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RELATIONSHIP ORGANIZATIONAL CULTURE AND ORGANIZATIONAL COMMITMENT IN HEALTH INSTITUTIONS

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A R T I C L E I N F O

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Abstract

Shared and learned values, norms, believes, behaviors and symbols which are known as organization culture; is a holistic element that describes organizational aims and helps organization members to understand organizational objectives within and beyond the organizational environment. From this point of view, successful firms have to establish an organization which is powerful and unique in their organizational cultures. One of the critical factors for the organizations to be consistent or to expand its existence to the long term in a competitive environment, is that; for the each individual to adopt organization as an independent phenomenon and to feel commitment to the identity, policy and the vision of the organization for which they work. At this stage, it would not be wrong to perceive the organizational commitment which is the basic determinant of the identity, the mission and the vision of the organization. From this point purpose of this study of relationship between

organizational culture and organizational commitment to determine the effects in the health sector. The study, conducted in the Aegean and Black Sea region has tried to work in this sector. Applied to the field research and statistical analysis of the data obtained in tests, the levels of organizational culture on organizational commitment has revealed the extent.

This survey was applied to 200 poeple randomly selected from the employers in Farabi Hospital and Nazilli State Hospital. Survey method was utilized as data collection method. The main issue of the research is constituted from the question as "Do the organizational culture and organizational culture dimensions of Hofstede have an effect on the organizational commitment and organizational commitment factors?" As a result of the research, It is concluded that the all five dimensions of the culture affect the commitment and the organizational commitment significantly changes according to the sex.

Introduction

1. THE CONCEPT OF ORGANİZATİONAL CULTURE

1.1 The Concept of the Organization

Many different definitions of the organization are made. Barnard, (1938) describes organization as " a system of two or more individuals to consciously coordinated activities or forces and suggests that an organization is willing to contribute to action in order to achieve a common goal and they are individuals that communicate with each other (Erdem, 2007). According to Hasanoğlu, "the organization is expressed as an organic system that constantly renovated of regulation and funtioning of human material resources in order to resolve one or more requirements of individuals. In this system, supplying the goals and needs of the organization of those who govern and management purposes (Hasanoğlu, 2004).

1.2 The Conception of Culture

The first time, the meaning of lifestyle human has been installed in 1750s. According to definition of Tylor, "culture is a whole that include knowledge, belief, art and ethics, customs and traditions, habits that individual connects (Nişancı, 2012). As a concept, culture is a word that not agreed definition of it, having a wide area and range. The culture which is a concept related to the human is expressed a meaning system that formed in date.

1.3 The Concept of Organizational Culture

The concept of organizational culture; is one the working area under organizational behavior and consisting of behavioral disciplines such as Psychology, sociology, social psychology, anthropology and political science. The organizational behavior in business is indicative of the business culture. Organizational culture can be regarded as valued and encouraged the kind of behavior in organization.

Deal and Kennedy define organizational culture as " doing business and the execution format and state values of the elements of the organizational culture, practices in the workplace, heroes and the stories told with more indirect communication channels (Kaya, 2008:122).

2. THE CONCEPT OF ORGANİZATİONAL COMMİTMENT

2.1 The Definition of Organizational Commitment

It is the sum of internalized normative pressures to move to meet organizational interests (Wiener, 1982). As an attitude, devotion is identification with organization. As the behavior, devotion is the change in the direction of joining the organization to benefit from organizations such as pensions or wages (Shaw and Reyes, 1992).

The organizational commitment is an important issue for organizations and according to managers, always is seen as giving rise to significant consequences such as being late, poor performance and absenteesim (Ceylan and Şenyüz, 2003). Researches showed that employee has organizational commitment have high share more effort in fulfilling their responsibilities, they stay longer in the organization and the person who seeing the positive aspects of communication with organizations and continue to contribute to the organizations increased efficiency.

3. ORGANIZATIONAL CULTURE AND THE RELATIONSHIP OF ORGANIZATIONAL CULTURE

The organizations have a strong organizational culture an increase the organizational commitment of employees by knowing what is the organizational commitment, the reasons behind and how to develop. This situation is very important for organizations (Tiryaki, 2005). In today, the most important factors will create a competitive advantage for organizations is that members of the organization have high organizational commitment. In this context, the contribution of the organizational culture cannot be ignored in the creation of organizational commitment of employees by establishing a link between employee's goals and organization objectives. In that it contributes to the formation of a sense of belonging among members of the organization.

Research

This scientific research is made in random by selected 200 people from the employees of KTU Medical School Farabi hospital and Nazilli state

Hospital. As the data collection method, the survey methods were applied. In front of the questionnaire used to gather data, there are gender, education level, work time and demographic questions showing of the living. There are 26 questions about organizational culture and commitment on the other side of survey.

4.1 Status of Problem

The main problem of the research investigates the question "do the organizational culture and the organizational cultural dimensions of Hofstede (1980) have an impact on the organizational commitment factors? The survey was aimed to investigate this problem.

4.2 Importance and Aim of The Issue

In today's rapidly changing conditions, it is stated that should give importance to the concept of organizational culture and organizational commitment in order to the realization goals of the organization, maintain their survival and development. Because, the most important factor that will create a competitive advantage over other organizations "employees" are accepted to organizations. As the reason of this, the technology, products and other similar factors can be easily imitated, but the human element cannot be imitated opinion is showed.

4.3 Assumptions

There must be an investigation that may affect the assumptions and for the cases excluded in the study. Situations which may affect our research and the situations excluded in the study: It is considered that KTU and Nazilli State Hospital have the organizational culture. It was admitted that research method appropriates to subject and its aim. The responses received to the questionnaire is one of the another assumptions that reflect the actual views of the **respondents.**

4.4 Limitations of The Research

The research that made to determine the impact of organizational culture of KTU Farabi Hospital and Nazilli State Hospital on organizational commitment is limited to personnel who servet during the period surveyed. Another thing that limits me in research is that I have only been able to apply in two provinces due to the difficult accessibility.

4.5 Universe and Sample

The feature of the source of data collection is to be important for the results of the research is available, reliable and to be available. The most accurate result is results obtained from all of the sources obtained the information sought. However, this is not always possible. Especially, when the source is very large and widespread to make it extremely is difficult and rigorous. Therefore, instead examine all of the resource will be required to work on a specific example. While some examples is adequate to fully represent the universe, this representation is not available in some examples. The sample must be selected smoothly for it. In the Aegean and Blacksea, health workers constitutes he universe of the research. On the other hand, in Trabzon and Aydın, in a total, 200 health care workers in hospitals I chose consist the resampling.

4.6 Data Collection Facility and Methods

Firstly, literature search have been related to the organizational culture and organizational commitment issues, secondly, the survey was conducted in two hospitals in the two cities of Blacksea and the Aegean Region. The all data's for research have been tried to collect with the questionnaire method. Taşkın Kılıç's individual and collective qualification process survey was used fort he survey questions.

The survey was applied to 200 patients. A total of 26 questions were asked in the survey. Questions are 5 choices (strongly disagree, disagree, unstable, agree, strongly agree) and answers were asked according to likert scale. SSPS 16 package was utilized during the evaluation of results. All of the paricipants respond to all questions in the survey were made. Reliability analysis, correlation analysis, regression analysis, frequency analysis, T-test and anova analysis were made in the evaluation of data obtained in the research.

Findings and Comment

5.1 Reliability Test

	Number of questions	Number of Participation	Reliability degree
Organizational culture and organizational commitment	26	200	0,91

Chart:5.1 Reliability Test

Before interpreting the survey stage the level of reliability was measured. Confidence level was measured as 91 in the 26-question survey that applied to 200 people. The survey was considered as reliable because of exceeding 70 level.

5.2 H1 Hyphothesis Analysis and Correlation and Regression Analysis

	Masculunity-Feminity	Power Distance	Uncertainty avoidance	Individualism Approach	The Orientation
Commitment	,016	,00	,00	0,00	0,00

Chart:5.2 H1 hypothesis, correlation analysis

It is determined to understand whether there is a significant relationship between the dimensions of the culture and commitment. There is a significant relationship between culture and commitment because of 0,016<0,05.The significant value of another 5 size was found as 0,00.Another 5 size have a strong significance relationship with comment due to increase the level of relations when approaching to "O". Our H1 hypothesis was admitted 5 dimensions of culture affects the commitment.

Masculunity Feminity	Power Distance	Uncertainty avoidance	Individualism Approach	The Orientation
0,24	0,64	,283	0,318	0,422

Chart:5.2 H2hypothesis regression analysis

The five dimensions of culture creates a positive effect on the commitment was seen with the above regression analysis. To increase 1 unit the commitment, how much value should is on the chart. 0,422 time orientation commitment is the highest value is the most affecting size.

5.3 H2 Hyphothesisanalysis and t-test

	Masculunity Feminity	Power Distance	Uncertainty avoidance	Individualism Approach	Time Orientation
Aegean	2,79	2,78	3,59	3,52	3,67
Black sea	2,78	2,61	3,43	3,38	3,52

Chart5.3 H2 hypothesis analysis and t-test

T-test was used to see whether five dimensions of culture has significantly changed according to region and the significance levels were found as the values on the chart. As it can be seen from this, we determines that the organizational culture has not change according to geographic region and no significant relationship because all values are great from 0,05. Our H2 hypothesis was rejected.

5.4: H3 Hypothesis analysis and t-test

	Number of person	Number of percent	Significant Degree	The average of the answers
Aegean	100	50	0,151	3,25
Blacksea	100	50	0,151	3,11
Total	200	100	0,151	3,18

Chart:5.4 H3 hypothesis analysis and t-test

As it can be seen from this chart, 100 person from Aegean Region an 100 person from Blacksea Region participate to survey. The significance level was found 0,151. Nonetheless, there is no a significant relationship between living geographical area and the commitment.

5.5: H4 Hypothesis analysis and t-test

	Number of person	Number of Percent	Significant Degree	The average of the answers
Female	102	51	0,005	3,04
Male	98	49	0,005	3,32
Total	200	100	0,005	3,18

Chart:5.5 H4 hypothesis analysis and t-test

As it can be seen above chart, 102 is female and 98 is male from 200 person who participate to survey. The significance level among the genders is 0,005. There is a significant diversity due to 0,005<0,05. Dependence of men are more different significantly than women. Consequently organizational commitment is changing according to gender and our H4 hypothesis was admitted.

CONCLUSIONS AND FUTURE PROJECTIONS

Organizations are in a constant competition in order to maintain their existence in today with the effect of globalization and keep in the same level or raise their market share falling due to the new rival enterprises in the market. There are almost no opportunities in which the high market share can be acquired. It is very important for organizations to realize the 'human' factor and its significance which is the hearth of the matter for having a successful tendency vision. In this sense, as the efficiency of the employers is the part of the achievement of the organization, it is necessary to have a strong organizational culture that helps developing the organizational commitment level. In today's world, together with the foundation of multinational enterprises and the necessity to make business in various cultural environment, organizational culture and organizational commitment issues have become a strategical factor in the organizational management. At this point, the organization culture provides consistency within the organization by differentiating the enterprises from other organizations a well as expressing the whole cultural elements that help gaining an identity status, and through the development of the sense of self of the employers. The success rate of a structure with employers whose commitment level are raised through a deeply rooted organization culture, is certainly higher comparing to the other organizations. The sympathizer culture within the organization is reflected to the commitment and a strong organization structure can be developed.

According to Freel (2003), men have a higher dependence on organizations than women. Similarly, rooted organizations with settled procedures and routines have a difficulty in complying with basic changes. The aforementioned routines and procedures pose an obstacle for innovation (Freel, 2003).

The study that was conducted by Scheepers et al. (2008) shows that some of cultural dimensions within an organization increase the profitability, performance and organizational dependence of the organization in the long term and they also increase the

general value of the organization. In this sense, the results of this study tally with the findings of the study that was conducted by Scheepers et al. (Scheepers, 2008). Tiryaki (2005) and Atan (2001) carried out a study similar to my study and acquired similar results. In the study applied in the banking sector, Güçlü also reached nearly same results. Özcan (2011) measured the relation between the organization culture and commitment at Uludag University and found no significant relationship.

The organization culture that shaping on organization is an important factor which may have a chance to be noticed among her competitors. As institutions that collect the people who come from different cultures, organizations have an important mission in understanding the importance of organizations culture and ensuring emphasis on people in organizations issues. The success rate of a foundation created by the people who raised the level of commitment with the foundation of a strong organizational culture will be high compared to other organizations undoubtedly. A strong organization structure that reflected will occur reception culture commitment in institutions.

This study has been made to explain whether the relationship between organizational culture and commitment in health institutions what it is. Literature review, various studies have benefited from Works written about it. Various questions were posed by choosing two provinces over two regions by the survey method to hospitals in here. The answers were analyzed with SPSS and reached the following conclusions.

- There is a relationship between the organization culture and the commitment.
- There is no significant relationship between organization culture and living geographical region.
- There is no significant relationship between organizational commitment and living geographical region.
- The organizational commitment is significantly changing according to gender.

It is necessary to pay attention to the time orientation at which the culture affects the commitment in a significant way. Punctuality can be given as an example to this dimension. For instance; In America punctuality is very important while in countries such as Turkey, Italy, Spain, punctuality is much flexible. When it is concluded that in terms of institutional structure, the ignorance of time concept affects the organizational commitment, it should be provided for all of the employers in an organization to pay attention to this dimension in a maximum level.

According to the result obtained in the study as “the organizational commitment of men are much higher than women”, it is necessary not to be irrelevant to the demands of the women and to be provided for women to use their rights related to maternity leave, breast feeding leave and other maternal rights that are the primary family responsibilities of women.

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SEASONAL AND MIGRANT FARMWORKERS' SATISFACTION LEVEL OF HEALTH CARE SERVICES IN SEMI-RURAL AREAS OF ESKISEHIR

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Abstract

Seasonal and Migrant Farmworkers and their family members (SMF) who have known as disadvantaged risk group all around the world due to their some characteristics. Providing highly qualified and accessible health care services to this group is critical. Aim of the study was evaluating the status of

applications to SMF for gaining the health care services and determining the satisfaction level of SMF with the health care services. The study was conducted in seven tent cities in Eskisehir. A three part questionnaire that includes questions related to socio-demographic characteristics of SMF, applications of SMF to health care services due to their health problems and SMF's satisfaction level of health care services. We conducted multivariate logistic regression to identify the socio-demographic and other factors that related to SMF's satisfaction level of health care services. We reached total of 46.3% SMF. The mean and standard deviation of age were 24.9±16.4 years. Among the SMF 39.4% were male, 53.1% applied to the state hospitals, 63.5% applied for examination, 89.8% were satisfied with health care services. Distance from the tent cities to the city center and educational level of SMF were associated with their satisfaction level of health care services. SMF prefer the secondary health care services rather than primary health care services. Therefore primary health care services should be advised to SMF for their health problems. Also expectancy of SMF from the health care services might be increased. Further qualitative and intervention researches will be needed to determine need and expectation of SMF about health care services.

Introduction

Agricultural sector is one of the largest employment area in Turkey as well as all over the world (Doğan, Arslan, & Berkman, 2015). Also Seasonal and Migrant Farmworkers and their family members (SMF) are defined the heart of sustainable agriculture activities (Hurst, Termine & Karl, 2005).

SMF are individuals who had to travel to another city or region to meet the needs of the agricultural workforce so that he/she was unable to return to his/her permanent residence within the same date (United States Department of Labor ETA, 2015).

In Turkey SMF migrate from Eastern, Southeastern Anatolia Regions to Çukurova, Black Sea and Marmara Regions for working in agricultural activities such as cotton, hazelnut, tobacco, tea, grape and sugar beet harvest in spesific dates.

According to the data of Turkish Statistical Institute 2011, in Turkey, 25 million people have known as main workforce. Of them, 26% worked as agriculture workforce and about 13% was called as SMF ("Turkish Statistical Institute Report, 2011).

Today it has been estimated that there are 450 million SMF all over the world (Hurst, Termine & Karl, 2005). According to the International Labour Organization data SMF meet 35% of total agricultural workforce (International Labor Office, 2011; Hurst, Termine & Karl, 2005). Particularly ABD, Canada and some developed European countries meet their agricultural workforce need from their disadvantaged regions or from other undeveloped countries (Bell, 2002; Taran & Geronimi, 2003).

According to the International Union of Food 2003 report there were some work deficits in agriculture sector. For instance, in every year, about 200.000 agricultural workers die as a result of accidents, 4 million people are affected by pesticides and suffer from poisoning. Agricultural workers are among the groups with the highest incidence of poverty in many countries and the majority of SMF are excluded from social protection (IUF, Geneva 2002). SMF can be determined as the highest risky group in terms of these deficits.

SMF have known as disadvantaged and dissatisfied risk groups all around the world due to some specific characteristics; unsuitable living and housing conditions, malnutrition, industrial accidents and injuries, reproductive health problems, pesticide exposure, the risk of heatstroke, frostbite, infectious diseases and premature child deaths and inadequate access to health care services (Şimşek, 2012).

The factors which effect the SMF's satisfaction level of health care services were determined as; factors related to the patient (their expectations, age, gender, educational level, health status, the perceptions about their health conditions etc.), factors about health care services providers (personel characteristics of health staff, status of shown kindness and care, scientific knowledge levels of health staff etc.) and environmental and institutional factors (closeness of hospital, income status, working duration etc.) (Aytar & Yeşildal, 2004). For these reasons, providing high quality and accessible health care services to these disadvantaged risk groups is so critical.

In light of this, evaluating the status of applications to the health care services and determining SMF's satisfaction level of health care services was aimed.

Materials and Methods

The cross sectional study was conducted in seven tent cities (Alpu, Sevinc-1 ve 2, Karacahoyuk, Bozan, Sakintepe ve Osmaniye) which had 20 and more tents and where located in Public Health Department of Eskisehir Osmangazi University Medical School Education and Research Regions in Eskisehir in 2014. Eskisehir is located in Central Anatolia, Turkey. In there the majority of people are engaged in agriculture especially in rural areas. Therefore, Eskisehir is one of the most preferable cities by SMF for agricultural activities.

Although Eskisehir has so wide and arable rural areas for agricultural activities, it needs agricultural workforce due to the intensive external migration. Every year a large number of SMF comes to Eskisehir from Southeastern and Eastern Anatolian Region for agriculture activities (Karabıyık, 2014) (Yildirak, Gülçubuk, Gün, Olhan, & Kiliç, 2003). The study was reviewed and approved by the relevant institutions. We aimed to reach all people that sheltered in the tent cities.

According to the literature a three part questionnaire was constituted to collect the data by the researchers. First part included the socio-demographic characteristics of SMF, second part included applications of SMF to health care services due to their health problems and third part included SMF's satisfaction level of health care services. SMF's satisfaction level of health care services were determined with their own expressions of SMF. All the tent cities were reached by researches. All participants gave informed consent. We used the face to face conversation method to collect data. Data of people less than 15 years was obtained from their parents.

Data were analyzed using the SPSS 20.0 (IBM). We used descriptive statistics to evaluate socio-demographic characteristics and SMF's satisfaction level of health care services. Then we conducted multivariate logistic regression to identify the socio-demographic and other factors that related to satisfaction level of SMF. A value of $p \leq 0.05$ was considered statistically significant.

Results

In the study days, we reached total of 482 (46.3%) SMF, who applied at least one time to health care services due to their health problems, responded the questionnaire. No difference was found between the tent cities in means of the number of responded SMF ($p>0.05$). The average number of application to health care services was 0.96±1.61 and ranged between 0 and 22. The mean and standard deviation of age were 24.9±16.4 years and ranged between 0 and 87 years. Table 1 shows socio-demographic characteristics of SMF.

Table 1. Socio-demographic characteristics

	n (482)	%
Gender		
Male	190	39.4
Female	292	60.6
Age		
14 and less	136	28.2
15-24	116	24.2
25-34	107	22.2
35-44	53	11.0
45-54	46	9.5
55-64	18	3.7
65 and older	6	1.2
Educational level		
Illiterate	304	63.0
Literate	62	12.9
Primary school	116	24.1
Marital status		
Single	197	40.9
Married	285	59.1
Having regular income		
No	233	48.3
Yes	249	51.7
Social Insurance		
No	116	24.1
Yes	366	75.9

Among the SMF 39.4% were male; 63.0% were illiterate, 40.9% were single, 51.7% had a regular income, 75.9% had a social insurance. Table 2 summarizes the characteristics of applications of SMF to health care services due to their health problems.

Table 2. The characteristics of applications of Seasonal and Migrant Farmworkers and their family members to health care services due to their health problems

Characterictics of applications	n (482)	%
Institution applied		
Family Medicine Center (FMC)	56	11.6
Integrated District Hospital	157	32.6
State Hospital	256	53.1
University Hospital	13	2.7
Who did you apply for?		
For me	326	67.6
For my children	139	28.8
For my wife/husband	9	1.9
Other	8	1.7
Cause of application		
Emergency	79	16.4
Examination	306	63.5
Control	14	2.9
General body control	1	0.2
Surgery	6	1.2
Mouth and teeth health	12	2.5
Pregnancy	37	7.7
Family planning	2	0.4
Prescription	1	0.2
Other	24	5.0
Cause of preferences		

Obligation	95	19.7
Closeness	319	66.2
Satisfaction of services	40	8.3
Advise	13	2.7
To have a familiar person	1	0.2
Habit	3	0.6
Other	11	2.3

Among the SMF; 11.6% applied to the family medicine centers, 32.6% applied to the integrated district hospitals, 53.1% applied to the state hospitals and 2.7% applied to the university hospitals. Additionally among the SMF; 16.4% applied for emergency cases, 63.5% applied for examination. The predictive factors among the applications to the health care services were reported as closeness of hospital (66.2%), obligation (19.7%) and satisfaction of health care services (8.3%). Table 3 shows SMF's satisfaction level of health care services.

Table 3. Seasonal and Migrant Farmworkers and their family members' satisfaction level of health care services

	n (482)	**%**
Did you satisfied with the health care services?		
No	49	10.2
Yes	433	89.8
Will you prefer the same doctor in each application?		
No	246	51.0
Yes	236	49.0
Can you share your complaints with your doctor clearly?		
No	24	5.0
Yes	445	92.3
Partially	13	2.7
Were you informed adequately about your health conditions by the doctor?		
No	37	7.7
Yes	417	86.5
Partially	28	5.8
Were you satisfied with the treatment?		
No	32	6.6
Yes	424	88.0
Partially	26	5.4
Were you satisfied from auxiliaries staff?		
No	13	2.7
Yes	444	92.1
Partially	25	5.2
Time of wait for examination		
Long	68	14.1
Normal	414	85.9
Short	0	0.0
Were you satisfied from cleaning of hospital?		
No	0	0.0
Yes	467	96.9
Partially	15	3.1
Will you recommend the health care services institution to your relatives?		
No	23	4.8
Yes	414	85.9
Partially	45	9.3
Can you assess quality of health care services compared to where you came from?		
Where I come from is better?	78	16.2
Here is better	271	56.2
No difference	133	27.6

Table 4. The related socio-demographic characteristics regarding the satisfaction level of Seasonal and Migrant Farmworkers and their family members according to logistic regression analyses

		95%Confidence Interval		
	Exp (B)	Lower	Upper	p value
Age	0.865	0.666	1.125	0.280
Gender	0.617	0.309	1.231	0.171
Distance from the tent cities to city center	0.495	**0.255**	**0.960**	**0.037**
Educational level	0.682	**0.468**	**0.993**	**0.046**
Marital status	1.576	0.696	3.569	0.276
Who did you apply for to the health care services	1.169	0.650	2.102	0.603

Of the SMF, 89.8% were satisfied with health care services, 49.0% went to the same doctor in each application, 92.3% had a good communication with their doctors, 86.5% were informed by the doctor adequately about their health conditions, 88.0% were satisfied from their treatment. Table 4 shows the related socio-demographic characteristics regarding the satisfaction level of SMF according to logistic regression analyses.

According to the logistic regression analyses, distance from the tent cities to the city center and educational level of SMF were associated with SMF's satisfaction level of health care services. The satisfaction level of SMF decreased as the distance from the tent cities to

city center increased. And also the odds of having high level of satisfaction of health care services was approximately twice in SMF with low level of education.

Discussion

In present study, evaluating the status of applications to the health care services and determining SMF's satisfaction level of health care services was aimed.

In this study approximately half of the SMF reported that they oftenly prefer the state hospital in Eskisehir City Center. The SMF may consider that the state hospital provides high quality and comprehensive health care services to them and the state hospital locates nearly to their tent cities. However this situation has caused that secondary health care services are being unnecessary.

In the 2010 report of The Ministry of Labor and Social Security, it has been recommended and aimed that all primary health care services to SMF should be given by FMC and Community Health Center (CHC) (ÇSGB, 2010).

The majority of SMF applied for the health care services for the examination. These consequences may be connected with inability of SMF to find suitable time for primary preventive health care services due to their hard working conditions. Thus, SMF are deprived of primary health services. According to the regulations about CHC (Sağlık Bakanlığı Türkiye Halk Sağlığı Kurumu, 2015) primary health care services should be planned and be provided to SMF appropriately.

In addition to this suggestion, in the report of "Farm Workers' Living and Working Conditions in South Africa," it has been emphasized that the most important system of health care delivery to SMF is the "Community Health Care" programme.

In present study, most of the SMF applied the nearest health institution because of the following reasons; inability to find suitable time, loss of income, inability to let vehicles. Furthermore when the distance between tent cities and hospital increased, the satisfaction level of SMF decreased. We suggested that the primary health institutions should be located at the near to the tent cities. Because closeness of health institution to the places of people is one of the most effective factor for determining their preferences to benefit from health care services (İlhan, Tüzün, Aycan, Aksakal & Özkan, 2006; Özcebe et al., 2003).

Of the SMF 89.9% reported that they had a good satisfaction level of the health care services. The factors; taking more quality health care services compared to their homelands, cleanliness of hospitals in Eskisehir, attitudes and behaviors of hospital staff, good communication between SMF and doctors, may be associated with the satisfaction level of SMF. Ozcan et al. told that 76 percent of individuals, who applied to Silvan State Hospital, had a good satisfaction level of health care services (Özcan, Özkaynak & Toktaş, 2008).

On the other hand, highly educated individuals had low satisfaction level of health care services ($p=0.037$). The lower expectancy of SMF from the health care services might be resulted with the higher level of satisfaction. Ercan et al. told that when the educational level increased, the satisfaction level of individuals decreased (Ercan, Ediz, & Kan 2004).

Conclusion

Finally, SMF prefer the secondary and tertiary health care services rather than primary health care services for certain reasons (obligation, closeness of hospital etc.). It burdens to secondary and tertiary health care services unnecessarily. Therefore primary health care services (FMC and CHC) should be advised to SMF for their health problems. CHC should take a primary part of monitoring the health care need of SMF and providing health care services to SMF. On the other hand lower expectancy of SMF from the health care services might be resulted with higher level of satisfaction. Further qualitative and intervention researches will be needed to determine needs and expectations of SMF about health care services.

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THE RELATIONSHIPS BETWEEN PSYCHOLOGICAL CONTRACT, ORGANIZATIONAL CYNICISM AND TURNOVER INTENTION

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A R T I C L E I N F O

Key words: Organizational Cynicism, Psychological Contract, Turnover Intention, Health Care Workers.

ABSTRACT

Aim. Hospital establishments are complex structures that embody various business fields. That is why the attitudes of employees towards organization can be affected positively or negatively. If this effect is negative, the employees can display insulting and ironical negative attitudes and can cause cynical attitudes and psychological breach of contract. This situation can increase the turnover intention. The aim of this research is to identify the effects of organizational cynicism and psychological contract subdimensions on turnover intention. **Method**. The employees (N=324) of a state hospital in Tokat (Turkey) province were included this study and the datas were obtained by using survey method. In order to test hypotheses correlation and regression analysis. **Findings.** In the study the effect of organizational cynicism subdimensions on turnover intention was not found significant (p>0,05), however the effect of operational psychological contract which is subdimension of psychological contract on turnover intention was found positive and

significant (H2a:β=0,191,p<0,01). Besides, it was determined that the operational psychological contract had a positive and significant effect on organizational cynicism (H3a:β=0, 279,p<0,01). Whereas, it was detected that the effect of relational psychological contract on organizational cynicism was negative and significant (H3b:β=-0,413,p<0,01). **Results**. The conclusion is that at the end of the study, operational psychological contract had positive effect on the turnover intention and organizational cynicism.

INTRODUCTION

Hospital establishments are complex structures that embody various business fields. Within these complex structures as a result of multiple relations of employees among themselves, patients and hospital management, their commitment on organization can be affected negatively or positively. If this effect is negative, there will be decrease in efficiency of staff and display negative attitudes towards organization. One of the negative behaviors attitudes is cynicism. Cynicism is a determined personality trait that is innate and originates from personality of individual. Cynicism generally reflects negative perceptions regarding human behavior (Tokgöz and Yılmaz, 2008: 285).

As for psychological contract, it is defined as a cluster of conceptions or personal beliefs related to mutual liabilities between the organization and employees (Morrison and Robinson, 1997). Including the non-written expectations of the members of the organization, psychological contract covers the mutual liabilities between the employer and employee. Some of these mutual liabilities are regarded as written while some others are seen during official work contract, but, different from the official work contracts, psychological contracts are not significantly defined clearly. The fact that these liabilities are not defined clearly makes these psychological contracts open to violations (Anderson and Schalk, 1998: 637-638).

The highness of organizational cynicism and psychological contract breaches prevent hospital establishments continue their activities in healthy way. It is very important that hospital managers should manage well and aware of these situations that affect the motivation of employees and increase their turnover intention. With this aim it is thought that our research will contribute literature and applications regarding subjects such as organizational cynicism, psychological contract and turnover intention.

1. CONCEPTUAL FRAMEWORK

1.1. Cynicism and Organizational Cynicism

Cynicism is a concept which its beginning grounded on ancient Greek. It is a way of life and a concept of explaining school of thought (Dean et al., 1998: 342). General Cynicism is arising from the an individual's personality a personality trait that is innate and determined. General Cynicism involves a concept that reflects generally negative perceptions about human behavior (Tokgöz and Yılmaz, 2008: 285). Organizational cynicism however defines negative display of an employee towards his job, manager or organization (Andersson and Bateman, 1997: 454-455). According to the definition of organizational cynicism by Dean, Brandes and Dharwadkar (1998:345); organizational cynicism is “the negative attitude that includes three dimensions that a person develops towards the organization that he/she works in”. These dimensions are respectively, (1) the cognitive dimension which is a kind of belief that there is no honesty within the organization, (2) the affective dimension that contains bearing negative feelings for the organization, and (3) lastly the behavioral dimension that contains exhibiting

derogatory and critical behaviors against the organization.

1.2. Psychological Contract and Psychological Contract Breach

Psychological contract as a concept defines individual beliefs regarding mutual responsibilities between organization and employees. Psychological contract is a concept that depends on subjective perception of employee working individually (Morrison and Robinson, 1997: 228; Walker and Hutton, 2006: 434; Üçok and Torun, 2014: 234). The properties of psychological contract can be ordered like this; psychological contract is a subjective perception that changes from person to person, that is why it involves differences between individuals. Psychological contracts are dynamic, their meanings between employer and employee can change in time. Psychological contracts involve mutual responsibilities between employer and employee. They form bond for the content of relation that is why individuals or organizations cannot form psychological contract on their own (Anderson and Schalk, 1998: 640).

Psychological contracts are informal contracts that are based on volunteering. The parties that make up the contract are dependent on each other. Because the psychological contracts are generally connected to topics that have emotional commitment, strong emotions show up when they are violated (Cihangiroğlu and Şahin, 2012: 7-8).

Generally psychological contracts are divided into two as operational and relational. Operational psychological contracts are related with economical exchange and define "fair relation between work and wage". Operational contracts involve economic contribution provided to employees and limited encouragements in response to contribution of employee to the work. Also operational contracts focuse on short term relation between employer and employee as well as they involve well defined responsibilities of employees, little flexibility regarding mutual responsibilities and limited development regarding performed work. On the other hand relational contracts are related with social exchange and focus on long term relation. Relational contracts are contracts that involve important responsibilities for both employees (gaining of talents peculiar to establishment) and employers (mass education). Relational contracts have economic, emotional and holistic structure. In relational contracts fulfilling of obligations take long time, obligations can be partially implicit and terms of contract can easily change (Büyükyılmaz and Çakmak, 2014: 584).

Psychological contract breach concept is defined as "employee reaching an opinion of not fulfill one or more than obligation when he compares his contributions" (Üçok and Torun, 2014:234). Psychological contract breaches occur when employees think their employers or chiefs did not keep at least one of their (Morrison and Robinson, 1997:234; Aslan and Boylu, 2014:36). While, in some cases, these violations are made because one breaks his/her word, in some other cases these violation show up because of the delay of keeping these words. That is, it emerges when the employee sees that there is an inconsistency between what was promised and what he/she gets. If a gap is felt in the contract as a result of the process of comparing whether both parties have fullfilled their own liabilities or not, the result that "psychological contract is violated "attained (Morrison and Robinson, 1997:231; Aslan and Boylu, 2014: 36).

1.3. Relations Between Organizational Cynicism, Psychological Contract And Turnover Intention

Turnover intention is generally defined as a wish of an employer to release from his actual organization

consciously and intentionally (Cho et al., 2009: 374). According to researches as organizational cynicism increases, turnover intention increase so a positive relation was obtained (Polat and Meydan, 2010: 160). Mesci obtained in his research that when the turnover intention of an individual increases, cynical attitudes also increase (Mesci, 2014: 201-204).

Psychological contracts depend on confidence base. That is why, when psychological contract is strong, this causes emotional reactions and sense of betrayal. When psychological contract breach is weak, this causes high turnover intention, low confidence and low job satisfaction, low commitment to organization and organizational citizen behavior (Anderson and Schalk, 1998: 644).

The employees whose psychological contract is complete and whose expectations are met won't think of leaving their jobs. In the case that the psychological contract is violated, the employees feel that they are not being able to make it and that they are not being realized among others or they are conflicting with their colleagues or executives and ın such cases, they think of leaving their jobs in order to get rid of this situation that's been bothering them (Özgen and Özgen, 2010: 6).

Starting from this point, it is thought that there are significant relations between organizational cynicism and psychological contract with turnover intention. Accordingly the hypothesis of study was formed as follows.

H1: Organizational cynicism has a significant effect on turnover intention

H1a: Affective cynicism has a significant effect on turnover intention

H1b: Cognitive cynicism has a significant effect on turnover intention

H1c: Behavorial cynicism has a significant effect on turnover intention

H2: Psychological contract has a significant effect on turnover intention

H2a: Operational psychological contract has a significant effect on turnover intention

H2b: Relational psychological contract has a significant effect on turnover intention.

H3: The psychological contract has a significant effect on the organizational cynicism.

H3a: Operational psychological contract has an important effect on the organizational cynicism.

H3b: Relational psychological contract has an important effect on the organizational cynicism.

2 . METHOD

2.1. Aim and Contribution

This study tries to identify the effects of organizational cynicism and psychological contract subdimensions on turnover intention. With this aim, the effect of organizational cynicism and psychological contract on turnover intention was researched. The findings obtained at the end of this research are thought to form differentiation in subjects of health sector such as organizational cynicism, psychological contract and turnover intention and make contribution in literature as well as especially in human resource management applications for health care staff.

2.2. Population and Sample

The doctors, nurses, medical secretaries and other healthcare staff working in a state hospital in Tokat (Turkey) province formed the population of research. In the scope of data taken from hospital 324 people formed the population. 5% of error margin in 95% reliability limits was taken into consideration and the

lowest sample size was calculated as 177 people (Altunışık and Coşkun, 2005:127). In the population face-to-face interviews were made with 220 people randomly by taking conversation rate into consideration. However 16 questionnaires were obtained as invalid and were taken out. As a result 204 questionnaires formed the sample of study. This rate forms 63% of distributed questionnaires. 129 of participants are female and 75 are male, 44 of them are between age of 18-27, 79 of them are between 28-37, 60 of them are between 38-47 and 21 of them are over 48. It was stated that 156 of them are married and 48 of them are single. According to their educational status, it was obtained that 45 of them have high school, 70 of them have foundation, 65 of them have university and 24 of them have postgraduate degree. According to their experiences, 46 of the participants have been working in the organization for a time less than 5 years, while 46 of them for 6-10 years, 36 of them for 11-15 years, 30 of them for 16-20 years and 46 of them for 21 years and more. To line them according to their titles, 30 of the participants are executive personnel, 21 of them are doctors, 98 nurses and 13 health providers as well as 42 persons have been working in the organization. 192 of the participants have taken on the administrative liabilities, while 6 persons have been working for less than 5 years, 5 persons for 6-10 years and 1 person for 11- 15 years. It was determined that 128 of the participants have an monthly income of 2500 TL and below, while 53 of them between 2501 and 4500, 23 of them more than 4500.

2.3. Data Collection, Analyzing Method and Scales

In the study the data are collected by survey method. The questionnaire form is consisted of 4 parts and 42 questions. In the first part there are 8 questions regarding demographical properties of healthcare staff. In the second part there are 17 expressions regarding psychological contract perceived by healthcare staff. Psychological Contract Scale was developed by Millward and Hopkins (1998). Turkish validity of scale was done by Mimaroğlu (2008). The scale is consisted of two subdimensions. The first subdimension is operational psychological contract dimension that focuses financial gainings such as wage, income involves 10 items. The other subdimension is relational psychological contract regarding education, development, job security involves 7 items. Cronbach alpha security coefficient of Psychological Contract Scale was found as 0.710 whereas it was found 0.668 for operational psychological contract and 0.677 for relational psychological contract. In the third part, a scale involves 14 expressions and was developed by Brandes(1997) is used in order to obtain cynical behaviors of employees. Turkish validity of Organizational Cynicism Scale was done by Erdost and his colleagues (2007). The validity and security study of scale on healthcare staff was done by Topçu and his colleagues (2013). The scale of organizational cynicism is consisted of 14 items and three dimensions as cognitive, affective and behavioral. Cronbach alpha security coefficient of Organizational Cynicism Scale was found as 0.934 whereas it was found 0.932 for affective cynicism; 0.841 for cognitive cynicism and 0,861 for behavioral cynicism. In the fourth part for measuring turnover intention a unidimensional scale with tervarient that was developed by Bluedorn (1982) and Netemeyer and his colleagues (1997) starting from the definition of Mobley, Griffin, Hand and Meglino (1979), was used Özer (2010). Cronbach alpha security coefficient of scale was found as 0.823. The questionnaire was applied to participants in March 2015. The relation between correlation analysis and variables were checked and in order to test hypotheses regression analysis was benefitted.

3. FINDINGS

In Table 1 when organizational cynicism and psychological contract subdimensions were examined, there found positive correlations in the same direction between operational psychological contract with cognitive (r=0,221), behavioral (r= 0,228) and general cynicism (r=0,163). With the separate evaluations of affective (r=-0,373), cognitive (r=-0,323), behavioral (r=-0,288) and general cynicism (r=-0,373) done with relational psychological contract, there found negative correlations in the same direction. There also found negative direction correlation between general psychological contract and affective cynicism (r=-0,222). There found positive correlations in the same direction between turnover intention with affective (r=0,166), cognitive (r=0,181), behavioral (r=0,219) and general cynicism (r=0,199). There also found positive correlation between turnover intention and operational psychological contract (r=0,146). As a result of correlation analysis the relations are found weak.

As the relational psychological contract increases, cynicism and the sub-dimensions of cynicism decrease (in a negative way). In other words, as cynicism increases, the violation perception of relational psychological contract decreases. As the cynical attitudes increase and the violation perception of operational psychological contract increase, the turnover intention also increases.

Table 1. Defining Statistics

Variable	Average	Std. Deviation	Correlations							
			1	2	3	4	5	6	7	8
1. Affective Cynicism	2,26	0,96	1,000							
2. Cognitive Cynicism	2,38	0,97	,542**	1,000						
3. Behavioral Cynicism	2,41	0,96	,483**	,875**	1,000					
4. General Cynicism	2,36	0,86	,730**	,938**	,921**	1,000				
5. Operational Psychological Contract	3,01	0,66	-,018	,221**	,228**	,163*	1,000			
6. Relational Psychological Contract	2,77	0,71	-,373**	-,323**	-,288**	-,373**	,210**	1,000		
7. General Psychological Contract	2,91	0,54	-,222**	-,009	,021	-,081	,836**	,672**	1,000	
8 Turnover Intention	2,32	1,00	,166*	,181**	,219**	,199**	,146*	-,088	,045	1,000

*p<0,05, **p<0,01

In the scope of study, the effect of organizational cynicism on turnover intention is examined. In this frame the effect of three dimensions of organizational cynicism that are affective, cognitive and behavioral on turnover intention was researched. When the results in Table 2 are examined, it was found that the effect of affective, cognitive and behavioral cynicism on turnover intention is meaningless (H1a:β=0,134,p>0,05; H1b:β=-0,097,p>0,05; (H1c:β=0,260,p>0,05). Accordingly H1a, H1b and H1c hypotheses are rejected.

Table 2 : The effect of organizational cynicism on turnover intention

Hypothesis	**Model Summary**		**ANOVA**		**Regression coefficients**			**Hypothesis**
H1a: Affective cynicism→ Turnover Intentıon	R	R^2	F	P	Beta	t	P	Reject
	,269(a)	,073	5,217	,002(a)	,134	1,556	,121	
H1b: Cognitive cynicism→ Turnover Intentıon					-,097	-,621	,535	Reject
H1c: Behavioral cynicism → Turnover Intentıon					,260	1,748	,082	Reject

*P<0,05, ** P<0,01

In the scope of study, secondly the effect of psychological contract on turnover intention is examined. In this frame the effect of two dimensions of psychological contract that are operational and relational psychological contract on turnover intention was researched. When the results in Table 3 are examined, it was found that the effect of operational psychological contract on turnover intention is positive and significant (H2a:β=0,191,p<0,01) whereas the effect of relational psychological contract is meaningless (H2b:β=-0,101,p>0,05). Accordingly when H2a hypothesis is accepted, H2b hypothesis is rejected.

Table 3: The effect of psychological contract on turnover intention

Hypothesis	**Summary of the Model**		**ANOVA**		**Regression coefficients**			**Hypothesis**
H2a: Operational Psychological Contract → Turnover Intention	R	R^2	F	P	Beta	t	P	Accept
	,194(a)	,038	3,932	,021(a)	,191	2,683	,008	
H2b: Relational Psychological Contract → Turnover Intention					-,101	-1,419	,157	Reject

*P<0,05, ** P<0,01

Table 4: The effect of psychological contract on organizational cynicism

Hypothesis	**Summary of the Model**		**ANOVA**		**Regression coefficients**			**Hypothesis**
H2a: Operational Psychological Contract → Organizational Cynicism	R	R^2	F	P	Beta	t	P	Accept
	,441(a)	,195	24,302	,000(a)	,279	4,283	,000	
H2b: Relational Psychological Contract → Organizational Cynicism					-,413	-6,347	,000	Accept

*P<0,05, ** P<0,01

Thirdly, within the scope of the study, the effect of psychological contract on organizational cynicism was examined. Within this framework, the two dimensions of psychological contract, the effects of operational psychological contract and Relational Psychological Contract on Organizational cynicism were searched. When the results in Table 4 are examined, it was determined that the effect of operational psychological contract on organizational cynicism was positive and significant (H3a:β=0, 279,p<0,01). While it was determined that the effect of relational Psychological contract on organizational cynicism was negative but significant. (H3b:β=-0,413,p<0,01). Therefore, H3a and H3b hypothesizes are accepted.

RESULT

The aim of this study is to examine the effect of organizational cynicism and psychological contract on turnover intention. With this aim, in the study correlation and regression analyses were benefitted.

As the findings are evaluated as a result of analysis of datas, when organizational cynicism and psychological contract subdimensions were examined, correlations were obtained positive and significant. There found negative correlations in the same direction between relational psychological contract and cynicism and subdimensions of cynicism. There found negative direction correlation between general psychological contract and affective (r=-0,222) cynicism. There found positive correlation in the same direction between turnover intention and affective (r=0,166), cognitive (r=0,181), behavioral (r=0,219) and general cynicism (r=0,199). There found positive correlation between turnover intention and operational psychological contract (r=0,146). As a result of correlation analysis the relations are found weak.

The effect of affective, cognitive and behavioral cynicism that are sub dimensions of organizational cynicism on turnover intention was identified meaningless (H1a:β=0,134,p>0,05; H1b:β=-0,097,p>0,05; (H1c:β=0,260,p>0,05). Accordingly H1a, H1b and H1c hypotheses are rejected. In other words there found no effect of organizational cynicism on turnover intention. It can be said that organizational cynicism attitudes of employees do not affect turnover intention.

When results of the effect of two dimensions of psychological contract that are operational and relational psychological contract on turnover intention are examined, the effect of operational psychological contract on turnover intention is positive and significant (H2a:β=0,191,p<0,01). The effect of relational psychological contract on turnover intention was found meaningless (H2b:β=-0,101,p>0,05). Accordingly when H2a hypothesis is accepted, H2b hypothesis is rejected. In other words in relational psychological contracts, it was obtained that the perceived breach increased turnover intention.

The reason behind this is defined, as it was mentioned in the operational psychological contract before, as the short term relationship between the employee and employer, the economy and financial factor-oriented contributions that were made to the employees, the limited incentives given in return for the participation of the employee and the mutual liabilities. In the case that there are difference between what is perceived and what is expected, the operational psychological contract conceptions of the employees may increase the employee's turnover intention. Besides, ın the case that negative results are attained while expecting good results according to the existing, skills of the employees, it can be said that their turnover intention may increase.

In parallel with our findings, in the findings of Büyükyılmaz and Çakmak (2014), the violation that was perceived in the relational psychological contract has a positive impact on the employees' turnover intention. But on the other hand, ıt was determined that a violation perceived in operational psychological contract doesn't have any important impact on the turnover intention.

When the two dimensions of psychological contract, namely the operational psychological contract and Relational Psychological contract's effects on organizational cynicism are examined, it was detected that the effect of operational psychological contract on organizational cynicism was positive and significant (H3a:β=0, 279,p<0,01). While ıt was determined that the effect of Relational Psychological contract on organizational cynicism was negative and significant (H3b:β=-0,413,p<0,01).

Therefore, H3a and H3b have been accepted. In other words, the operant and relational psychological

contract has an impact on the increment of organizational cynicism. An increase seen in the operational psychological contract increases the organizational cynicism. For this reason, the operational psychological contract conceptions of the employees are said to increase the organizational cynicism in the case that there are differences between what is perceived and what is expected. In the case that the economical contributions made to the employees are not met, many more cynical attitudes will be exhibited.

An increase seen in the perception of the violation of relational psychological contract reduces the cynicism. For this reason, in the case that there are differences in the relational psychological contract perceptions of the employees, it can be said that it can decrease the organizational cynicism.

In parallel with our study, Arslan and his colleagues (2012:118) determined that there is a positive relationship between operational psychological contract and organizational cynicism while there is a negative relationship between organizational cynicism and relational psychological contract.

As a result, perception of operational psychological contract breach for healthcare staff in question is seen efficient for turnover intention. Different from other organizations, since the requirement for healthcare staff is more, it is thought that healthcare staff can find jobs more easily. Operational psychological contracts focus on financial incomes more. When these expectations are not satisfied efficiently, turnover intention increases for healthcare staff in question. This research is limited with the data taken from hospital and used methods. It can be advised that researchers towards healthcare staff should be increased.

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THE RELATIONSHIP BETWEEN HEALTH EXPENDITURE AND SOCIOECONOMIC/DEMOGRAPHIC INDICATORS: AN INTERNATIONAL COMPARISON

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A R T I C L E I N F O

Keywords: Health Expenditure, socio-demographic indicators, health and inequality

Abstract

Health is a matter of human rights. Factors affecting health includes health expenditures. All health expenditures are regarded as investments in human beings and is necessary for the development of society. It is known that the health status of countries which allocate more resources in health is higher. The current research was performed to analyse the relationship between countries' health expenditures and socioeconomic /demographic factors.

In the study, five health expenditure variables and eight socioeconomic /demographic factors were examined. A total of 180 countries with available data were included in the study sample. Data was obtained from World Health Statistics (2014), "data.worldbank.org" and the Human Development Report (2014). Descriptive statistics were calculated and correlational analyses were performed. Data was analyzed using the SPSS 19.0 software.

It was found that there are significant differences in health expenditures across countries. Regarding total health

expenditures, there was a 10-fold difference between the highest and lowest values. Countries with high income allocated more resources in health and significant relationships between health expenditure variables and socioeconomic /demographic factors were found. It is concluded that the general economic and health status of undeveloped/developing countries can be improved by developing appropriate economic policies.

Introduction

Health is a matter of human rights. The concept of health evolves its extent and content through social, political, and cultural experience and international laws; which constitute the historical heritance of humanity (Ateş, 2013). Blum, who brought an environmental approach to health, indicated that health status is comprised of four basic factors and their sub-factors: environment, behaviour, genetics, and health services. However, Blum ignored social factors (Schulze et al., 2003). The social context is an important cornerstone of health and is classified under the separate title of "social determinants of health" in the literature. The elements associated with health such as social, cultural and economic factors are generally defined as social determinants of health (Lloyd et al., 2004). People's life styles and work conditions have a major impact on their health and lifespan (Wilkinson et al., 2003) Link et al. (1995) emphasized that the fundamental reason of illness is social conditions. Social indicators of health include the health system, environments people are born into, and environments where people grow up, live, work, and grow older (World Health Organization, 2013). Improvement of health status is strongly related to the improvement in such social factors. In the past, efforts to promote health focused on preventing and curing diseases, however, these efforts failed to improve health conditions at a desired level. Today, health in its social context is considered as a tool to improve economy. According to this view, sparing increased funds from national and international resources and investing them in health and its social indicators will result in economic growth (Çelik, 2011).

In order to constitute a healthy population, it is essential to have a strong economy, to provide sustainable growth of economy and to support health care by meeting the needs of the population. All expenditures spent in health care constitute health expenditures. Expenses to regain health as well as expenses on prevention and improvement efforts such as vaccination, STD (sexually transmitted diseases) prevention, and nutrition are considered as health expenditures (Akın, 2007). It is important to know the amount spared for health expenditures in order to manage resources of a country and to make international and intersectoral comparisons. The outcome of health expenditures, which is defined as health status, is considered as a measurement of a country's level of development (Mutlu et al., 2002).

All health systems in the world fundamentally target building a society of healthy individuals. Healthy individuals and societies compose the core of security, power, stability, wealth and happiness (Ersöz, 2008). Nowadays, governments place more importance on health expenditures. Health expenditures play a key role in economic growth and differ from one country to another depending on the level of development. Specifically, health expenditures are relatively larger in developed countries compared to developing countries (Akar, 2014). In countries with a certain level of economic development, the spared budget for health expenditures increase, and in turn, individuals' awareness of health improves. Therefore, the improvement of health status would accelerate economic growth (World Bank, 2014).

The present study was conducted in order to show the differences in health expenditures on an international level and to determine the relationship between health expenditures and socioeconomic/demographic factors.

Material and Methods

This study employed a descriptive and retrospective design. The universe of the study was planned to comprise of 194 countries which are members of the World Health Organization (WHO). As a result of difficulties faced in accessing accurate and up-to-date information, 180 countries were included in the sample. Based on the available information pertaining to countries and the relevant literature, 5 dependent and 8 independent variables were defined. The dependent variables were health expenditure per capita, total health expenditure, public health expenditure, private sector health expenditure and out of pocket (OOP) health expenditure. The independent variables were life expectancy at birth, maternal mortality, infant mortality, annual population growth rate, total fertility rate, gross national income per capita, the mean years of education, and the expected years of education.

Data was collected from the WHO Statistics-2014, Human Development Report-2014 and the World Bank's official website. Data was analysed using the SPSS 19.0. Descriptive statistical methods, frequency analysis and correlational analyses were used.

Results

Table 1
SOCIOECONOMIC/DEMOGRAPHIC VARIABLE'S MINIMUM, MEDIAN AND MAXIMUM VALUES

	Min.	Medyan	Max.
Life Expectancy at birth (years)	45,6 (Sierra Leone)	73	83,6 (Japan)
Maternal mortality ratio (per 100 000 live births)	1 (Belarus)	60	1100 (Sierra Leone)
Infant mortality rate (probability of dying by age 1 per 1000 live births)	2 (Norway, Finland, Japan)	16	117 (Sierra Leone)
Annual population growth rate (%)	-0,8 (Bulgaria, Moldova)	1,3	7,9 (Oman)
Total fertility rate (per woman)	1,3 (Bosnia Herzegovina, Singapore, Portugal)	2,3	7,6 (Niger)
Gross national income per capita (PPP int. $)	104 (Egypt)	8.883,5	119.029 (Qatar)
Expected years of schooling (of children) (years)	1,3 (Burkino Faso)	8,35	12,9 (USA)
Mean years of schooling (of adults) (years)	4,1 (Eritrea)	12,8	19,9 (Australia)

Table 1 shows the minimum, median and maximum values of socioeconomic/demographic variables. As shown in Table 1, the lowest life expectancy was in Sierra Leone (45.6 years) and the highest life expectancy was in Japan (83.6 years). Maternal mortality rate was 1/100.000 in Belarus and 1100/100.000 in Sierra Leone. Infant mortality rates in Norway, Finland and Japan were 2 in 1000, while it was 117/1000 in Sierra Leone. Bulgaria and Moldova had an annual population growth rate of -0.8 % and Oman had a rate of 7.9 %. Fertility rates per woman in Bosnia Herzegovina, Singapore and Portugal were 1.3; while Niger had a rate of 7.6. Per capita income was the lowest in Egypt ($104), while Qatar had the highest income ($119,029). Mean years of education was 1.3 in Burkina Faso and 12.9 in the United States of America. Expected years of education was 4.1 in Eritrea and 19.9 in Australia.

Table 2
FREQUENCY ANALYSIS ON HEALTH EXPENDITURE

	Min.	Medyan	Max.
Expenditure on health, total (% of GDP)	1,80 (Myanmar)	6,40	17,90 (USA)
Health expenditure per capita (current US$)	15 (Dem. Republic of Congo)	335	9276 (Switzerland)
Health expenditure, public (% of GDP)	0,40 (Myanmar)	3,5	11,50 (Mikronesia)
Health expenditure, private (% of GDP)	0,20 (Brunei)	2,5	12,60 (Sierra Leone)
Out-of-pocket health expenditure (% of total expenditure on health)	0,10 (Kiribati)	31,40	76,20 (Sierra Leone)

Table 2 describes the information of minimum and maximum health expense variables. According to Table 2, the largest budget spared from GDP to health expenditure was in USA by 17,9 %, and the smallest was shown as 1,8 % in Myanmar. The health expenditure per capita was 15 dollars in Democratic Republic of Congo and 9276 dollars in Switzerland. Public health expenditure in Myanmar was 0,4 % of their GDP and it was 11,5 % in Micronesia. Brunei Darussalam showed the lowest private health sector expenditure (0,2 %) and this rate was 12.6 % in Sierra Leone. In inspection of OOP health expenditure, 0,1 % of total health expenditure of Kiribati was OOP and 76,.2 % of Sierra Leone's as the highest.

Table 3
HEALTH EXPENDITURE AVERAGE AND STANDART DEVIATION (FOR INCOME GROUPS)

	Expenditure on health, total		Health expenditure per capita		Health expenditure, public		Health expenditure, private		Out-of-pocket health expenditure	
	Avg.	*Sd*	*Avg.*	*Sd*	*Avg.*	*Sd*	*Avg.*	*Sd*	*Avg.*	*Sd*

High	7,86	3,03	2996,15	2351	5,53	2,33	2,32	1,42	21,48	11,35
Upper-Middle	6,31	1,98	466,04	211,95	3,83	1,54	2,49	1,16	31,28	15,27
Lower-Middle	6,37	2,47	149,89	89,12	3,56	2,26	2,81	1,66	38,24	20,41
Low	6,21	3,14	38,40	19,5	2,62	1,48	3,79	2,48	43,33	19,63
OECD	9,30	2,30	3839,50	2493,64	6,70	1,75	2,59	1,46	18,98	8,61
Global	6,76	2,73	1040,14	1782,18	4,04	2,22	2,75	1,72	32,37	18,36

The World Bank classifies countries based on their economic extent in four groups; low, lower-middle, upper-middle and high (World Bank, 2014). The countries' health expenditures were shown in Table 3 according to OECD and this classification. In Table 3, total health expenditure of high income level countries was 7,86 % and 6,21 % in low income level countries. OECD countries' average rate was 9,3 %. Per person health expenditure was $2996,15 in high level countries and $38,40 in low level countries. Public health expenditures had a rate of 5,53 % in high income countries and 2,62 % in low income countries. The private sector health expenditure in high income countries was 2,32 and 3,79 in low income countries. OOP health expenditure in high income countries was 21,48 and 43,33 % in low income countries. In OECD countries 18,98 % of total health expenditure was spent OOP.

Table 4
HEALTH EXPENDITURE AVERAGE AND STANDART DEVIATION (FOR WHO REGIONS)

	Expenditure on health, total		**Health expenditure per capita**		**Health expenditure, public**		**Health expenditure, private**		**Out-of-pocket health expenditure**	
	Avg	Sd	Avg	Sd	Avg	Sd	Avg	Sd	Avg	Sd
Africa	6,46	2,83	138,09	211,34	3,14	1,65	3,26	2,27	36,14	18,6
Americas	7,37	2,46	966,91	1697,88	4,29	1,68	3,10	1,65	30,55	14,92
Europe	8,03	2,24	2244,92	2396,22	5,40	2,18	2,61	1,26	28,30	15,30
Western Pacific	6,45	2,81	1040,23	1659,30	4,56	2,92	1,89	1,13	24,81	19,29
Eastern Mediterranean	5,19	2,35	534,30	542,32	2,53	1,30	2,67	1,86	40,81	21,93
South-East Asia	4,15	1,80	125,30	162,22	2,09	1,16	2,07	1,22	41,72	22,89
Global	6,76	2,73	1040,14	1782,18	4,04	2,22	2,75	1,72	32,37	18,36

In Table 4, regional health expenditures according to WHO's classification was shown (World Health Organization, 2014). In terms of total health expenditures, the lowest rate belonged to South East Asia (4,15%) and the highest rate was in Europe (8,3%). Per person health expenditure was 125,30 $ in South East Asia and 2244,92 $ in Europe. Public health expenditure rates were 2,09 % in South East Asia and 5,4 % in Europe. The lowest private health expenditure rate was in Africa (3,26 %). Comparison of OOP health expenditures showed that South East Asian countries had the highest rates (41,72%) and West Pacific countries had the lowest rates (24,81%).

Table 5
CORRELATIONS BETWEEN HEALTH EXPENDITURE AND SOCIOECONOMIC/DEMOGRAPHIC VARIABLE

	Life Expectancy	Maternal Mortality Ratio	Infant Mortality Rate	Annual population growth rate	Total fertility rate	Gross national income per capita	Expected years of schooling	Mean years of schooling
Expenditure on health, total	0,210**	-0,078	-0,190*	-0,320**	-0,194**	0,117	0,297**	0,310**
Health expenditure per capita	0,546**	-0,364**	-0,456**	-0,249**	-0,396**	0,664**	0,579**	0,568**
Health expenditure, public	0,414**	-0,332**	-0,409**	-0,409**	-0,343**	0,284**	0,515**	0,481**
Health expenditure, private	-0,224**	-0,328**	0,266**	0,042	0,167*	-0,200**	-0,225**	-0,166*
Out-of-pocket health expenditure	-0,307**	-0,320**	0,365**	0,152*	0,239**	-0,366**	-0,441**	-0,372**

Table 5 showed the relationships between health expenditure and socioeconomic/demographic variables. Correlation coefficients were defined as; 0 to (-) 0,30 low, (-) 0,30 to (-) 0,70 medium and (-) 0,70 to (-) 1 high (Saruhan et al., 2013). According to these results, the strongest relationships involved the annual growth rate of a population. There was a negative correlation between total health expenditure and growth rate of population (r: -0,32). The relationship between health expenditure per person and national income per person was found to be positive and at a medium level (r: 0,664); public health expenditure and expected years of education were positively related at a medium level (r: 0,515); private sector and maternal mortality rate were negatively related at a medium level (r:-0,328) and OOP health expenditure and expected years of education were negatively related at a medium level (r: - 0, 441).

Discussion and Conclusion

The main objective of the current study was to examine countries' health expenditure distribution by income groups and regions and to determine the relationship between health expenditure measures according to target socioeconomic/demographic variables. Data pertaining to 13 variables was collected for 180 countries from the 2014 World Health Statistics Report, the 2014 Human Development Report and the World Bank's official website.

As shown in Table 1, there were significant differences between countries' socioeconomic/demographic indicators. In terms of the most important indicator of health status in a country; life expectancy was found to be 45.6 years in Sierra Leone and 83,6 years in Japan. Consideration the world median value of 73 years, this difference seems to be significant. In Table 2, statistics of health expenditure was shown. Similar to socioeconomic/demographic differences, health expenditures showed major differences. The Democratic Republic of Congo had $15 of health expenditure per person, while Switzerland had $9276.

Examination of countries based on income groups (Table 3) showed that all health expenditure types were positive correlated with countries' income levels. Higher income group countries showed higher public and per person health expenditure rates. On the other hand, lower income group countries showed lower health expenditure, higher OOP, and private sector health expenditure rates.

Table 4 presented average health expenditure by regions and there were no significant differences across countries. This finding can be explained by the fact that countries were not homogeneously distributed by region. South East Asia included a total of 10 countries, while Europe included 51. However, South East Asia showed lower average health expenditure rates, while European countries had higher rates.

The majority of health expenditure and socioeconomic/demographic variables were associated at a statistically significant level. Although correlation

coefficients were relatively low, they were statistically meaningful nonetheless. Inclusion of most countries and avoiding sample choosing seemed to increase the reliability of the analysis conducted in the current study.

In conclusion, there were major discrepancies between countries' health expenditure rates. These differences were due to the socioeconomic and demographic features of the countries as well as their health policies. As previously mentioned, health expenditure variables and other factors were associated. As health expenditure per person increased, life expectancy also increased. In addition, as health expenditures increased, national income per person also increased. In this context, it is recommended that instead of attempting to explain health expenditures with one or a small number of variables, it seems more appropriate to evaluate social indicators of health from a wider perspective. Nevertheless, previous research showed that a country's income level has a very strong relationship with health expenditure rates, while keeping other variables stable. In other words, as a country's economy grows, health becomes more important and larger funds are spared for it. Therefore, to avoid discrepancies between countries' health expenditures, first, a country's economy needs to be strengthened. It is suggested that countries reconsider their health policies in order to increase welfare of their populations. In case of insufficient national resources, support should be accepted from international organizations and developed countries.

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PSYCHOLOGICAL, SOCIAL AND ECONOMIC EFFECTS OF MEDICAL MALPRACTICE ON PATIENTS AND THEIR RELATIVES

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A R T I C L E I N F O

Keywords; Malpractice and Patients, Effects Of Malpractice, Health Care Management and Malpractice,

ABSTRACT

According to a research conducted recent years in our country, a noteworthy increase related to health expenditures has been observed. This study includes the answers of following questions; Is all of the spending on health expenditure necessary? Are applied treatment methods accurate? Or how accurate is the diagnosis? Is prescribed medicine really necessary? By asking these questions to patients, relevant data is aimed to be obtained. In this context, malpractice cases filed under the name of the case has been examined, what the socio-economic loss of the patients who are exposed to incorrect application is has been tried to be identified by asking the patient, and literature review of the data obtained is given. The effects of malpractice on health economics have been death in a broad perspective.

This study contains important information and experiences of malpractice, to be more precise, it has crucial information for service related loss to be prevented and to be compensated properly.

INTRODUCTION

The emergence of human life is a natural right, and wanting to maintain a healthy way of life is the most natural right. However, this ideal situation may not always happen. During certain times of every human life, there may be some deterioration not only on mental but also on physical health. Any kind of the disruption that occur confront the patient with health care providers. Patients may consent to giving physicians the right to interfere with the physical integrity to the inactivation of factors threatening the health. Here is a kind of contractual relationship resulting from the meeting of the patient and the physician. That is, when the patient is accepted to healthcare organization, contract is established between the physician and the patient. Accordingly, doctors should give patients the expected standard diagnostic and treatment services, must demonstrate due diligence and loyalty. Although the intervention to life, health and body completeness is against the rights and is basically forbidden, laws gave physicians the right to intervene for improvement over the body (Yenerer, 2003).

Medical interventions cover a wide range of operation from simple to the most severe diagnosis and treatment medicine. However, although the ultimate result is to cure the patient completely, sometimes undesirable results may occur (Ayan, 1991). This undesirable result is called defective medical practice. In the declaration of 44. General Assembly of World Medical Association conducted in 1992, malpractice (malpractice) has been defined as "during treatment, the physician's not following standard practice, damage caused by not treating ot the lack of skills "; and the cases which are experienced through medical care and treatment and not physician's fault's being distinguished is emphasized. Additionally, it has been stated that the deficient actions of physicians are not simply limited to diagnosis and treatment, but it is also about any kind of acts and behavior in their profession. That is, a physician has important responsibilities not only in terms of the diagnosis and treatment defects; also in terms of the relationship with their patients and colleagues (Koç, 2006).

MALPRACTICE AND MEDICAL MALPRACTICE CONCEPTS

Malpractice literally, is derived from Latin for "Male" and "Praxis" and its route is the word "bad, incorrect application" . That is, it can occur in any profession. Widely, it is used as imperfect movements that emerge when the profession is implemented incorrectly. If malpractice applications occur in health care professions, it is called "Medical Malpractice". World Association of Medical defines malpractice as; ", the physicians' not implementing the current practice standards during treatment, damage caused by lack of skills or not treating the patient.''

In the United States, "The Joint Commission on Accredition of Healtycare Organizations (JCAHO)" has defined malpractice as follows; " It is ,frequently in the public health service centers, professions' not behaving in a professional and appropriate way and is inadequate and negligent acts in the masked application (Hancı, 2002).

MEDICAL MALPRACTICE DATA

Malpractice has shown a noticeable increase recently. It has become a multi-faced, multi-dimensional issue discussed within its ethical, legal, medical, educational and administrative aspects especially in some developed countries and all over the world in recent years. Despite this; in official institutions or organizations, the studies determining the rates of malpractice are still inaccessible.

Malpractice applications related news has increasingly come to the fore and has drawn the attention of the community. Lately, the cases related to medical malpractice penalty and compensation has increased significantly.

In the US in 2000, according to a detailed report published by "the Harvard Medical Practice Study" and a research based on two retrospective studies in Utah and Colorado, in hospitals in the United States, it is confirmed that per year 98000 people are reported to die directly because of the medical mistakes. In Japan in March 2002 - March 2003, it was found that because of medical errors 900 cases were sued (Birgen, 2006).

According to the results of the limited studies conducted the largest part of the malpractice lawsuits are filed for physicians.

Birgül Tüzün, Emergency Diamond, Haluk Slim "Defective Medical Application Related Deaths" (1997) compared to the incidence in this study and the frequency medical defect causes are;

• Inadequate monitoring,
• delays in medical interventions,
• delays in patient referral, referral without taking adequate measures,
• Infection resulted in inadequate treatment and inadequate measures,
• improper or careless treatment
• Inadequate diagnosis
• incapable persons' interfering medical interventions

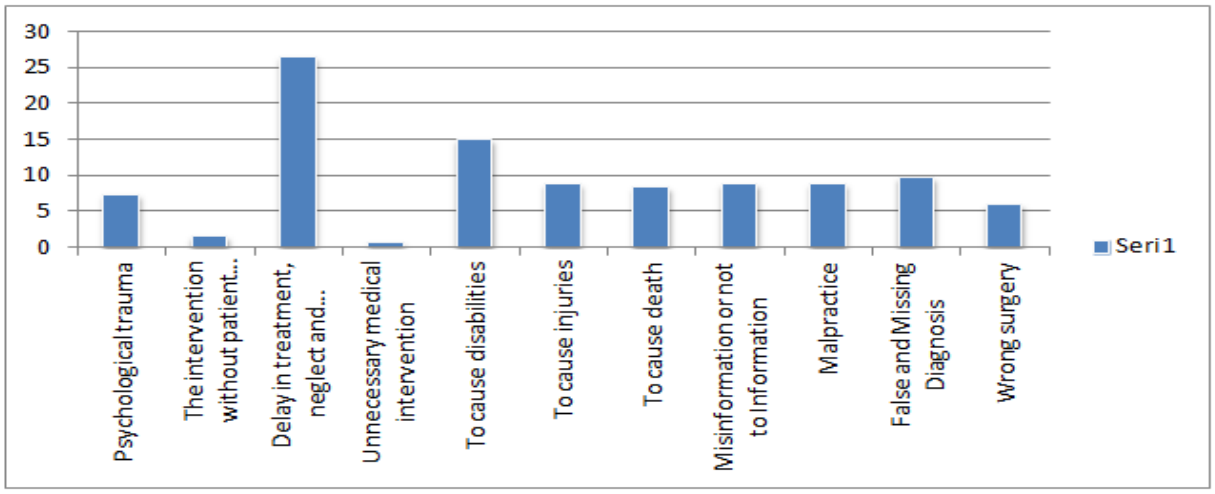
According to a research, 805 malpractice cases out of 1458 have been sued. In second rank, there are cases involving teams who are found guilty. It is noteworthy that assistants are sued the least.

Medical malpractice, is rarely thought to occur due to a single cause. Generally, there are human factors (ignorance, carelessness, such as mental reasoning errors), environmental factors and some other factors such as medical devices that increase the risk of failure. However, because medical care is a team work, those factors causing failure are generally overlapped (Çetin, 2006).

Also there are limited number of studies in medical malpractice that are related to the judiciary action. In light of debates on the subject in our country, there is a need for research with regard to the review of all cases of medical malpractice.

Even though a part of the malpractice lawsuits are not considered as medical errors, when the cases accepted as malpractice are observed, there has been a dramatic increase compared in different years. But these are the data of cases that resulted in the error pop-up applications and medicine case, not only accurate data. Of course, there was and there has been some cases where the patients who were-have been exposed to many malpractice, are silenced off the books, it is very difficult to reach these data.

Litigation Causes:



Grafik.1. Causes of legal cases

The maximum number of cases that the physicians were sued has been on delay in treatment, negligence, misdiagnosis and mistreatment.

Increasing problems in the health system; medical malpractice and criminal cases and civil cases in this context; has led to the increase of the everyday professional insurance. These results in a vicious cycle and doctors are exposed to unjustified medical malpractice charges.

3. FINDINGS

Demographic Variables	**n**	**%**
Age (Years)		
20-30	65	65
31-40	18	18
41-50	11	11
51-60	6	6
Gender		
Male	48	48
Female	52	52
Marital Status		
Single	55	55
Married	43	43
Other	2	2
Educational Status		
Primary School	5	5
Secondary School	8	8
High School	18	18
University	59	59
Other	10	10
Total	**100**	**100.0**

Exposure Rate to Malpractice	**n**	**%**
Patients Are Exposed Malpractice		
Yes	33	33
No	67	67
Whose Familiar Exposed Malpractice		
Yes	58	58
No	42	42
Total	**100**	**100.0**

According to the survey data obtained 100 people of 33 itself exposed to malpractice. The 58 were subjected to a close malpractice. As it can be seen from the data 25 people have been exposed to both himself and a close malpractice. The total is fluent in 91 of 100 people close to malpractice or self.

NO	**Survey Data**	$\overline{X}$	S
1.	Wrong treatment changed my life in a negative way.	4,256	1,060
2.	My social relationships were negatively influenced due to wrong treatment.	3,756	1,497
3.	My exposure to malpractice has affected those around me.	4,189	1,178
4.	Wrong treatment caused me to move away from the community.	3,297	1,619
5.	Exposure to malpractice reduced my social activities.	3,824	1,520
6.	My social environment stopped going to the doctor who practiced malpractice.	4,135	1,388
7.	Wrong treatment has changed the perspective of the society towards me.	2,797	1,543
8.	Wrong treatment reduced my frequency of going to the doctor.	3,500	1,563
9.	Wrong treatment reduced my confidence towards people.	3,364	1,429
10.	Experience of side effects of the drug has reduced my frequency of attending social environment.	2,905	1,623
11.	Misdiagnosis has caused people around me pity me.	3,229	1,684

12.	Unnecessary tests caused me not to prefer that hospital.	3,878	1,470
13.	Wrong treatment I have experienced reduced my confidence towards doctors.	4,283	1,079
14.	I've had great tension because of wrong treatment.	4,135	1,197
15.	Wrong treatment has changed my view of the world.	3,243	1,478
16.	Wrong treatment made my life upside down.	3,473	1,528
17.	Wrong treatment made me a pessimistic person.	3,378	1,486
18.	Wrong diagnosis caused me to undergo a stressful period.	4,270	1,173
19.	My tendency of violence increased towards doctors applying wrong treatment .	2,918	1,505
20.	Wrong treatment caused my familiy to misbehave the doctor.	3,067	1,607
21.	Being exposed to wrong treatment caused some problems in my job and daily life.	3,702	1,362
22.	I began to be prejudiced against all doctors.	3,797	1,344
23.	Wrong treatment resulted in self-esteem.	2,864	1,564
24.	Drugs prescribed wrong caused psychological side effects.	3,135	1,674
25.	I thought I would die because of the wrong diagnosis.	2,837	1,680
26.	I worried about my future due to the misdiagnosis result.	3,689	1,461
27.	I had some economical losses I hadn't expected .	3,837	1,526
28.	I spent a lot of money to fix the wrong treatment.	3,675	1,614
29.	I had a difficulty in overcoming the economical consequences resulted from wrong treatment.	3,675	1,553
30.	Wrong treatment caused me to lose time.	4,310	1,237
31.	I wasn't able to meet the costs of sueing for malpractice.	3,067	1,777
32.	I can not afford to sue for a malpractice.	2,554	1,664
33.	I paid a lot of money to lawyers for malpractice lawsuits.	1,810	1,449
34.	It was a financial burden for me having been examined by more than one doctor.	4,108	1,330
35.	I believe that the wrong diagnosis and treatment harms the country's economy.	4,229	1,309
36.	I believe that misdiagnosis is increasing health expenses.	4,662	0,848
37.	Wrong treatment may lead to unnecessary expenses.	4,729	0,708
38.	Wrong treatment increases the workload of doctors.	4,734	1,161
39.	Unnecessary tests requested may result in negative effects on patients with urgency.	4,608	0,824
40.	Prescribing unnecessary and wrong medication can cause economic losses.	4,716	0,767
41.	Unnecessary tests requested are a burden both for the individual and the government economy.	4,635	0,900

	n	**%**
Exposure To Wrong Treatment Type		
Placing misdiagnosis	29	39,2
Prescribing the wrong drug	22	29,7
Demanding unnecessary tests	16	21,6
Exposure to the wrong surgery	3	4,1
Doctors abusing their tasks.	1	1,4
Doctors causing death	3	4,1

Total	**74**	**100.0**

Out of 74 people getting the survey, 29 of them were misdiagnosed. 3 of them resulted in death due to malpractice.

	n	**%**
Where Explosed to malpractice		
Public Hospital	55	74,3
Private Hospital	15	20,3
Family Health Center	4	5,4
Total	**74**	**100.0**

As can be seen from the survey data, malpractice in public hospitals are more prevalent.

	n	**%**
Why exposed to malpractice		
Doctor Error	12	15,8
Careless doctors	24	31,6
Insufficient control	2	2,6
Insufficient training	10	13,2
The indifference of the doctor	12	15,8
Inexperience	7	9,2
Doctors not knowing current information	2	2,6
Overloading the doctor	3	3,9
Giving Priority to familiy members	1	1,3
Profit making	3	3,9
Total	**76**	**100.0**

Most of the people taking part in the survey stated that they were exposed to malpractice due to the carelessness of doctors.

Variables	**n**	**%**
Confidence in the Health Care System		
Yes	8	8
No	42	42
Partially	50	50
Total	**100**	**100.0**

Only 8 of the respondents rely on the health care system in Turkey.

4. CONCLUSION

Today, in an environment where the rights of patients are assessed as a consumer protection, health sector is seen as the service sector. Medical malpractice allegations have been seated on the agenda and have come forward in the recent years because of the medical care system's being evaluated in the aspect of a relationship like client- service provider, and because of patients' rights' being thought as a media material (Baydar, 2002; Donaldson, 1975; Akt.: Özkaya, 2006)

Malpractice concept appears to be multi-dimensional and multi-faceted concept. It occurs as a result of

negligence, carelessness, ignorance, inexperience and patient. Increase in medical information, the development of the technology used in the medical field, increasing the number of physicians using technology directs doctors to make some applications they do in the past and these often increase malpractice complaints and lawsuits. This increase brings medical care costs not only to patients exposed to malpractice, but also to physicians found guilty

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