) is significantly higher than that of SES_2 (3.58; 3.20 – 3.98) meaning that SES_1 is higher on number of GPs per 10,000.

The difference between SES_1 and SES_2 with respect to the growth of number of GPs per 10.000 per year is not significant. This means that the difference between the two groups with respect to number of GPs per 10.000 (the difference in regression slopes) is significant but the difference is not growing at a higher rate as years pass by.
year * SES_1= 0.16 (0.11 – 0.21)
year * SES_2= 0.12 (0.075 – 0.17)

SD (SES_1) is 2.21 (1.7 - 2.81) and it clearly shows that regression slopes for SES-1 vary across cities significantly. SD (SES_2) is 1.13 (0.88 – 1.46), it means that regression slopes for SES_1 vary across cities significantly however the variation in SES_2 is far below than in SES_1 (Fig.4).

Fig.4



5. DISCUSSION

Studies on OECD countries indicate that (as demonstrated by cross-sectional studies); there is evidence of a correlation between the level of economic development of a country and its level of human resources for health. Countries with higher GDP per capita are said to spend more on health care than countries with lower income. While the distribution of medical practitioners is more balanced in many countries, due to the higher demand of specialist physicians from people with high income, it is seen that there is not a balanced distribution of specialist physicians [27, 28].

In our study, through the years even though there is a decrease in the acceleration rate of increasing number of specialists and GPs who prefer higher income cities and the preference is more among specialists compared to GPs. The variation of number of specialists between the cities is much higher compared to GPs. Cities with higher number of doctors initially attract more doctors as years pass by. The correlation is higher among specialists compared to GPs.

Matsumoto et al., [29] indicate that constant increase in the number of physicians per unit population during the past 25 years did not result in an equal distribution of physicians proportional to community population in Japan and the US, there is no improvement of inequal distrubution of physicians. The US physicians may continue to concentrate according to income, rather than according to population health needs. Correlation between physician-to-population ratio and per capita income among the communities was stronger in the US than in Japan and has increasingly been strengthened during the period 1980 and 2005.

In the study of Toyebe et al., [30] compare the numbers of physicians in Japan between 1996 and 2006, as the number of physicians increase, working at hospitals has significantly increased in urban wealthy areas. This results into exacerbation of mal-distribution of physicians between urban and rural areas. The unequal distrubution of physicians between the urban and rural areas will be a long term trend in Japan.

In our study, we have found that, between 1987 and 2000, as the income level of the cities increased, the number of physicians in those cities increased as well, and we have determined that this relation is stronger for specialists than practitioners.

With increased specialization, physicians need access to large populations to find sufficient number of patients, populations with enough financial resources to afford the expensive treatments. Population with lower household income or regions with lower socioeconomic status were associated with fewer specialists per population [1, 31].

The study of Rutten [32] is to determine the macro-economic impacts of migration of skilled medical personnel from a receiving country's perspective; health workers migrate to beter developed countries to improve their socioeconomic and financial situation or for the purpose of career development. Migration of health care workers can seriously impact the regional distrubition of physicians. There is a relation between the economic development level of a country and its human resources for health. In both developed and developing countries, rural ares of physicians have much lower concentration in contrast to urban areas [22].

In the study of Isabel et al., the geographic disparities in physicians density is a result of geographic income inequality. As a result, the socioeconomic level of the cities are improved and there will be an equal regional distribution and observed inequlity of physicians to population ratio will be decreased [18].

The increasing political attention for addressing health inequalities needs to be accompanied by more evidence on how to ensure that interventions reach lower socio-economic groups [33]. To improve the imblanced socioeconomic factors between the urban and rural areas, adequate number of health care workers, determined and rationalist political approach are the essentials for equal distribution of the health workforce [6].

Limitation of this study is that only physician to population ratio and GDP was used for assessing geographic imbalances of physicians. Health status, number of hospitals and hospital beds, healthcare needs, branch of medical practices or physicians demands of employment were excluded from this study.

Turkish politicians consider primary reason for unequal distribution of physicians is to increase the number of physicians. However, only increasing the number of physicians is not a real solution for the problem of the unequal distribution. Despite the increase in the number of physician per population, the distribution imbalance continues to exist.

6. CONCLUSION

Comparing our final model (in which we have introduced PCI as class variable) with the previous one (random coefficient model with one explanatory variable – "year") yields the following:

- The deviance test (Hox, 2002), comparing two models is significant for both specialists and GPs at 95% confidence level ($p<0.001$ for both). This is to state that our final model fits significantly better than our previous models.

We noted down the following conclusions as per our final model reveals:

- Comparing intercepts, it is revealed that either the number of specialists or GPs per 10,000 in the "higher income cities" (SES_1) is higher than that of the lower income cities (SES_2).
- Among specialists; annual growth rate for the number of specialists per 10,000 is significantly higher in SES_1 compared to SES_2. In other words, the gap between the higher and the lower income cities has grown during 1991 and 2000 period. Among GPs, there is no statistical evidence that the gap between the SES_1 and SES_2 is getting wider.

As per our findings we concluded that there had been geographically unfair distribution of physicians and this continued, indeed, deteriorated between the years 1991-2000. Cities with high income attracted more and more physicians, and this tendency is more among specialists compared to the GPs.

In our study, during the 10-year between the 1991 and 2000, we found that as the GDP increases so does the level of specialist physicians and practitioners. All of which shows, that the permanent solution to inequality of healthcare and distribution of specialist, physicians and practitioners can be effected by the reduction of socio-economic disparities.

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LEGAL DISCUSSIONS ON SURROGATE MOTHERHOOD

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A R T I C L E I N F O

Key words: Surrogate motherhood, IVF method, Islamic Fiqh, religious aspects**.**

Abstract

The surrogate motherhood and IVF (test-tube baby) practice has currently reached an advanced level and people who are not allowed to pregnancy for medical reasons, look at positively the surrogate motherhood. The surrogacy is permitted worlwide in many countries like USA except in New Jersey, Michigan and Arizona states). Georgia, Thailand, India, Belgium, England, Brazil, some countries of Africa. It is banned in Germany, Sweden, Italy and Norway.

In Turkey, The Presidency of Religious Affairs has given a permission that there is no harm in IVF method. Although the practice of surrogacy seem to be as an aid to couples without children, it has some legal, social and psychological problems, such as, the status of child, her/his custody, moral degradation in society, degrading the human dignity and emotional problems of the child and surrogate mother.

The Islamic jurists made surrogate motherhood is impermissible due to generating problems of cultural, religious, juristical, individual and social, On the otherhand, Twelver Shia jurisprudence have accepted surrogacy within the frame of mutah marriage. Based on the five principles of conservation of life, protection of generation, protection of

intelligence, protection of property and protection of the religion, the over all the Islamic jurists have forbidden all types of surrogacy and artificial fertilization with aggreement.

This applications must be controlled to some extent by the competent governmental authorities throuhout the world and some regulations should be introduced for this.

1.Introduction

The Surrogacy (surrogate motherhood) and IVF (test-tube baby) practice has now reached an advanced level. In this study, it is addressed and examined that both the current IVF practice technologically came to what level in terms of health technology, as well as the problems emerging from intersection of reached point with society's religious, social, cultural and moral the understandings. The woman who is married and could not have children and due to lack of a uterus to carry the crop of pregnancy or for any reason inability to conceive; getting pregnant by placing the embryo resulting from outside fertilization of sperm taken from men with egg cells of woman in another woman's womb, carrying the baby in her womb and woman giving birth is called surrogate mother. Those who do this process for a fee is called to ""rent surrogate mother", and those who do without being paid named as "volunteer surrogate mother" [1]. The cases causing for surrogacy are as follows: Either the woman has no egg or the woman has the egg but there are medical obstacles to pregnancy. Else or permanent pregnancy loss and, even if the uterus exist, there are cases where the uterus is conducive to pregnancy. Also cases where a woman's risk of giving birth are involved. There are those whose womb had to be taken at young age or born with no uterus

People who are not allowed to pregnancy for medical reasons, look at positively the surrogate motherhood. Babies born this way carries the genes of their parents. In other words, spouses are the baby's biological mother and father. If there is a problem with the woman's eggs or she has no ovary, in this case the egg cell can also be received from a third person as well as surrogate mother. If the egg is taken from surrogate mother, in this case she is genetically also mother of the baby.

1.1 Surrogate Motherhood In Our Country: In our country, the baby's mother legally is considered the person gave birth to a baby. The Hadith related to this matter is like this" The child born belongs to owner of the mattresses. There is also deprivation to adulterers" [2] ,[3]. Based on this, the person is the mother who gave birth to baby regardless from whom eggs or sperm are taken. The views of lawyers about surrogate motherhood are as follows: Eventhough surrogate mother gave birth to the baby, the parents who claim the baby, have to register the baby's birth registration on them; this case will means changing of the baby's paternity. This is because the biological mother of baby is the one who owns the baby, so the mother is the one who has given the egg. However, the person who will receive the baby in her pedigree is the mother given birth to a baby. This will also mean the changing of baby's paternity, and this behavior is considered a crime according to the Turkish Penal Code [4]. In our country, the application of surrogacy has not been accepted as legal [5].

The following conclusion is depicted from a fatwa given by Presidency of Religious Affairs in response to a question asked: There is no harm in IVF method, provided that a fertilized egg should develope in the womb of woman who is the owner

of the egg, not in another woman's womb, and this process has medically proven having no negative effects on physical, spiritual and mental health of both parents and the child to be born. But, the following statements are also made on the continuation: The starting and resulted test-tube baby (IVF) application is not permissible between the persons who are not actually married since it degrades or hurts the feelings of humanity and transports the elements of adultery.

1.2 Countries Allowing Surrogacy: In some countries surrogacy is permitted. These countries are: Georgia, Thailand, India, Belgium, USA, England and Brazil. Surrogate motherhood is also permitted in many countries in Africa. In law in Cyprus the phrases have been used such as, surrogacy can be done likewise and also can not be done. Although the surrogacy is banned in Turkey, there are some going secretly abroad to perform this operation. In Turkey, surrogate mothers are illegally rented at a higher amount by disobeying the ban. In social media, those who want to be a surrogate mother in return for a fee to the couples who can not have a child, by giving their contact information and informing that they can be a surrogate mother. Most of the women announcing this advertisement are married and their spouses or husbands also support them on this regard. But those who want to do it legally apply to the private hospitals in Georgia, not doing it in Turkey. Those who want to make this process in Turkey are invited to Georgia by agencies.

In Georgia State the surrogacy is officially implemented in the state control and by making contract with surrogate mother within a framework of a certain program. Georgia with her legal framework for surrogate motherhood is one the few countries that provide international surrogacy [6]. According to Georgia legislation surrogate mothers never own the baby after the birth. The eggs and sperms are obtained from the couples applied for the surrogacy process and by fertilizing these eggs and sperms like in test-tube baby (IVF) process they are transferred into the womb of surrogate mother. For this process, before the embryo transfer for the development of female eggs in vitro fertilization (IVF) treatment of woman of applied couples is performed in the city she lives. While this treatment is made, the surrogate mother is simultaneously prepared for embryo transfer in a clinic in Georgia. When approaching the end of treatment, the couples perform the operation by going to Georgia. The contract is certainly signed before the operation. The name of surrogate mother is not written on the birth certificate only mother and father's name are written.

This application is free in many countries in Europe, except in Italy. In Italy, the practice of surrogate motherhood is prohibited by the results of the referendum with 51 % vote due to the influence of the Pope, the leader of the Catholic Christians, who lives there. This practice is partly allowed in Ukraine, Russia, Spain, England, Belgium, Holland, France, Crete Island dependent of Greece, and in Iran. The mutah marriage in Iran serves to facilitate this event. The man accept, the woman who will donate the egg, as his wife with temporary marriage, after the egg is taken according to Twelver Shia jurisprudence, under which Mutah is practiced, man leaves her and goes back to his ex-wife.

In USA, the practice of surrogacy is free except in New Jersey, Arizona and Michigan. On the other hand, it is banned in Germany, Sweden and Norway. In Australia, it is recognized free except for one province. The families can bear the costs of the surrogate mother until the baby is born [7].

In the legal context as being example for some remarkable problems that may require the control of IVF centers; the cases can be mentioned that the magazine world's few famous people making decision among themselves to have child out of wedlock. In this context again, the unwanted applications include acquiring hundreds of children from the same person's sperm taken from a sperm bank. Such inconvenient practices constitute sufficient reason to keep this work under control on a global level and for taking necessary measures.

The definition of a crime within the meaning of hiding and changing of legitimacy is held in TCK's 231. matter [8]. Here the main interest is the benefit of the child. The paternity is important from point of the fact that the family constitutes the foundation of society and state, and for having the right to determine the future of the embryo. As a rule, the child is always connected to the mother.

2. Materials and Methods

With this study, the religious dimension of the issue is tried to be clarified in terms of different fiqh sects (Islamic Jurisprudences) and even from the point of different religions. Both the ideas were acquired and defined by recoursing to related experts about how in vitro fertilization process developed and the approaches were tried to be uncovered on this subject by researching various sources of Islamic Jurisprudence (Fıqh) and the opinions of the different schools of fiqh related to the process definition emerged.

3. Results

The criticism might come about surrogate motherhood of the following points:

In case of acceptance of human body as a commodity or known ordinary goods that can be sold in exchange for predetermined amounts, the corruption in society, an unfair and unjust access and distribution system are invited, since in this kind of system the rich are always be on receiving side, the poor will be on giving side [9].

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3.1 Legal Aspects of Surrogate Motherhood: In case the surrogate mother is married,the husband will be considered the child's legal father, the genetic father can not legally recognize the child provided that he did not refuse the lineage. If the surrogate mother is not married, then the child will be in the status of child out of wedlock and therefore, the custody of the child will be in surrogate mother. In addition to these, there may be the cases, such as the surrogate mother is not giving baby back by saying that the baby belongs to her or decide to make abortion by ceasing to have a baby. As it can be seen that the surrogacy application will raise many legal issues in content [10].

3.2 Sociological and Psychological Aspects of Surrogate Motherhood: The maternity is not just giving birth to baby by bearing the baby in the womb. Although the pregnancy and birth, are biological things, it should be noted that it has emotional aspects. Though the surrogate mother carry a baby, who is not belong to her, in her womb, having an emotional closeness during pregnancy is not something that can be avoided. It should not be looked at this event just from point of surrogacy. How the baby's genetic mother, who will take the delivery of baby, will establish a bond with the baby, and how to acquiesce to the baby is also a controversial issue. Although the science has been developed and many scientific studies have been put forward, there are no specific study about to examine and set out the prospective social and psychological status and aspects of developments of the children born by this method

Although the practice of surrogacy seem to be as an aid to couples without children, there are many social and psychological discussions under it. By ignoring them all, whatever happens, to address the issue only in the framework of having a child is quite wrong angle of view [11].

3.3. Religious Aspects of Surrogate Motherhood: The scholars of Islam stated that the purpose of the religion is the protection of the five basic principles which the religious and worldly affairs depends on itself. These five principles are as follows: conservation of life, protection of generation, protection of intelligence, protection of property and protection of the religion. In the context of generation protection, as Islam prohibited living together out of wedlock, similarly has banned the ways that could lead to it. Although the practice of artificially fertilization of man's sperm with the surrogate mother's eggs and placing it in the womb of surrogate mother is not considered adultery with truest sense of the word, while bringing baby to the world by the help of reproductive technologies, it has gone willingly or unwillingly beyond the institution of marriage and the principle of protection of lineage and generation has been violated [12].

Maternity is accepted as long as in natural ways. Surrogacy is strictly forbidden. In Qura'an Allah (C.C) has stipulated that the child's mother is the woman who gave birth to. "Those among you who make their wives unlawful to them by (Zihar i.e. by saying to them "You are like mey mother's back") they can not be thier mothers except those who gave them birth. And verily, they utter an ill word and a lies. And verily, Allah is Oft-Pardoning, Oft-Forgiving" [13]. In another ayat, it is also ordained that" And We have enjoined on man (to be dutiful and googd) to his parents. His mother bore him in weakness and hardship upon weakness and hardship, and his weaning is in two years" [14]. Today's medical and scientific research say that all kinds of internal state (like what she is eating and drinking) of a mother carrying a baby in the womb has significant impact on nature of the child to be born

Some typical problems resulting from the practice of surrogacy is sufficient to prove the fallacy of this practice. The following problems can be listed as examples on this subject; it causes moral degradation in society, perceiving baby as a thing that can be bought and sold, considering woman as a "baby birth machine", and also emotional problems may be experienced by the child to be born and by the children of surrogate mother.

This idea that destroyes the human dignity, and though hiring woman to a certain period of time, by taking opportunity of knowing the financial hardships and difficult circumstances which she is in, looks at women (who is the most valuable asset) as a highly disreputable commodity. This idea does not have a base in principles and values of Islamic teachings and can not be explained consistently [15]

4. Discussion

As for the causes of differences of opinion around the world these can be summarized as follows:

It is a clear fact that the societies, looking at the issue in terms of religious and moral perspective, are skeptical to allow surrogacy application. But in countries where the society has gotten away from religious point of view and seeing everthing permissible for sake of freedom or accepting surrogacy as legal, the permission for surrogate motherhood is easily given.

As mentioned above İslamic jurists, based on the idea that this application can generate many problems of cultural, juristical, individual and

social, say that surrogate motherhood is impermissible. They can not accept it since this application at foremost means opposing to the divine will. Yet they argue some verses as evidence [16]. In this context, they also mentions this verse " To Allah belongs the kingdom of the heavens and the earth. He creates what He wills. He bestows female (offspring) upon whom He wills, and bestows male (offspring) upon whom He wills. Or He bestows both males and females, and He renders barren whom He wills. Verily, He is the All-Kower and is Able to do all things" [17].

Some scholars, argue that the surrogacy is permissible, say that there is no definite prohibitive Quranic verses on this issue and they assert that the original thing in goods is the doctrine of permission [18]. They defend that yearning for a child is the basic need for individuals and even they look at it as a requirement of the principle of necessity to increase the lineage . They claim that the alleged problems could arise in the future might possibly be solved with some legal and medical arrangements.

Beside these discussions, according to the over all the Islamic jurists, when a third party person is mixed to the fertilization of the germ cell, all types of surrogacy and artificial fertilization are forbidden with aggreement. The all types of applications that are done through the donation of sperm or egg and mixture of reproductive cells with the cells of a strangers or those performed without any medical necessity are forbibidden. Thus, Islamic Fiqh Academy is certainly found surrogacy inconvenient by its decision taken in 1985 [19].

5. Conclusion and Suggestions

To put the problem in general surrogacy is not considered appropriate by Sunni scholars [20]. On the other hand, there are some Shiite scholars who see it permissible. Although it is as an opinion of minority, some Islamic jurists have given permission to this process only under certain conditions

Should I express this matter as a person who is investigating and questioning, the surrogate motherhood in Islamic Fıqh is forbidden. Having children of married spouses is a grace of Allah (C.C) to them. Beyond this, it is considered accurate, up to a point, for those people without children somehow to apply to treatments and search for cure in this way. On the continuation of this process, if the problem is still unsolved and if the experts are suggesting IVF (test-tube baby) to the family, this application is also legitimate. Despite everthing, people without children should never involve a relationship out of marriage, whereas they must be steadfast to the discretion of Allah (C.C). It might be advised to the women who could not get a result at all, to be a foster-mother for the babies not reached at two years of age yet by breastfeeding and to establish a milk kinship between them and themselves. However, also on this way, true maternity facility absolutely has not been considered to be established. The most stable and most accurate way to keep or for the maintenance of human generation and descent, there has to be marriage bond between men and women only. In our religion, unification of men and women and having a closeness is named prostitution so called evil. Therefore, externally surrogacy application degrades to human dignity. The lineages of children produced in this way are mixed. As stipulated by Islamic law, the protection of each individual's modesty and dignity is a fundamental principle in society. It is obvious that in future secret or open talks will be made about the child produced in surrogacy, his/her personality will be offended and his/her dignity will be broken

This kind of behaviors are not welcome by religion. Besides the method of surrogacy, striving to have a child against all odds, is interpreted as an

attitude contrary to the divine will and Allah's creation that this attitude has also been condemned in religion [21]. In some of the ways of surrogacy application when a father or mother of the child is not known clearly, then adoption, paternity can not assign inheritance. Beside the nexus and relationships desirable between the people have broken and also that child would be deprived from heritage.

Apart from these, there are problems arising from public concern and when parents of the child, as a foreign entity, share the same home or environment with child problems may arise. In addition, problems are also found such as when breaching of the distance between the mother who is in position of carer and child the child and when the child acts rebellious he/she is easily dismantled by elders and thrown into the Street.

At the global level the number of travel agencies, health agencies and organizations that shed this work to trade and health tourism is increasing every day. It is also true that the number of companies engaged in organization of hiring, selling, donation, transferring of sperm, eggs and ovary and surrogate mothers will increase exponentially by each passing day

The contact information circulating on the internet is the most obvious evidence of this. Moreover, as a human being does not have the right to rent out his/her organs, it is not legitimate religiously and morally opening his/her own intimate parts in the treatment process with such purposes. Having child with the cells of ones from outside without the bond of marriage also leave the health care workers under the suspicion and it leads to shake confidence against these institutions. The most accurate way for the people is to submit nicely to Allah's discretion about themselves and to trust in Allah.

New developments in the field of health and artificial reproductive techniques and their applications must be controlled to some extent by the competent governmental authorities and some regulations should be introduced for these. Otherwise, some people who take advantage of legal gaps will exploit these dazzling developments in the field of medical technology. We believe that this field should not be left adrift. Allah knows the best.

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BALANCED SCORECARD APPLICATIONS IN HEALTH CARE

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A R T I C L E I N F O

Keywords: Healthcare Management, Performance Evaluation, Balanced Scorecard

Abstract

With reference to the saying 'You can't manage what you can't measure' making management by measuring is possible with Balanced Scorecard which is one of the performance evaluation models. It is not only accepted as an element of strategic management, it is also accepted as a management system that allows the business strategies become measurable. Balanced scorecard provides the businesses to be evaluated in a holistic sense by means of financial, customer, internal processes through learning and development aspects. This model can also be used in many industries to improve corporate performance. The model which is also increasingly being used in the health sector, has also been found that it can be applied in health care organizations in different scales. The study aims to examine the feasibility and assessment of the Balanced Scorecard in terms of the aspects used in the health care.

1. Introduction

In addition to the successful implementation of the Balanced Scorecard in service and industrial establishments, the implementations in the hospitals can be seen in many countries despite the scarcity of the number [1]. The Balanced Scorecard was changed by various researchers and applied in health care providers and suggested to be an effective performance measurement model [2]. According to Zelman, it's also been confirmed that Balanced Scorecard implementations exist in the health sector group including hospital systems, hospitals, university departments, long-term care services, psychiatric centers, insurance companies, national health service organizations, federal governments as well as local governments [3]. Chang et al., implemented the Balanced Scorecard successfully in Mackey Memorial Hospital which has 2149 beds and more than 9.000 outpatients daily. They attributed this to two reasons: Firstly, The Balanced Scorecard management team consisted of senior executives and board members from the beginning of the implementation, secondly the modular Balanced Scorecard implementation which was launched successfully, was implemented to the entire organization two years later, depending on the budget planning. It can be concluded from this that the Balanced Scorecard which can be implemented in Mackey Memorial Hospital successfully can also be implemented to the other health care organizations [4]. According to the results of the research carried out in 121 hospitals out of 555 hospitals in Canada by Chan and Ho, 80% of the hospitals namely 97 hospitals have heard the Balanced Scorecard before and 43 hospitals have been implementing the Balanced Scorecard [1]. As a result of this implementation, the Balanced Scorecard have been recognized as one of the modern management tools by hospital managers. According to Coşkun, the Balanced Scorecard can also be used for the hospital units, too. There are Balanced Scorecard samples prepared for Pediatrics, cardiology, intensive care units, hospital emergency room, anesthesia units, burn treatment center, cardiology unit, obstetrics and mental illness treatment centers available [5]. An example to be given for one of these departments is that Chun-Ling uses the Balanced Scorecard that they prepared to measure the patient flow and patient density level in the emergency unit [2].

2. Balanced Scorecard Implementations in Health Care

When the studies are revealed, it is seen that Balanced Scorecard implementations exist in many countries, mainly the USA.

a. Mayo Clinic

Mayo Clinic-specific key performance measures are determined by the team that developed the measurement system. As a result of the collection and analysis of data that will contribute to the formation of the Balanced Scorecard four performance criteria within eight dimensions were determined on [6]:

1. Customer satisfaction: Primary care and minor health care delivery rate,

2. Clinical efficiency and effectiveness: The clinical efficiency of physicians per capita for each working day of each business day for the number of physicians per capita outpatient treatment,

3. Financial: costs of service units,

4. Activities (internal processes): The average examination time in one day, patient complaint rates, waiting times of patients,

5. Mutual respect and diversity: percentage of staff from the less represented groups, employee satisfaction surveys,

6. Social responsibility: Mayo Clinic's contribution to society,

7. Foreign bystanders' hospital assessments: environmental studies done by organization managers, Mayo Clinic's market share,

8. Characteristics of the patients: geography and income groups of patients.

b. Duke Children's Hospital

The most used strategic aspects that Duke Children's Hospital used in the performance measurement via the Balanced Scorecard are research, education, and training aspects instead of the customer and financial aspects [7], [8].

c. Bridgeport Hospital

At the beginning of 2000, the Balanced Scorecard Implementation was based on 12 critical success factors established by 56 criteria. By the year 2001, Bridgeport Hospital which lead to improvements increased the success factors to 5 and reduced the criteria to the 35s and continued to make performance measurement. In 2002, thanks to the quality and process improvement studies, by reducing the critical success factors (aspects) to 4 in total, the Balanced Scorecard is used with the final state [9]. The Balanced Scorecard implemented by the Bridgeport Hospital is limited to the following four performance aspects [7]:

1. Increasing market share
2. Quality improvements,
3. Process improvements,
4. Organizational health.

d. Sema Hospital

Still continuing its activities in Istanbul, Sema Hospital implemented a strategic plan in 2007 within the framework of the Balanced Scorecard.

The senior management of the hospital studied this strategic plan under the name of "Hospital United Balanced Scorecard" in four aspects. In the established criterions four aspects are used to measure the performance of both the hospital and the laboratory services [10]:

1. Customer perspective: How do patients and their families see our hospitals? How are we known? What is important to them? Criteria that are used: patient satisfaction, employee satisfaction, employee turnover rate.

2. Financial Perspective: How investors see our hospital? What is important to them? The criteria that are used: the number of the patients, patient use templates, patient demographic information, financial records, major surgery number / total number of operations increase.

3. Functional Perspective: what areas do we need to be successful in our work? What are the areas that will harm our business if done wrong or badly? Criteria Used: quality improvement efforts, infection rates, waiting times.

4. For the Learning and Innovation: How can we continually improve our securities in the health sector? How can we do better for our patients, community or Turkey?

The criteria that are used: the education per capita, business development efforts.

a. Vakıf Gureba Teaching Hospital

The Balanced Scorecard model was implemented in Vakıf Gureba Teaching Hospital within the standards of Joint Commission International (JCI) by Türkeli and his friends [11].

As a result of the studies carried out with "Quality Management Development Committee (KYGK)", the vision, mission, corporate objectives, internal and external factors, alternative strategies, strategic objectives, aspects, key performance indicators were identified. In the implementation, all 150 JCI criteria used for inspection of the Ministry of Health took place. Besides, more than 100 criteria selected from the criteria used by the international institutions were shared with KYGK.

As a result of both surveys, in the enterprises where the researches were carried out, it was detected that the Balanced Scorecard wasn't measured as frequently as the criteria within current performance aspects (infrastructure assets) were identified as important. The Balanced Scorecard was used for performance measurement in Brilliant Hospital and Balanced Scorecard measurements were carried out through the four traditional aspects. The patient satisfaction was the only measure of performance in the Customer aspect. In the financial aspect, return on net assets, competitive positions, growth in business volume, the decline of the cash payment, and increase in the cash flow, new product development in the process aspect, excellent services that are offered, strategic sensitivity in the aspect of learning and development while using outcome measures related to the clinical quality criteria, leadership research and criteria that are used in the form of training time per employee aspect were used [5].

Changi General Hospital, is a public hospital that operates in Singapore and uses the Balanced Scorecard performance measurement tool models which was created in the framework of a strategic plan. The key performance indicators of the Balanced Scorecard were implemented through five indicators, having been created according to the strategy of Changi General Hospital in the departments such as the hierarchical, administrative, operational and clinical. These indicators are respectively as follows:

Corporate (overall corporate) aspect,

1. The aspect of being better (better),
2. The aspect of being faster (faster),
3. The aspect of being less expensive (cheaper),
4. The aspect of patient satisfaction

In the implementation where the same aspects (indicators) were used for all units, indicators were implemented under the name of "quality indicators" [12].

3. The Aspects of the Balanced Scorecard Used in Health Care

Despite Kaplan and Norton created the Balanced Scorecard in four aspects as the original one, they later added new aspects to it, which can be changed in accordance with the strategy of the organization. For example, while Provost and Leddick (1993) added the aspect of "human capital" which was seen as an element of the importance of this area to be used in manufacturing and service industries [3], Potthoff et al. stated that these aspects were of "development and community-oriented", "human resources", "care and quality of service" [13].

Baker and Pink, in their study, proposed a strategy to adapt the Balanced Scorecard to the health care organizations. With this strategy, Kaplan and Norton's four proposed aspects were turned into clinical utilization and outcomes aspect, system integration and change aspect, financial performance and patient satisfaction aspect without adding a new aspect, re-conceptualizing (financial, customer, learning and internal processes and developments aspects) [14].

According to Griffty and White, adopting the Balanced Scorecard into the health care services

after having some changes made in accordance with the strategy of the organization is a widely used method [15]. Santiago (1999) made a similar change with an extension in the work of Baker and Pink, increased the number of aspects to five. Accordingly, these aspects were: learning and development aspect that investigate the complexity and accessibility of information systems with measures evaluating the innovation initiatives, length of stay, mortality, complications, side effects, duration of response (response time) and internal process aspects focused on the functional and financial results, such as cost per service units, patients, families, those who pay and health-related quality of life with employers, functional level, the ability to perform daily life activities, satisfaction and market share protection and expansion criteria directly related to the aspect of the customer and the financial aspect, consisting of investment criteria, including, such as added economic value [16].

In the health care services, four aspects are chosen by making changes on the original version of the Balanced Scorecard to measure the performance of patient flow and density the emergency department. These aspects [2] were: Patient experience, hospital processes, learning and development and the accountability.

According to Pakdil, the performance measurement in health organization are performed through indicators from different areas such as performance indicators based on the process of the business, financial performance indicators, patients (customers) related performance indicators, performance indicators related to employees, supplier performance related indicators and medical performance indicators [17].

Hospital performance is multi-dimensional structure; there is no single detailed performance criteria covering hospital. In studies to define the performance of the hospital, the cost indicators, output ratios and many financial measures were used. In one of the studies that Gruca et al. conducted, they identified the hospital performance in three criteria: financial performance, operational/business performance, and marketing performance. The hospital performance indicators were studied in four groups by Tengilmoglu et al. as the service indicator, the indicator related to the use of beds, staff-related performance indicators, indicators related to the financial performance [18], [19]. Accordingly, the indicators used to measure the service performance of a hospital are in the following order: the polyclinic number, the number of discharged patients, the number of patients who died the number of operations, the number of birth, the number of boarding days, the number of emergency room visits.

Some of the indicators taken place in the 2008 report of The World Health Organization were collected in five areas (Smith et al: patient safety, quality of mental health services, the quality of health promotion, disease prevention and primary care services, the quality of diabetes care, the quality of Cardiac care [20]. According to Lin and Durbin, it is necessary for the available data to be calculated, for the potential indicators to reflect the strategic objectives and for the measures to be in a applicable level, short and understandable [21].

4. Conclusion and Evaluation

Balanced Scorecard makes both financial and non-financial indicators of the businesses an effective strategic element by evaluating material and non-material wealth together. The model is not only implemented in the services and industrial enterprises, but it is also implemented in many health care organizations in different scales throughout the world, particularly in hospitals. In

addition to the traditional aspect in the most of the organizations, some aspects that can be evaluated by the patients were added. It can be concluded from this point of view that a holistic approach with a patient perspective are followed in the health care where the Balanced Scorecard is implemented.

In addition, health care organizations need to identify their goals and define the mission and vision according to mission of this technique. The employees of the health organization need to get trained about this subject, so that all the staff adopt and implement the model in a holistic sense.

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EFFECT OF LABORERS' OVERQUALIFICATION PERCEPTION ON JOB SATISFACTION AND ORGANIZATIONAL COMMITMENT: AN EMPIRICAL STUDY ON HEALTH SECTOR IN TURKEY

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ABSTRACT

Over-qualification perception can be defined briefly as laborers' perception of being overqualified according to requirements of current job. While reasons like globalization, technological developments, increasing population and increasing competition in all markets are causing high unemployment rates especially in developed and developing countries, members of new generations who want to avoid of being unemployed incline on self-development and higher education more and more. While this trend is positively affecting the quality of labor markets unfortunately quality and quantity of suitable jobs are not affected as much. Consequently, many laborer candidate who think that his/her qualifications are more superior for the current jobs are choosing to stay unemployed or unwillingly accepting a job which is unsuitable for his/her educational background or interests. Laborers perception of over-qualification is accepted as one of the antecedents of job satisfaction and organizational commitment, which are directly related with employee turnover,

alienation to job and organization, higher job stress, efficiency and behaviors of counter production. The aim of this study is empirically investigating effect of overqualified laborer perception on job satisfaction and organizational commitment of administrative workers on health sector in Turkish context. Data are collected from 142 administrative laborers working at private hospitals in Ankara. According to results, having a difference, duration of employment and income appeared as significant variables affecting over-qualification perception addition to education level in health sector. Moreover, over-qualification appeared as an important antecedent of both job satisfaction and organizational commitment.

Introduction

Probably education would be at the top of the list if people are asked for solutions for social problems like high crime rates, corruption, inefficacy or unemployment that our societies suffer these days. Following this hypothetical prescription, governments and people are increasing their investments on education year by year. Efficacy of these investments is not subject of this study but for sure, young generations are having higher levels of education. However, together with higher education levels, rates of unemployed people with college degrees are also increasing because numbers of high quality jobs are not increasing as fast. The percentage of higher education graduates inside unemployed population shows significant increase both in the USA, Russia, China, Brazil, Argentina and Finland in comparison with the recent years [1]. Highly educated laborer candidates who do not prefer the available jobs or who deem that these jobs are not suitable for them have been gradually forming an expanding group among the unemployed category for whom employment opportunities do not improve as fast.

In this framework, examining the unemployment statistics according to education level in Turkey, it is shown that higher education graduates constitute the largest group of unemployment with 12,9% [2]. From a different perspective, unemployment ratio among high school, university and post university graduates was 43,6 % in 2008, whereas this rate increased to 51,6 % in 2014 [2]. After a while these people with different educational degrees, different qualities and/or knowledge who could not find a job suitable with his/her expectations can no longer tolerate the economic, social and psychological pressures of being unemployed and feel forced to choose a job which they do not think suitable for themselves. Khan and Morrow [3], define this kind of people as overqualified laborers (OQL).

Job satisfaction and organizational commitment of OQLs are main topics of this study. Except the study of Erdoğan and Bauer [4] conducted with a retail organization workers in Istanbul and study of [5] conducted with workers from engineering, textile, chemical equipments and food industries there is not any study examining OQLs in Turkish context.

Studies examining OQLs mostly determine that OQLs are more common at service sector than manufacture sector [6], [7], [8]. Considering this fact, administrative workers of private hospitals in Ankara chosen as the sample of this study as representatives of service workers.

The Overqualified Laborer (OQL) Perception

The concept of OQL functionalized in two different ways. The first definition related with perceptions claim that being OQL is only a perception of laborers who deem that their qualifications are much more than needed to conduct the current duties [4], [9]. The second definition is focusing to the facts like job descriptions and official qualifications of laborers that this point of view defines being OQL as having more official qualifications than required in t, he current job description [10]. In the literature examining behavioral consequences of being OQL, the functionalizing approach focusing on perceptions is more commonly

suggested [11]. In this study we also considered perceptional approach as the main theoretical framework.

Crosby's [12] *Relative Deprivation Theory* is considered as one the main theories to explain effect of OQL perception on individual attitudes and behaviors [13]. According to this theory, it is not enough to consider only the context and situations for understanding and estimating the behaviors of individuals. Situations and conditions might be perceived differently at different times and separately for everybody. So it is perceptions that determine the meanings loaded on context, situation and contingencies [12]. In this framework relative deprivation theory claims that when a person could not reach an object which is highly deserved, this causes a disappointment directly proportional with intense of deserving thought [12]. In this theoretical framework Erdoğan and Bauer [14] claim that, laborers with high objectives about working basis on their high level of education, knowledge, experience, talent or only self-esteem might feel deprivation or disappointment while they are obliged to accept low quality jobs and this kind of perceptions might trigger some negative attitudes like low job satisfaction and intention to quit.

Another well-known theory explaining effect of OQL perception on attitudes and behaviors is Hackman and Oldham's [15] *person-job fit theory*. According to person-job fit concept if the laborer has the qualifications defined as requirements for the job it is more likely that laborer fit to his/her job and display a better performance [16]. Nevertheless, not only having deficient qualities but also having over qualities is something undesired.

There are two approaches conceptualizing OQL with one and two dimensions. First approach consider OQL concept as a unique dimension as mentioned above [4], [17]. Second approach defines two dimensions of OQL as: *mismatch dimension* – perceived lack of match between laborer qualifications and job requirements, and *no-grow dimension* – a perceived stable job environment with lower opportunities to learn new things or promote [13], [18]. In this study, we considered unique-dimension approach.

Organizational behavior researches related with OQL concept commonly reach the results that OQL has negative relations with job satisfaction, organizational commitment and positive relation with intention to quit [13], [19], [20].

OQLs are considered to be inconvenient and refused by employers especially for low skilled or unchallenging works in general [21]. The researches on employers for the reasons of refusal of overqualified candidates reveal that employers frequently affirming such candidates would demand for more remuneration and early promotion, wouldn't like to work with the managers who have less experience and information, wouldn't adopt to their work easily, wouldn't be motivated effortlessly and would quit their jobs once they receive a better job offer [20], [22]. For these reasons, employers might display a tendency to choose candidates who mostly suit to requirements of job, no less and not more [13].

Although over-qualification is considered as a negative characteristic for employees at HRM literature [19], [20] some researchers suggest that this kind of employees might turn into valuable assets for organizations by some HRM applications like employee empowerment, job enlargement, job enrichment, target oriented job contracts [1], [13], [14].

OQL Perception and Job Satisfaction

By a simple definition, job satisfaction is the degree of contentment of laborers from the job [23]. Low job satisfaction may result in high turnover rates, absenteeism, intention to quit, low organizational commitment, alienation, work stress, counter production behaviors like damaging machines or facilities, mental and physical health problems along with inefficiency [24]. Job satisfaction is generally discussed in terms of internal and external dimensions.

However, the recent studies reveal that some other dimensions like social satisfaction and satisfaction from supervisors might be added to job satisfaction phenomenon [25]. The internal dimension of job satisfaction is related to emotional satisfaction from the work itself; the external dimension is related to the situation of harmonization of the concrete outputs of the work with the expectations of the laborer whereas the social dimension is being contented with the colleagues and supervisor satisfaction is related with satisfaction from supervisors [26].

Job satisfaction is generally considered with single dimension in the studies carried out as an output of OQL perception with a negative relation [13], [14], [26]. However, it is possible to reach different results if job satisfaction taken into account with its sub-dimensions like inner, external and social satisfaction. Because, even though there is no inner and external satisfaction employee may have compatible relations with the colleagues tolerating other problems. Considering the fact that employees of administrative services in health sector like doctor assistants, secretaries and information desk consultants are mostly women they might have close and sincere relations with each other and might have high social satisfaction even they are not glad with internal and external outputs of work. Satisfaction from supervisors might be considered as another dimension of job satisfaction. Although it is hard to estimate the effect of supervisors in this pattern, it is envisioned that they would be in a type of interaction similar to social satisfaction. The hypotheses that have been produced in this framework are listed below:

H-1: OQL perception has a meaningful but negatively relation with inner satisfaction.
H-2: OQL perception has a meaningful but negatively relation with external satisfaction.
H-3: OQL perception has a meaningful and positive relation with social satisfaction.
H-4: OQL perception has a meaningful and positive relation with satisfaction from supervisor.

OQL Perception and Organizational Commitment

Salancik [27], defines organizational commitment as an individual attitude that covers variables like occupational commitment in the framework of organization, loyalty to organization, beliefs about organizational values. Organizational commitment is a desired employee attitude that it is highly correlated with positive organizational characteristics and attitudes like organizational identity, employee satisfaction, belonging perception, security and trust perceptions [17]. Organizational commitment has also strong relations with person-job fit, fear of being unemployed, normatively feelings about organization and emotionally commitment to organization [17], [28].

Organizational commitment mostly taken into models with its three sub dimensions as affective, normative and continuance commitment conceptualized and functionalized by Allen and Mayer [29]. In this framework: "*affective commitment is defined as denoting an emotional attachment to, identification with, and involvement in the organization, normative commitment reflects a perceived obligation to remain in the organization and continuance commitment means denoting the perceived costs associated with leaving the organization*" [30].

In the *job characteristics model* of Hackman and Oldham [15], match between expectancies and job characteristics are defined as prior antecedent of employee efficiency. Considering person-job fit theory and job characteristics model, personal expectancies based on perceptions about personal characteristics can be defined as an important antecedent of organizational commitment. Supporting this hypothesis it is revealed in the literature that OQL perception is negatively correlated with organizational commitment [11], [28], [31]. However comparing OQL perception with organizational commitment's sub dimensions, depart

from other two dimensions, continuance commitment is positively correlating with OQL perception [31]. Considering definitions and theory, positioning normative commitment close to continuance commitment seems more logical in this interaction model. Consequently, we expect that administrative laborers of private hospitals who perceive themselves as overqualified for their positions might be not affectively committed to their hospitals but their continuance commitment and normative commitments might be higher. Hypotheses formed in this framework are listed below.

H-5: OQL perception has a meaningful but negatively relation with affective commitment.

H-6: OQL perception has a meaningful and positive relation with normative commitment.

H-7: OQL perception has a meaningful and positive relation with continuance commitment.

Research Model

Research model and hypotheses are displayed at Figure-1.

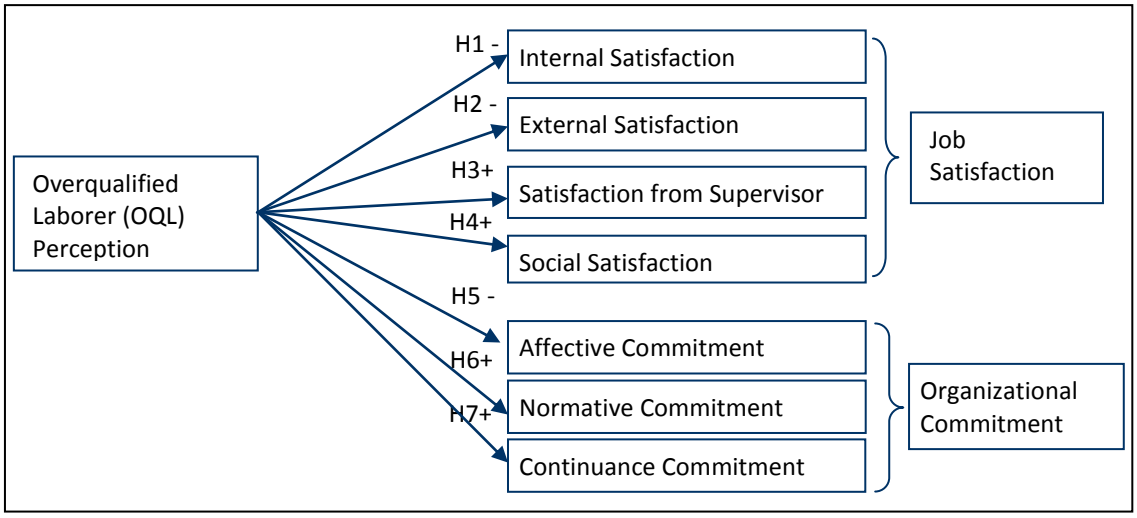


Figure-1: Research Model and Hypotheses

METHOD

The Sample

The research purposes to perform in a sample that includes individuals who operate in service industry, with no specific technical education for work; but also with different age, gender, educational background and work experience. The discussions among the researchers has resulted that the best group which demonstrates those characteristics is the workers at "executive branch" in hospitals. In order to test this hypothesis, the OL perception scale has been implemented to 32 administrative worker of a private hospital in Ankara as a pilot research. The results have showed that the ratio of OL perception is 65 percent, which is sufficient for our research. Therefore, we have decided to perform the research in private hospitals.

In accordance with the data provided by The Ministry of Health, there are 355 general hospitals throughout Turkey, 21 of which are located in Ankara. Around 1250 staff, including physician assistants as well as consultants, are employed in these hospitals [32]. Six of the private hospitals in Ankara accepted our offer for research, in this way we reached 227 consultants and physician assistants. Accordingly, the

general universe of the research consists of managerial staff of private hospitals in Turkey, while the research universe is based on the managerial staff of 21 general private hospitals in Ankara. On the other hand, the sample involves the managerial staff of only six of those hospitals.

Within the context of the research, the participants are asked to answer questions in 227 survey sheets, out of which 142 forms are worthy of the research to use, with the validity rate of 62,55 %. 52% out of those participants (74 people) are married, whereas 45% (64 people) are single and 3% (4 people) are divorced. The average for age is 28.2, while the most of the participants are within the range of 26 and 30. On the education side of the research, it is founded that 28 participants have been graduated from secondary schools, while 38 participants have high school degree. Additionally, 44 participants have college degree, whereas 22 of the participants have a degree of undergraduate of graduate school. Only 10 people have not indicated their degree of education. 38% out of the sample have been working at their institution less than a one-year period; on the other hand, the rate of the staff working at the hospital for ten years of more is around 8.25%. The average level of income ranges between 1,000-1,500 TL.

Scales

The Overqualified Laborer Scale: In our research, the four-sectioned scale, which developed by Johnson and Johnson [9] and translated into Turkish by Erdoğan and Bauer [4], is applied (α=.72). The scale, which is a 6-point Likert scale with only one dimension, includes questions such as "my education level exceeds my job", "I cannot perfectly use my capabilities in my current job". In our study total reliability of the scale determined as α=,818.

Job Satisfaction Scale: The Minnesota Job Satisfaction Scale, which developed by Weiss et.al [32] and translated in Turkish by Baycan [33], is used in order to determine the job satisfaction degree of the employees. The scale has two dimensions and consists of 20 items (internal satisfaction and external satisfaction). The scale, which is implemented as a 6-point Likert scale, includes statements such as "I like to work in this place", "I like my job". The items of 1,2,3,4,7,8,9,10,11,15,16 and 20 addresses the internal satisfaction, while the items of 5,6,12,13,14,17,18 and 19 determines the external satisfaction. In this research, the 5 items out of the external satisfaction form two different dimensions. Two of these statements are related to the satisfaction for the supervisors (items 5 & 6), whereas the other three items (number 17,18, 19) are associated with the satisfaction of social relations in workplace. Accordingly, the third dimension is called "the satisfaction over the supervisor", while the fourth dimension is named as "social satisfaction". In our study total reliability of the scale determined as α=,844. Reliability results of sub dimensions as internal satisfaction, external satisfaction, satisfaction from supervisor and social satisfaction are α=.945, α=.849, α=.778 and α=.746 in order.

Organizational Commitment Scale: The commitment of the employees is determined through the 18-item scale developed by Meyer and Allen [30] and translated into Turkish by Wasti [34]. The scale consists of emotional, continuance and normative commitment dimensions. Each dimension consists of 6 items. The total reliability degree of the research is α=,872 and emotional, continuance and normative commitment's reliability results are α=,933 α=,844, α=,901 in order.

ANALYSIS AND RESULTS

The data is analyzed through IBM-SPSS-21 program. The data, except the variable of gender, significantly fits to normal distribution. Most of the participants are female due to the job characteristics of the sample group. Confirmatory factor analysis and correlation analysis are implemented in order to determine the dimensions of the scales and the relationship between the variables. Beside, t-test and one-way ANOVA analysis are implemented in order to

determine the OQL perception as well as the differences among groups depending on demographic data.

In accordance with the results of the research, the 64,78% of the participants (92 participants) evaluates themselves as overqualified for their jobs. There is no significant differentiation among the OL perception for the gender, the hospital, the marital status and the age; whereas there are significant differentiations among the OL perception for the education level, the working period and the monthly income.

As seen on Table 4, when the education level increases, the OL perception increases, as well.

Table-4: relationship between education level and OQL

F=3,370; p=0,021<0,05

Education level	OL perception-Average	N	Standard Deviation
Secondary school	3,0357	28	1,00396
High school	3,3026	38	1,22909
College	3,8409	44	1,42964
Undergraduate	3,9091	22	1,27836
Total	3,5265	132	1,30042

The same relationship can be recognized between the working period and the OL perception, as well as between the income and the OL perception. In this context, the participants with less or more working period as well as the participants with low or high income identifies themselves as “less OL”. Table 5 and Figure 1 demonstrates the change in the OL perception against the income level, while Table 6 and Figure 2 shows the change in the OL perception against the working period

Table-5: Relationship between monthly income and OQL

F=3,017; p=0,013<0,05

Monthly income (TL)	OL perception-Average	N	Standard Deviation
0-999	1,9375	8	,60872
1000-1499	3,5227	66	1,44430
1500-1999	3,8750	28	1,23884
2000-2499	3,4167	12	1,30268
3000 & over	2,7500	4	1,44338
Total	3,4426	122	1,39242

Table-6: Relationship between working duration and OQL

F=4,398; p=0,000<0,001

Working period (year)	OL perception-Average	N	Standard Deviation
1-2 Years	3,258	62	1,29350
3-5 Years	4,066	30	1,18322
7-10 Years	4,035	14	,68139
11-13 Years	3,100	10	,64550
16,00	2,5000	2	,00000
21,00	2,0000	2	,00000
Total	3,5458	120	1,30649

Figure-1: OQL Through Income

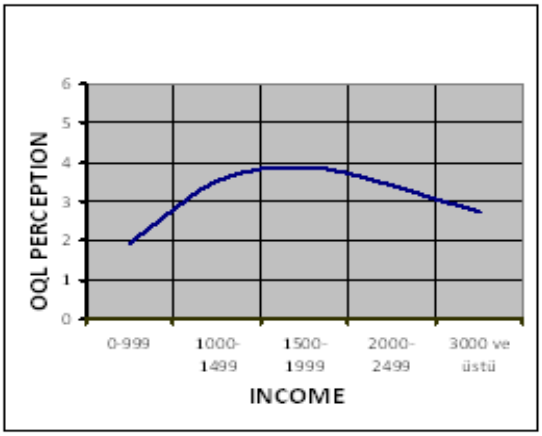
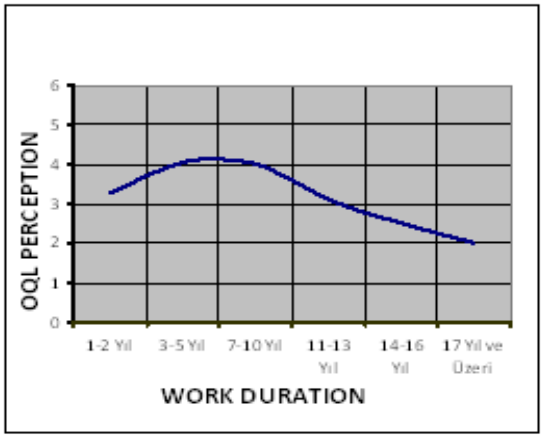


Figure-2: OQL Through Work Duration



Relations between basic variables of study can be seen in Table-7 Correlation Table. Accordingly a meaningful negative relation between internal satisfaction and LO perception was found ($r(142)= -,169$, $p<0.05$); there is not any other meaningful correlation between other job satisfaction factors and LO perception. According to this, H1 was accepted, H2, H3 and H4 were not accepted. When the relation between affective commitment, other independent variable in the model, and OL perception was analyzed, a meaningful negative relation between affective commitment and OL perception ($r(142)= -,233$, $p<0.01$), and a meaningful positive correlation between continuance commitment and OL perception ($r(142)= ,218$, $p<0.01$) was found. But, a meaningful correlation couldn't be found between normative commitment and OL perception. According to this, H5 nd H6 were accepted, H7 was not accepted.

According to regression analysis of OL perception and job satisfaction and organizational commitment; it can be seen that, OL perception predicts continuance commitment %3 positively, and internal satisfaction %6 negatively (Table-8).

	1	2	3	4	5	6	7	8	9	10	11	12	13
1. OQL Percept.	$\bar{X}$:3,54 SS:1,10												
2.Affect.Commit.	-,233**	$\bar{X}$:3,32 SS:1,32											

3. Cont. Commit.	,218**	,319**	$\bar{X}$:3,43 SS:0,99										
4. Norm. Commit.	,017	,289**	,081	$\bar{X}$:3,78 SS:1,16									
5. Int. Satis.	-,169*	,083	-,106	,413**	$\bar{X}$:4,21 SS:0,97								
6. Ext. Satis.	-,010	,033	,004	,197*	,263**	$\bar{X}$:2,92 SS:0,90							
7.Satis. From Superv.	,039	,039	-,017	,103	-,373**	,490**	$\bar{X}$:2,97 SS:0,85						
8.Sos. Satis.	,179*	-,028	,149	,336**	,097	,272**	,114	$\bar{X}$:3,72 SS:1,08					
9. Work Durat.	-,103	-,025	,078	,026	,194*	-,003	-,224*	-,304**	$\bar{X}$:4,16 SS:4,43				
10. Edu.	,456**	-,177*	,018	,124	,141*	-,277**	,047	,211*	,106	Y.Okul SS:1,07			
11. Salary	-,080	-,029	,063	,003	,056	-,058	,050	,120	,277**	,046	1250TL SS:1500		
12.Org.Comm.	-,068	,539**	,445**	,739**	,336**	,131	,067	,274**	,057	-,064	-,091	$\bar{X}$:3,51 SS:0,68	
13.Job Satis.	-,109	,142	,086	,542**	,871**	,112	-,080	,442**	,072	,078	,197*	,449**	$\bar{X}$:3,82 SS:0,60
* p<0.05; ** p<0.01 level of meaningful correlation													

Table-7: Correlation table

Independent Variable	Dependent Variable	Sig.	R^2	F	B	S.E.	β
OLP	Affective Commitment	,003**	,062	9,273	-,254	,095	-,233
OLP	Continuance Commitment	,039*	,030	4,347	,197	,073	,218
OLP	Normative Commitment	,848	,000	,037	,017	,086	,017
OLP	Internal Satisfaction	,034*	,032	4,609	-,189	,079	-,169
OLP	External Satisfaction	,535	,003	,387	-,041	,067	-,010
OLP	Satisfaction from Supervisor	,389	,005	,748	,055	,063	,039
OLP	Social Satisfaction	,057	,026	3,673	,147	,071	,135
* p<0.05; ** p<0.01							

Table-8: Regression Analysis

DISCUSSION AND CONCLUSION

Although there are hundred thousands of job opportunities at labor markets, the reasons of increase at unemployment rates can be explained by not admiring the current jobs due to rising education level at young generations [13]. Beside this, having qualifications more than required can become an obstacle on the perspective of employer [22]. OQL perception might occur not only at highly educated unemployed laborer candidates but also at the employees who gained extra qualifications during their working periods and developed herself/himself over time. If OQL perception does not balanced with other factors over time can cause negative work attitudes like low satisfaction, low commitment, counter productive behaviors, high work stress, and high turn over rates for organizations [4]. As the results of OQL studies show that, OQL perception will gain more importance in business life and human resources management for the next years.

In this study, the OQL perception of the administrative staff of health sector and its effects on job satisfaction and organizational commitment examined in the context of Turkey. Although, we do not have a hypothesis about effect of demographic variables on OQL perception, some important results were found.

First, educational status is presented as one of the most important cause of OQL perception in the literature [13], [31]. Harmonious with these results we also detected a strong relationship between education level and the OQL perception (r=,456, p<0,01). As shown in Table-4, grouping the participants according to their education, the average level of the highest OQL perception was found at the graduated participants, followed by undergraduates, high school and junior school graduates. However, education level should not be regarded as the equivalent or the unique reason of the OQL perception. According to results of this study while the percentage of participants with OQL perception who are graduated from universities is 54%, this ratio is 61% for junior school graduates.

Although there is not a direct relationship between the OQL perception and monthly income and duration of employment, while participants are grouped according to their income, duration of employment and OQL perceptions, the graphics show a bell curve. Thus, the ones who have low duration of employment and income do not feel over qualified. While duration of employment and income increases, the OQL perception is also increasing. But when the income and duration of employment is more increased, the OQL perception restart decreasing (Figure-1 and 2). Although this bell curve might be result of several causes, we determine that primer reason is perceptions about challenges of the job. Considering the fact that new starters would not have enough experience about the challenges of their work they are not able to make realistic evaluations. As well the experienced employees who

realize the real competences of their job do not evaluate themselves as overqualified. However, we are aware that more evidence needs to support this argument. Other variables like self-efficacy, psychological capital, cultural values etc. may also be affective in this results.

Organizational commitment is one of the most researched attitudes in OQL literature [13], [14]. It is common to face with a negative correlation between OQL perception and organizational commitment [11], [35]. In this study, although the participants have organizational commitment above the average (x= 3,51), no direct relationship found between OQL perception and organizational commitment. However, when the organizational commitment was taken with its sub-dimensions, a significant negative correlation detected between OQL perception and affective commitment (r= -0,249, p<0,01), and a significant positive correlation detected between OQL perception and continuance commitment (r= 0,174, p<0,01). With these results, we evaluate that, the employees who see themselves as overqualified, stay in her/his current job because of not having a better alternative. Therefore, these employees do not develop an affective commitment to their organizations.

Job satisfaction is another variable commonly located at OQL research models [36], [37]. Commonly a negative relation between job satisfaction and OQL perception is detected in these researches. Although it is possible to say that the participants are highly satisfied from their current job in general (x= 3,82) and highly feel themselves as over qualified (x= 3,54) we could not detect any significant correlation between job satisfaction and OQL perception. But, in this study, we added job satisfaction to our model with its sub dimensions. But examining the interaction of sub dimensions with OQL perception we detected that OQL perception is negatively related with internal job satisfaction (r=-0,169, p<0,05) and positively related with social satisfaction (r=0,179, p<0,05). Internal satisfaction, is the sub dimension of job satisfaction focusing to work itself and the feelings of the employee while doing the work, includes the matters like gaining the outputs expected from organization, opportunity to work independently, congruence between personal values and organization's ethical values, availability to display creativity, and attract of job itself [38]. The low level of internal satisfaction of the participants with high OQL perception can be linked to the idea of feeling useless in the current job although having outstanding qualities and perception of lack of harmony about social statute of current job and the job that expected. Another important output of the research is positive correlation between OQL perception and social satisfaction, which is related with being glad with colleagues [26]. Social satisfaction averages are higher at the participants with higher OQL perceptions. The reasons of this relation can be listed as the gladness from the facilities of the workplace, good relationship among the employees with similar perspectives, developing a common identity as colleagues and participating same feelings.

In this study, we tried to examine OQL perception as a new concept developed at recent years and rarely handled in Turkish context. We researched effect of demographic variables to OQL perception and its relation with job satisfaction and organizational commitment both with their sub dimensions. In this process, we witnessed the fact that, OQL perception of employees might be related with many different attitudes. In order to utilize the qualifications (at least perceived qualifications) of these employees and diminish negative effects of this perception questions like; What kind of leadership approaches and human resource management styles should be exhibited to these employees?, How these employees can be retained and their efficiency and performance can be maintained? are some of the main questions which should be answered in future researches.

There are some limitations should be considered about the study. First, it is a cross-sectional research and data is gathered from self-reports. Because of

these reasons, the results might be affected by common method variance. In addition, the sample represents only the private sector and hospitals in Ankara. Thus, findings are limited to location, time and sample. Although number of sample might be considered enough for statistical analysis, it is more than being assertive to generalize the results. For future researches, it is recommended that, enlarging the research with different occupations from different regions. Also other behavioral variables like; personality traits, kind of graduated schools, family income, human resources management applications of organizations, leadership attitudes of supervisors, organizational culture, organizational climate, entrepreneurship etc. can be added to models. Also mediator, moderator and direct effects of OQL perception on performance, organizational justice perception, organizational citizenship behavior and some other variables can be examined in future researches.

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THE MANAGEMENT OF CORPORATE REPUTATION IN HEALTH CARE INSTITUTIONS: A RESEARCH STUDY FOR MEASURING THE PERCEPTION ABOUT CORPORATE REPUTATION OF EMPLOYEES WORKING IN PUBLIC AND PRIVATE HOSPITALS

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A R T I C L E I N F O

Key Words: Corporate Reputation, The Management of the Corporate Reputation, Health Care Institutions, Reputational Perception

ABSTRACT

That being one of the most important values of the institutions, the management of reputation, with its feature that cannot be imitated by its competitors, has become one of the crucial management tools in recent years. That it is one and perhaps the most important of the institution having vital importance in terms of trust, communication and behavior in social responsibility for its internal and external stakeholders, it becomes necessary for health care sector to deal with the issue of corporate reputation that will make great contribution to these institution in terms of creating the mentioned issues, ensuring sustainability and improving the quality of services.

The aim of this research was; to present how the management process has been executed especially on the basis of the health sector and analyze comparatively that according to their working status, at what level and in which differences the employees in public and private sector (public hospital and private hospital) perceive corporate reputation. In the study, by using a reputation scale, developed by Charles J. Fombrun a questionnaire was conducted on 253

nurses working in Nevşehir state hospital and 2 private hospitals in the same province in May of 2014. The questionnaire questions were asked to the participants with a face to face method within working hours. In order to simplify the research of the subjects that creates the roof of the research method, 3 research questions and 1 hypothesis were determined. On the prepared questions and the analysis and testing of the hypothesis, it was benefited from the programme SPSS for Windows 16.0. According to the results obtained from the research, the perceptions of the employees, (the nurses) in the hospitals (private and public) in Nevşehir city center, about the corporate reputation is moderate. This situation shows that the hospitals do not give enough attention to studies that can improve corporate reputation of the nurses who are the internal stakeholders of the hospitals. In addition, it was concluded that the level of perception of nurses differs according to the situation whether they work in public hospitals or in private hospitals. Accordingly, the perception about corporate reputation of the employees working in private hospitals is higher than the employees working in the state hospitals.

INTRODUCTION

Reputation is a multi-dimensional component that focuses on what is done and how it is done in institutions and it is based on perception according to the experiences of the stakeholders [1]. Ensuring the continuity and protecting the gained reputation is as important as gaining the reputation that has a great importance for institutions in terms of providing a competitive advantage. In other words, reputation should be protected against the risks it carries. Protection from risks depends on how much effectively the management of reputation is implied. In this context, institutions should conduct their own reputational risk studies by taking into account their own structure, the sector in which they exist, environment in which they operate.

Corporate reputation is the contribution of reliance created by an organization in the total market value and it is the equivalent of intangible value of an institution. It is known that corporate reputation that started to be taken into account in health sector and has crucial importance in the functioning of these institutions, affects the quality of service presented by the reliance and communication level between private and public health sector workers. However, representing the institutions that offer health service through private and public sector may make a difference in terms of service quality, it will similarly influence corporate perception of the employees and so the quality of health service.

It is seen in the researches conducted in this field, it is not mentioned the issue that corporate reputation perception may vary in terms of employees according to the situation whether health institution functions in public or in private sector. This study, in the literature, considered to contribute to the studies that targets the completion of this field, aims to support the theoretical background including information about the management of corporate reputation with a field study and set light to other large scale studies.

2. THE MANAGEMENT OF THE CORPORATE REPUTATION IN THE HEALTH CARE INSTITUTIONS: CONCEPTUAL FRAMEWORK

2.1. The Management of the Corporate Reputation in the Health Care Institutions, Its Importance and Its Stakeholders: Corporate reputation states the emotional and effectual reactions such as good or bad, weak or strong of the clients, enterprisers, employees, suppliers, administrators, credit providers, media and communities on what the institution is. In this aspect, corporate reputation is a set of perceptions regarding the evaluation of institution's past performance and its future behavior [2]. Fombrun [3] accepts corporate reputation as a concrete factor that determines the place of the company in the market. Contemporary businesses are obliged to create trust and credibility among intended population. Therefore, by becoming transparent and showing themselves to their client, they build a way to gain reputation and they are in need of managing the reputation besides other entities [4].

Corporate reputation is expected to provide many benefits such as permanent profitability, high earnings, competitive advantage and preferability ratios from the viewpoint of employees, clients and suppliers. However, for the sectors such as health care sector that offers a vital service and makes an effort to hold its service conditions equal for each demand, the phenomenon of corporate reputation is seen to be more important compared to other sectors that do not feel the necessity for offering their

services on equal terms. Although all treatment service conditions are equal for the treatment of a patient with a particular disease, those people, sometimes described as clients in the literature, may choose a hospital with a positive reputation.

As the subject of the service is human in health institutions, how reputation is perceived by stakeholders in health sector becomes important. Sorted by Fombrun [5], the stakeholders such as employees, clients, suppliers, enterprisers, member of the government, media, environmental organizations and opponents also can be considered as a stakeholder in the management of corporate reputation of health care institutions. It is possible to include all institutions and people that have been affected by the actions, decisions, policies and objectives of the institution among these stakeholders. It is possible for the institution to create a quality service approach in the eyes of the stakeholders, increase appreciation and preferability only by creating a positive reputational perception. When considered from this point of view, the stakeholders considered in health institutions directly affect the management of the reputation and reputational perception of these institutions. The frequency and content of demanded health care service is affected by the quality of the institution and its employees, whether the services are reliable, the communication it established with its environment and its consciousness of social responsibility towards to the society.

Carrying out the process of the management of the reputation successfully in the health sector is associated with how much institutions deal with some processes that has to be considered especially in service. Foremost among them is to establish an effective communication system. Communication that has to be used effectively during the process of creating a successful reputational perception should be based on a sense of confidence and institution should present the efforts towards enhancing the community's quality of life together with these two facts with corporate social responsibility studies. It is obvious that management of the corporate reputation in health institutions has to be applied in a serious spirit in order to minimize, remove or keep the difference between perceived quality level and expected quality level by the clients, one of the most important of the stakeholders of the management of corporate reputation, and patients in the health care institutions.

2.2. The Role of the Management of the Corporate Reputation and the Role of the Health Workers' Perception About Corporate Reputation in Improving the Quality of Service: While analyzing "placing positive thoughts about a product, a person or an organization in peoples' mind" meaning "creating an image" and " perceptional management" that its validity can not be refused in today's conditions, it can be seen that it is " being understood by the opposite side" in reality. The sense of satisfaction that is considered as a factor eliminating the differences between expected and offered service manner by the clients and the employees in health care sector should be evaluated in this concept. Being understood by the others is in one sense the perceived level of corporate reputation. A successful management of corporate reputation is an effective factor to create a positive image in terms of stakeholders. The management of the corporate reputation including image and perceptional management will also improve the quality of service given by employees who are the most important stakeholders. In this way, minimizing of the negative communication patterns, creating the sense of confidence and loyalty in all health care sector stakeholders, shortening the duration of treatment, eliminating of absences, leave of employment and involuntary working behavior and also increasing the recommended level of the institution are expected.

It is known that corporate reputation in health care institutions provides benefits such as attracting qualified workforce, increasing the loyalty of the employees, attracting clients and creating client loyalty, increasing the market value, providing financial gain and attracting the enterprisers [6]. As seen in the listed benefits; employees not only take part in providing corporate reputation but also they are one of the targets of it. Employees are the basis of the corporate reputation process. In other words, it is impossible for the institutions to have a strong reputation without gaining the support of the employees. For this reason, institutions that want to have a strong corporate reputation should be aware of this fact. Ensuring the participation of the employees to the corporate reputation process possesses a crucial importance.

Indeed, both at the point of interaction with external stakeholders and with what they produce and offer, employees influence the perception and evaluation related to the institution with their behavior. The given promises can be fulfilled only when employees show effort to keep these promises. As being a concept that encompasses the whole institution, reputation necessitates the active efforts of the employees who are the key of corporate success. As active internal corporate communication contributes to the creation of corporate reputation process, the support and participation of the employees at every stage of this process is required. Since being as a result of long years of a study, reputation influences the strength or weaknesses of corporate reputation that is created by the employees in the process. According to Kadıbeşegil [7]; basic policies related to the management of reputation are developed by the management but the protection of reputation is the work of all employees. For this reason, institutions

firstly should keep the perception of the employees related to corporate reputation high and then tell them their role in the process of corporate reputation and manage this process by gaining employees' support.

3. RESEARCH

3.1. Literature Review: In the conducted literature review, has been found in some studies that it was either focused on the issue of corporate reputation management or aimed to measure the perception about corporate reputation in various institutions. In the research named " Corporate Reputation Survey and an Application Example" by Eroğlu ve Solmaz [8], a survey was conducted to 258 public elementary school teachers working in the central districts of Bolu and the effects of the school managers to their perception level of corporate management was investigated. According to the survey result, it has been concluded that the school manager has an effect on this perception level. Accordingly, it has been determined that in terms of teachers' perceptions about corporate reputation and management style subscales, there is a strong relationship with a democratic and participatory-democratic management style; a moderate relationship with a sharing-authoritarian, a weak relationship with an authoritarian management style.

Another study named "The Management of Corporate Reputation and The Measurement of Corporate Reputation in a Public Institution" by Seval Yirmibeş [9] is an unreleased postgraduate thesis. In this study, with the questionnaire of corporate reputation including 25 questions and developed by Charles J. Fombrun, it was investigated that how corporate reputation is perceived by the 57 employees of Uludağ Exporters' Union General Secretary and union members. As a result, corporate reputation of Uludağ Exporters' Union General Secretary was perceived as positive, and the coefficient of corporate reputation was determined to be 76.5%.

In a study by Çiğdem Şatır [10] named "How External Stakeholders Perceive Reputation in a Public Institution Offering Health Care Service", conducted to the 1904 employees of a research hospital performing in public and health care sector, it was aimed to measure the perception about corporate reputation of the employees namely internal stakeholders. According to the participants, the most important components to create reputation actually are institutional functioning, communication, confidence, service quality and social responsibility. However, it has been concluded that this ideal harmony did not exist in the institutional functioning in their institutions and in communication. Another study is " A Survey of Determining the Effect of Corporate Reputation Over the Employees' Performance" by Bekiş and colleagues [11]. It was conducted to the 130 employees working at management position in 19 private hospitals or private branch hospitals in Niğde-Nevşehir-Kırşehir and it has been concluded that corporate reputation has a positive impact over employees' performance.

3.2. Research Model: In our country, the number of researches on corporate reputation appears to be insufficient. Still, it is seen that it is not touch on the issue that the management of corporate reputation can be evaluated through different perceptual ground by the employees according to the state of in which sector the health institution operates, in public or in private sector.

In the literature, this study that is considered to contribute to the work aiming to correct the deficiencies in this area, intends to create its theoretical background within the scope of the mentioned deficiencies, support the research problems with a field research and set light to other more comprehensible researches to be carried out. In the research, the reputational perception towards their own institutions of the nurses working in two private hospitals and in a public hospital was investigated. It is aimed to determine whether their perception about the corporate reputation differentiates according to in which sector the hospitals they work operates. It is seen that in private sector institutions, the concept of modern management and human resources practices are more known compared to public institutions and commercial concerns and motivational applications are more concerned. As being considered that this situation will affect the perception about corporate reputation of the employees who are the internal stakeholders, the main expectation in this study is for that the perception about corporate reputation of the nurses working in private sector is higher than the nurses working in public.

3 questions prepared in this respect and a hypothesis that is generated based on the 3rd question is as follows:

Question 1: At which level does the nurses who are working in public hospitals in Nevsehir province perceive the corporate reputation of the hospital they work in?

Question 2: At which level does the nurses who are working in private hospital in the city center of Nevsehir province perceive the corporate reputation of the hospital they work in?

Question 3: Do the perception about corporate reputation of the nurses who are working in public hospital and the perception about corporate reputation of the nurses who are working in private hospital in Nevşehir show differences?

Hypothesis 1 (HA): The perception about corporate reputation of the nurses working in public hospital in the city center of Nevşehir is different from the perception about corporate reputation of the nurses working in the private hospital.

3.3. The Type of the Research, Main Population and Sample: As of its nature, the research is descriptive and intends to demonstrate the current situation of the results to be achieved.

For the purpose of the research, 320 nurses in total (with integer sampling method) working in two private hospitals and in a public hospital in the city center of Nevşehir were asked to participate in the research through the survey form but the number of participants remained as 253. The nurses participated in the research constitutes 79% of the universe. 67 of the participants who were desired to be reached by face to face method and are in the scope of research did not participate in the research because of the reasons that they either did not want to participate in the research or were on leave with the reasons such as working hours, workload, birth and annual leave. The ratio of the sample number to the populace number is 79% in this research. Arlı and Nazik [12] states that minimum sampling of 10% is needed in descriptive researches. According to this information; the number of sampling of the research is highly enough for the reliability of the results.

3.4. Data Collection Method and Statistical Analysis of the Data Collected: In reaching to the sample, questionnaire method was used. In the first part of the questionnaire 8 demographic question were given, in the second part the scale including 25 questions of corporate reputation, developed by Charles J. Fombrun, [13 -within 9] was used. The questions were asked to the participants in working hours and through face to face interview method.

The expressions in the second part apart from the first 8 questions regarding the descriptive characteristics of the institutes surveyed were prepared by using a 5 point likert-type scale. The options in the expressions were assigned as from the most negative to most positive. The number "1" was assigned to the most negative and the number "5" was assigned to the most positive. The answers given to the negative expressions were numbered as 2, 5, 13, 14, 19 and coded backward in order to ensure the reliability of the results. While evaluating the results of the research, it was benefited from the programme SPSS (Statistical Package For Social Sciences) for Windows 16.0 for the statistical analyses and descriptive statistical methods such as number, percentage, mean, standard deviation and Independent Groups t-test were used. The results were evaluated bidirectional at $p<0,05$ of a significance level and %95 of a confidence interval.

3.5. Reliability Analysis: In the second part of the questionnaire, the reliability of the 25-item scale named "The Scale Of Corporate Reputation" developed by Charles J. Fombrun (Fombrun, 2001; within Yirmişbeş, 2010:93) has been tested and the reliability coefficient was found to be 0.911. A scale that has reliability coefficient between $O,80 \leq \alpha < l,00$ is accepted to be a reliable scale [14].

In the selection of the analysis that would be applied for testing the hypothesis of the research, the suitability of the data to a normal distribution was examined. the suitability of the data to a normal distribution has been examined. The most used distribution used in statistical studies is the normal distribution. The coefficient of skewness of the data set related to the level of the reputational perception is 0,461 and the coefficient of kurtosis is 0,257. For normal distribution these coefficients have to be between -2 and +2 and when the sample number is sufficient, some resources accept that the data shows a normal distribution when it is reached to the coefficient of skewness and the coefficient of kurtosis that are until (- +) 3,26 [15]. While analyzing the answers given to the scale questions, for the average values the results between 1,0-2.5 (including 2.5) were evaluated as low level, the results between 2.5-3.5 (including 3.5) were evaluated as moderate level and the results between 3.5-5,0 were evaluated as high level of the reputational perception. In this evaluation it was benefited from experts' opinion.

4. CONCLUSIONS AND FUTURE PROJECTIONS

4.1. The Results of the Descriptive Characteristics of the Participants: 8 descriptive questions in the first section of the questionnaire were asked to 253 nurses in the sample group and the data obtained is showed in Table 1 below.

Table 1. The Results of the Participants According to Their Demographic Characteristic

Age Ranges	Frequency	Percentage (%)	Service Unit	Frequency	Percentage (%)
18-25	103	**40,7**	**Internal Medicine**	23	9,1
25-35	71	28,1	**Surgery**	35	13,8
35-+	79	31,1	**Pediatrics**	15	5,9
Total	253	100	**Intensive Care**	59	23,3
Gender	**Frequency**	**Percentage (%)**	**Emergency**	30	11,9
Woman	230	**90,9**	**Other**	91	**36,0**
Man	23	9,1	**Total**	253	100
Total	253	100	**Working Type**	**Frequency**	**Percentage (%)**
Marital Status	**Frequency**	**Percentage (%)**	**Watch Method**	203	**80,2**
Married	140	**55,3**	**Shift Method**	50	19,8
Single	113	44,7	**Total**	253	100
Total	253	100	**The Hospital Working**	**Frequency**	**Percentage (%)**
Working Time in the Occupation	**Frequency**	**Percentage (%)**	**Public Hospital**	180	**71,1**
0-5	120	**47,4**	**Private Hospital**	73	28,9
05.Eki	42	16,6	**Total**	253	100
Eki.15	25	9,9			
15-+	66	26,1			
Total	253	100			

In Table 1 it is seen that 40,7% (103 people) of the nurses participated in the research is between the ages 18 and 25, 90,9% (230 people) of them are women, 55,3% (140 people) of them are married. The working time of 47,4 % (120 people) of the participants in the profession is between 0 and 5 years. 38% (91 people) of them are working apart from the given units, 80,2% (203 people) are working with a watch method, 28,9% of them are working in a private hospital, 71,1% of them are working in a public hospital.

4.2. The Results of The Participants' Perceptional Level About Corporate Reputation: The first of the research questions within the scope of the survey intends to identify the perception level of corporation reputation of the nurses who are a public hospital employees and the second one intends to identify the perception level of corporation reputation of the nurses who are a private hospital employees. The achieved statistical results in relation to the questions of the research and the average are as follows.

Question1: At which level do the nurses working in the hospital that is in the city center of Nevşehir perceive the corporate reputation of the hospital they work in?

Table 2. The Perception About Corporate Reputation of the Nurses Working in A Public Hospital

	HOSPİTAL	N	Mean	Std. Deviation	Std. Error Mean
MEAN OF PERCEPTION	Public Hospital	178	**2,9106**	0,43731	0,03278

As it is seen in Table 2 the mean level of perception of the 178 nurses working in a public hospital related to corporate reputation was found to be 2.9106. Thus, Question 2: At which level do the nurses working in the private hospitals that are in the city center of Nevşehir perceive the corporate reputation of the hospitals they work in?

the reputational perception of the nurses working in public hospital about their institutions is moderate.

Table 3. The Perception About Corporate Reputation of the Nurses Working in A Private Hospital

	HOSPITAL	N	Mean	Std. Deviation	d. Error Mean
MEAN OF REPUTATION	Private Hospital	75	**3,3659**	0,49006	0,05659

As it is seen in Table 3 the mean level of perception of the 75 nurses working in a public hospital related to corporate reputation was found to be 3.3659. Thus, the perception level of corporate reputation of the nurses working in a private hospital was found to be higher than the reputational perception of the nurses working in the public hospitals. However, as the values between 2,5-3,5 were identified as moderate, their perception level were also identified as moderate.

4.3. The Results Related to the Differences in the Perception about Corporate Reputation of the Nurses Working in Private and Public Hospitals: The last question in the scope of the research, a developed hypothesis based on the question and the gained statistical results related to both of them are as follows.

Question 3: Does the perception about corporate reputation of the nurses working in the public hospitals in the city center of Nevşehir differ from the perception about corporate reputation of the nurses working in a private hospital?

Hypothesis 1 (HA): The perception about corporate reputation of the nurses working in the public hospital in the city center of Nevşehir differs from the perception about corporate reputation of the nurses working in a private hospital

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Table 4. The Results Related to the Differences in the Perception about Corporate Reputation of the Nurses Working in Private and Public Hospitals

Independent Groups t-test

	HASTANE	N	Mean	Std. Deviation	Std. Error Mean
Generally	Publıc Hospital	180	**73,9278**	12,36278	1,92147
	Private Hospital	73	**87,0274**	17,42043	2,03891

		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	Sig.	t	df	Sig. (2-tailed)
Generally	Equal variances assumed	10,896	**0,001**	-6,742	251	0
	Equal variances not assumed			-5,855	102,693	0

When the sided t-test results were examined within 0.95 (1-α) confidence interval, the sigma value (0.001) was found to be smaller than the value of α (0.05 = significance level) (Table 4). For this reason, the hypothesis 1 has been accepted. Thus, the perception about the corporate reputation of the nurses working in the public hospital in the city center of Nevşehir is statically different at 95% of confidence from the perception about the corporate reputation of the nurses working in a private hospital. The independent groups in t-test, the mean of perception about corporate reputation of the public hospital employees towards their institutions was measured as 73,9278, the mean of perception about corporate reputation of the private hospital employees towards their institutions was measured as 87,0274. Therefore, the perception about corporate reputation of private hospital employees is higher than the perception about corporate reputation of public hospital employees.

As a result, according to the results obtained from the research, the perception level about the corporate reputation of the employees (nurses) working in hospitals (private and public) is at a moderate level. This situation shows that the hospitals do not give enough importance to the studies that can improve

their corporate reputation towards their nurses who are the stakeholders. Furthermore, it has been found that this perceptional level differs according to the situation that whether nurses are working in a private hospital or in a public hospital. Conducting the research to a large sample again, at the same time including the other stakeholders of the management of corporate perception in the research is recommendatory for the researchers of this subject. Moreover, conducting the research again according to the participants' age, working time etc., will enable researchers to obtain the results that can answer many questions related to this area.

Appendix 1: The expressions in " The Scale of Corporation Perception" developed by Charles J. Fombrun [13]

1. I have knowledge of the services of the institution in which I work.
2. Recently, I haven't heard and seen anything about the institution in which I work in the media.
3. The institution which I work is managed well
4. The institution which I work has talented employees
5. The institution which I work is generally insufficient and unproductive
6. The institution which I work is managed by clever and talented people
7. The institution which I work offers high quality service
8. The institution which I work is innovative
9. The institution which I work adds value to its employees
10. The institution which I work has remarkable resources
11. The institution which I work is very powerful.
12. The institution which I work is the leader among the others.
13. The institution which I work in general sense is a weak institution
14. The institution which I work has no different features from the other
15. The institution which I work can be distinguished from the other in terms of its operating format
16. I really know the institution in which I work
17. I have positive feelings about the institution in which I work
18. I usually believe in the explanations made by the institution in which I work
19. Based on my experience, I must say that the institution in which I work never keep its promises
20. The institution which I work is an institution I can trust
21. The institution which I work is reliable and honest on the communication with the community
22. The institution in which I work is an institution that cares about its employees
23. The institution which I work contributes to its employees.
24. The institution which I work is environmentally responsible.
25. The institution which I work concerns about the safety of its employe

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AN EVALAUATION OF HEALTH CARE PERSONNEL EMPLOYED IN THE PUBLIC HEALTH AGENCY OF TURKEY IN TERMS OF BUSINESS-FAMILY LIFE CONFLICT

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ABSTRACT

Purpose: The purpose of this study is to determine the understanding of the health care personnel working at Public Health Agency regarding the concept of business-family life conflict and the effects of business-family conflict and family-business conflict, which are the sub-dimensions of this concept, on the said personnel.

Material and Method: The study was administered to 147 health care staff members working at Karatay Public Health Center, Meram Public Health Center and Selcuklu Public Health Center, all affiliated with Konya Directorate of Public Health. "The Business-Family Life Conflict Scale", which was developed by Netenmeyer, Boles and McMurrian (1996), was used to collect the research data. Cronbach Alpha coefficient calculated for the overall reliability of the scale was calculated to be 0,65 ($p=0,000<0,05$). In the data analysis stage, frequency analysis was

used for descriptive statistics, reliability analysis was used to determine the reliability of the scale, t-test was used for two-way comparisons of the scale and one way anova test was used for multiple group analyses.

Findings: It was found that there was a positive correlation between the variable of business-family conflict resulting from the business life of the research participants and the hours an employee spends at work, whereas a negative correlation was identified between the variable of family-business life conflict resulting from family life and the number of children an employee has. The factor analyses made also reveal that these two scales are empirically different from one another. The findings in question indicate that both these scales are powerful in terms of reliability and validity.

Conclusion: When the business-family life conflict was compared with demographic factors, it was found to be significantly correlated with many factors. In other words, problems in our business life affect our family life and in turn problems in our family life affect our business life. Measures should be taken on an individual, organizational and national basis to reduce these conflicts to a minimum**.**

Introduction

It is about to discuss whether the life quality of employees increases when balancing private and professional life. The focus then is that 'Do enployees work more efficiently and creatively at work' and 'Are employees happier when spending more private time with their families? More and more publications of business life are dealing with the topic and that is the reason why this currently became an important issue of intensive researches [1]. As business and work is an issue for every individual, it is out of question that it has an effect on the life of people. Every individual struggles for better living conditions in the frame of society. Consequently, the balance between profession and privacy gets a different meaning; the people have to care about it. As changes in the world are occuring, this need of balance causes a development of strategies. The results of the researches mirror both, the focus on individuals and organisational groups. The increase of tension, the worsening performance and feeling of dissatisfaction in life are some result factors which came up in the researches [2] Thinking of a connection between privacy and profession, there are five theories to be mentioned[3,4,5,6,7,8,9,10,11,12,13,14,15,16,17,18 ,19,20].

'Rational Theory, Compensation Theory ,Contribution Theory, Overflow Theory , Conflict Theory'

While preparing their research, the rational and compensation theories emphasized the unit of time pressure. The rational theory depicts that the conflict is caused by time. According to the compensation theory, there is an interconnection between privacy and profession. As an individual experiences inefficiency at work, he/she tries to compensate this 'loss' by turning towards the private life. This phenomenon causes an inbalance in time. The contribution theory claims that the individual influences the organisational group and the other way around. The result is that the whole satisfaction depends on that. The overflow theory reflects that when any changes come up in private life – good or bad – this will also have an effect on the work life. The conflict theory shows that people have to fulfill many duties and they are responsible for those. In contrast, they have difficulties in realizing them because it is too demanding for them. Globalisation changed the whole World. One example of this modern progress is that, women get more and more involved into business life. This shows that the birth rates are decreasing, while the divorce rates and marriage at an old age rates are increasing. The more successful a women is in terms of career and the more she is getting into the leading position in her family provokes divorce cases. As a consequence, this is one of the most experienced privacy-profession-conflicts [21]. The resarch results show that it is not easy to presume that when the balance between privacy and profession is given, there will be fulfilled and satisfied employees. Identifying one reason is that both, the fields of work and family are flexibly changeable. The organisational groups are open systems and they can create a certain structure which is lived by the employees. Some factors of the organisational group influence are as following: purpose, culture, structure, styles of administration, working procedures and their administrative system arrangement. This includes also the definiton and needs of a work field. To sum up, changes can ocur easily. Besides that, the family itself is a kind of social organisation which is also not static. The employees face a variety of features while being at home such as biological, psychological, economic-financial, social and legal factors. As a consequence, there is obviously a flexible connection between famliy and work which means that it is highly possible that any slight

movement or change could create a conflict in one's life. When a conflicting situation inevitably occurs, it is necessary to manage it. To be able to tackle with problem cases between work and family, a valuable human resource policy should be developped, further organisational group arrangements and applications have to be realized. This is important for institutions and corporations because they have to know in order to act, if necessary [22]

Research Method

This research was carried out at the Karatay Toplum Sağlığı Merkezi, Meram Toplum Sağlığı Merkezi and Selçuklu Toplum Sağlığı Merkezi which are connected to the Konya Public Health Management. A group of 147 health staff members took part in the research. A limitation of the study is that some health staff members could not be reached because of their professional duties to attend the Aile Hekimliği Birimi, Aile ve Çocuk Sağlığı Merkezleri or some vaccination programmes at public schools. The methods of area research and literature research were used, finally the secondary literature was analyzed. The questionnaire technique was mainly used in the research. All collected data was analyzed by SPSS. The data was put together using the 'Family-Work conflict scale' developped by Netenmeyer, Boles, McMurrian (1996) [23] The first page of the scale included demographical features such as age, marital status, state of education. The second page of the scale included the family-work conflict scale questionnaire. It consisted out of total 10 questions created on the base of the 6-point Likert scale. To find out the dimensions of the family-work conflict scale, the Cronbach Alpha value was calculated as 0,88 ($p=0,000<0,05$). For proving the reliability of the questionnaire, the SPSS programme was used (65%). The data was analyzed with the help of frequency analysis, variance analysis and reliability analysis.

First, the demographical results were shown in a table, After that, the answers to the family-work conflict scale were enlisted.

Research Results

Table 1: Results of the demographical data

Length of Service	**N**	**%**	**Job**	**N**	**%**
1-5 year	24	16,3	Doctor	28	19
6-10 year	51	34,7	Nurse	35	23,8
11-15 year	41	22,9	Accoucheuse	32	21,8
16-20 year	26	17	Health officer	12	8,2
21 +	6	4,1	Technician	11	7,5
Study Year in Community Health Center	**N**	**%**	Technician	6	4,1
1-5 year	147	100	Administrative Staff	23	15,6
Working Hours	**N**	**%**	**Age**	**N**	**%**
40 hour	147	100	20-25	7	4,8
Marital status	**N**	**%**	26-30	28	19
married	133	90,5	31-35	45	30,6
single	14	9,5	36-40	34	23,1
Does your spouse work?	**N**	**%**	41-45	27	18,4
Yes	115	78,2	46 +	6	4,1
No	18	12,2	**Education**	**N**	**%**
Full-time Job	**N**	**%**	High school	2	1,4
Yes	147	100	Associate degree	35	23,8
No	0	0	Undergraduate	110	74,8
Gender	**N**	**%**	**Total**	**147**	**100**
Female	88	59,9			
Male	59	40,1			
Total	**147**	**100**			

As shown on the table, the research participants were about 19% doctors, 23,8% nurses, 21,8% midwives, 8,2% health officers, 7,5% technicians and 15,6% of administrative staff. Having a look at the age groups of the participants 30.6% are between 31-35 years old, so that they represent the majority. The minority participants are about 46 years old or older and represent 4.1%. The participants were mainly women (59,9%), the percentage of male participants were just about

40.1%. Their state of education differs, too. 1.4% were about high school graduates. The pre-license students were about 23.8%, while still the largest group was about the university graduates with 74.8%. The working years and the experience at work was mainly about 6-10 years which was in case of 34.7% of the participants. All employees work 8 hours a day on weekdays, which comes up to 40 hours in a week. The participants were married for 90.5% and their husbands/wives were actively working in business life for 78.2%.

Table 2: Answers to the 'Family-Work Conflict Scale

	I totally disagree		I agree little		I agree a little		I agree		I definitely agree		I absolutely agree	
	N	%	N	%	N	%	N	%	N	%	N	%
My job duties influence my family and home life in a negative way	9	6,1	18	12,2	28	19	39	27	37	25	16	10,9
As long as I work, it is difficult for me to fulfill my responsabilities towards my family	4	2,7	24	16,3	27	18,4	35	24	41	28	16	10,9
The activities I like to do at home are not to realize for me because of my job duties	9	6,1	16	10,9	29	19,7	34	23	40	27	19	12,9
The tension and pressure which are created by my work represent an obstacle for me in making my family dreams true	5	3,4	22	15	31	21,1	31	21	44	30	14	9,5
I have to change my family plans because of my job duties	7	4,8	26	17,7	22	15	32	22	43	29	17	11,6
The requirements my family need affects my work life in a negative way	56	38,1	50	34	37	25,2	3	2	1	0,7	0	0
My life at home requires that much duties that I have to postpone my work tasks	47	32	54	36,7	39	26,5	5	3,4	1	0,7	1	0,7
The responsabilities towards my family do not allow me to do professional activities I am interested in	58	39,5	50	34	35	23,8	3	2	1	0,7	0	0
My family life, arriving at work in time, fulfilling daily life needs and to work overtime are affecting my professional duties negatively	77	52,4	59	40,1	11	7,5	0	0	0	0	0	0
The tension and pressure caused by my family life affect me negatively in terms of realizing my job-related duties	58	39,5	50	34	35	23,8	3	2	1	0,7	0	0

Having a deeper look at table 2, it can be seen that the question 'My job duties influence my family and home life in a negative way' was answered with 'I agree' by 26.5%, while the percentage of people who marked 'I totally disagree' is about 6,1%. The statement'As long as I work, it is difficult for me to fulfill my responsabilities towards my family' was ticked off 'I definitely agree' by 27,9% of people. Only 2,7% marked the answer 'I totally disagree'. The next statement 'The activities I like to do at home are not to realize for me because of my job duties' was marked with a percentage of 27,2 as 'I definitely agree'. In contrast, 6,1% projected their perspective by ticking off I totally disagree. The following issue 'The tension and pressure which are created by my work represent an obstacle for me in making my family dreams true' is marked by 29.9% as 'I definitely agree'. The opposite case is the percentage of 3,4% with people who ticked off 'I totally disagree'. The issue 'I have to change my family plans because of my job duties' was marked by 29,3% as 'I agree'. The minority of 4,8% marked their opinion by 'I totally disagree'. The statement 'The requirements my family need affects my work life in a negative way' was marked by 38,1% as 'I totally disagree'. Only a percentage of 0,7% marked it with 'I definitely agree', further

nobody ticked off the answer 'I absolutely agree'. 'My life at home requires that much duties that I have to postpone my work tasks' was marked by 36,7% of people with'I agree little'. In contrast, 0,7% answered with 'I definitely agree' or 'I absolutely agree'. The issue 'The responsabilities towards my family do not allow me to do professional activities I am interested in' was ticked off by 39,5% as 'I totally disagree':, while a percentage of 0,7% marked the answer 'I definitely agree'. The following statement 'My family life, arriving at work in time, fulfilling daily life needs and to work overtime are affecting my professional duties negatively' was marked by 52,4% as 'I totally disagree'. Possible answers such as 'I agree', 'I definitely agree' and 'I absolutely agree' were not ticked off by any participants. The last issue 'The tension and pressure caused by my family life affect me negatively in terms of realizing my job-related duties' was answered by a percentage of 39,5% as 'I totally disagree'. A percentage of 0,7 ticked off 'I definitely agree' while the possible answer of 'I absolutely agree' was not chosen at all.

Resarch Analysis

Table 3: The One Way Anova Test and t Test

Work-Family Conflict							
Gerend	**Average**	**t**	**p**	**Age**	**Averagea**	**F**	**p**
Female	2,975	2.11	0,011	20-25	2,2	5,935	0
Male	2,7288			26-30 31-35	2.5393 3,1333		
				36-40	3,1206		
Marital status	Average	t	p	41-45	2,6741		
Married	2,9917	7,125	0	46 +	2,8333		
Single	1,7786			20-25	2,2		
Does your spouse	**Average**	**t**	**p**	**Education**	**Average**	**F**	**p**
Yes	3,0165	1,148	0,253	High school	3,35	1,373	0,257
No	2,8333			Associate degree	3,0086		
Job	**Average**	**F**	**p**	Undergraduate	2,8255		
Nurse	2,9286	0,757	0,605	**Experience**	**Average a**	**F**	**p**
Accoucheuse	2,9563			1-5 year 6-10 yıl	2,4375 3,0216	3,329	0,12
Doctor	2,6643			11-15 year 16-20 yıl	2,978 2,848		
Health officer	2,9833			21+	2,8167 Ortalama		
Administrative Staff	2,9			1-5 year 6-10 yıl	2,4375 3,0216		
Technician	2,9909			11-15 year	2,978		
Technician	2,6167						

The results of the research are shown in table 3. Referring to the signficance test, the value ($p<0,05$) was identified. When the participants sex is taken into consideration while trying to build up a coherence to the family-work conflict, there is a difference visible which has a certain meaning ($p<0.05$). In comparison to men, women face situations of family-work conflicts much more often. The results which are enlisted in table 3 also include the factor 'marital status'. Once again, a difference between single and married people, in terms of family-work conflicts, appears which also shows a certain meaning ($p<0,05$). In comparison to singles, the possibility of experiencing a family-work conflict as a married person is even higher. According to the research results, there is no differentiating importance whether the life partner works or not ($p>0,05$). According to the research scale results, family-work conflict stay in very strong interrelation with ages. As a result, the highest degree of family-work conflicts occur in the age group between 31-35. The lowest degree of family-work conflicts occur in the age group between 20-25. Moreover, the state of education

does not have an influential effect on family-work conflicts (p>0,05). The fields of work, as the participants profession was different from each other (doctors, nurses, technicians, etc.) does not have a significant differentiating effect (p>0,05). The tables which were created on the base of several analysis, there is no significant difference between family-work conflicts and work experience (p>0.05). Generally, it can be said that the possibility to live a conflict is on medium-level.

Discussion and Consequence

It is confirmed that the family-work conflict scale, which was used in our research, was proven to be reliable. When considering the difference between female and male participants in the issue of family-work conflict, the discrepancy shows that there is a meaning hidden. While the family-work conflict average for women is about 2,9750, for men it is just about 2,7288. As adding the criteria of marital status, there is a very clear and striking difference between the married and the single people. The risk of being confronted with family-work conflict is much more the case for married couples. Following the percentages, the percentage of married couples is about 2,9917 while the single people only have a percentage of 1,7786. The life partners of research participants were usually working which was also a factor for provoking a family-work conflict. Further, it can be assumed that the married couples have a possibility of about medium-level to face family-work conflicts. Having a look at the participants' age groups, there is a striking difference. The average of the age group 31-35 is about 3,1333 and the average of the age group 36-40 is about 3,1206. These results show a close connection between each other, moreover these two results represent the highest averages in the research. The average of the age group 20-25 is about 2,2000 and represents the lowest average result. One reason to explain this is probably the fact that comparatively the number of single people is higher than in the elder age groups. The three categories 'state of education', 'profession group' and 'work experience', which were involved and put into relation with family-work conflicts, do not show any deeper meaning in difference. The significant values of the categories are as following: 'state of education is about 0,257, the 'profession group' is about 0,605 and the 'work experience'is about 0,12. As the difference is higher than 0,05, the difference has no important meaning and the conflict rate is on medium-level. Modern institutions which have an understanding administrative leadership and are aware of the current problems, are already busy with creating and launching programmes against family-work conflicts. Even though, the negative affects are still not removed totally from real life. To manage with the conflict, everyone has to put personal effort in it, further it is neccesary that companies and corporations have to create programmes. The managers should make the human resources employees aware of its importance (Hammonds, 1996/16).

The results of this research represent very essential and valuable content for both, researchers who are focused on studies about family-work conflicts, as well as for professional administrators.

Based on this research results, further studies on family-work conflicts can be launched on issues as enlisted:

- The Family-Work Conflict should be analyzed by taking the five theories into consideration
- This research should be applied on different profession branches
- While carrying out this research, aspects like general profile and demographical features should be taken into consideration as well

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