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A Study On Patient-Physician Relations With The Framework Of Agency Theory: The Sample Of Isparta Province Center Hospitals*

Elif AKKAŞ[1] Ramazan ERDEM[2]

[1] Süleyman Demirel Üniversitesi/Turkey/ elif.akkas88@hotmail.com

[2] Süleyman Demirel Üniversitesi/Turkey / raerdem@yahoo.com

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A R T I C L E I N F O

Keywords: Patient-physician relations, agency theory, asymmetric information, trust in patient-physician relationship

Abstract

In the markets which information asymmetry exists, relationship of power of attorney occurs when the seller use this information on behalf of the association. In healthcare market, which is one of the the knowledge-intensive markets, relationship at power of attorney appears in the relationship of patient and physician. Physicians, who have one of the most important tasks to protect and upgrade the health of society, are competent at making decisions on behalf of patients by using their knowledge of medicine. Time to time ethical violations and abuse of authority occurs by using this competency and the moral hazard raise. Within the imperfect agency relationship, medical errors, unnecessary demand-creation behavior of physicians and efforts to obtain financial benefit, which are known as a kind of

market failure, thought to be the reason of the decrease in confidence to physicians.

In this study, it is aimed to investigate the reasons of negative perceptions towards the physicians within the framework of agency theory. For this purpose, perceptions of patients and their physicians under these problems were evaluated.

Population of the research, composed of physicians who are working in hospitals in Isparta province center, and patients in these hospitals. In this context, 124 physicians and 303 patients were reached. As a data collection tool the questionnaire namely “Patient-Physician Relationship in the Framework of the Agency Theory” is used which is developed by the researcher. In questionnaire, there are 43 statements to measure the dimensions such as “lack of confidence to the physician", "ethical problems", "financial benefit", "unnecessary demand", " bad medical practice."

According to the survey results, there is a significant difference between the physicians' perspective to their colleagues and the view of patients to the physicians. It is found that, patients' confidence to their physicians is lower than the physicians? confidence to their colleagues. Negative perceptions of patients about the physicians based on the behavior of physicians to obtain financial benefit, tendencies to take informal payments, being source of ethical problems and bad medical practices. Also, perception of physician-patient relationship differs according to age, education and income level of the patients; and seniority and income level of physicians and the ownership of the hospital in which the physician works.

1. Introductıon

In health care services the physician is in the leading position as determiner thanks to the information he/she has and can often takes unquestionable decisions within the frame of clinical independence. Agency theory, in the market in which there is information asymmetry, is a theory which explains the relationship between the principal and the agent who makes a decision on behalf of principal. In this concept, Mooney and Ryan, define agency theory as a relationship that is characterized by two people, one is representative and the other is represented, both of whom try to maximize their own independent benefit function [Şahin, 2004].The relation between patient and physician is principal-agent relation and includes asymmetric information problem.

2. Conceptual Framework

Clinic is a place where physician and patient meet willingly [Foucault, 2002]. This willing is a result of agency theory. Most health economists examined the topic of patient relations in health sector under the theory of agency. physician-patient relation is based upon the relation of agent-client in health services [Scott, 1999]. Agency theory in the relationship between parties is fictionalized to make the best decision for servers in the name of service claimers. Nevertheless, as the servers do not perform this ethical behaviour, there are problems in agency theory. Most of the problems generated during agency relation are associated to asymmetric information between physician and patient. This is fairly efficient in terms of patient-physician relationship and the maintenance of health service organizations [Vick, 1997; Adams, 1994].

Agency theory thinks to do the best treatment for the patient of physician. But in real the physician does not always

behave like this. Perfect physician is a physician who puts himself/herself in patient's shoes and chooses the best choice for the patient. This, as a medical ethic means that the physician focuses on patient's health, mainly benefit of patient. In this case if there was any conflict, this conflict would be due to patient's own choice [Kan, 1998].

This theory appears in two kinds, one is perfect agency relationship and the other is imperfect agency relationship. However, agency theory argues a perfect relationship would not be between physician and patient; a perfect relationship would be in theory. As Mooney and Ryan [Şahin, 2004] defined perfect agency relationship is a relationship which the physician in forms the patient completely and a relationship when the patient joins decision making process as well. However, as a more widely appearing model the most common output of imperfect agency is moral hazard which results in the patient's guidance of unnecessary demand.

3. RESEARCH

3.1. Population, Sample and Method

The patients and physicians who are principal and agency part of agency theory are determined to be applied as a population for the research. The population of research consists of 6 hospital's physician from governmental and private sectors operated in Isparta city centre and mature patients who take health service from these hospitals. The population of research, according to data taken from Ministry of Health, is 606 for physicians and 195 000 (Isparta city centre population) for the patients. Fault tolerance for population is %5, and if the reliability considered %95, a population of approximately 424 patients and 281 physicians can be sufficient [Kan, 1998]. For the research mentioned above, the permission is received and we reached 124 physicians and 303 patients with the convenience sampling method.

The data was analyzed by using SPSS 16.0 program. For the defining information and open ended questions, frequency and percentage calculation was made. In the questionnaire, the frequency of measurement in physicians' behaviours size and the importance of these behaviors were calculated with 5 point Likert scale by using arithmetic mean and standard deviation and statistical evaluations were made by average score.

In the cases where there are physicians' behaviours and parametric assumptions, the comparison of demographic variables of these statements' size is carried out, the difference of two average score (t test) is used to make a comparison of two groups; the analysis of variance is used (F test) to compare more than two groups. At the variance analysis result it is commented which group is different by examining Turkey's-b test. If parametric assumptions are not carried out, Mann-Whitney U test is used to compare two groups and Kruskal Wallis variance analysis is used to compare more than two groups. In the group in which it is determined a difference, it is applied Tamhane's T2 test to find the source of this difference.

3.2. Findings

Table 1: Psychometric Characteristics of physician and patient questionnaire in terms of perception of physicians

Perception size		Statement number	Max-Min	Cronbach Alfa		Patient		Physician	
				Patient	Physician	X	S	X	S
1.	Unreliability to Physician	12	1-5	0.727	0.851	3.093	0.606	2.382	0.651
2.	Ethical Problems	8	1-5	0.726	0.836	2.881	0.729	2.407	0.765
3.	Pecuniary Advantage	9	1-5	0.811	0.910	3.039	0.812	2.430	0.902
4.	Unnecessary Demand	5	1-5	0.656	0.782	3.055	0.825	2.546	0.837
5.	Bad Medical Treatment	9	1-5	0.826	0.879	3.083	0.983	2.416	0.733

The content of statements is not same and it is asked in different ways according to physician and patient. The five dimensions are:

- *The size of Unreliability to physicians*: Each statement is formed to put forward the reliability of patients to physicians and the reliability of physicians to their colleagues. (12 statements)

- *Ethical Problems Size*: It is formed to determine the perceptions of ethical problems of physicians work in Turkey. (8 statements)

- *Pecuniary Advantage Size*: Expressions are for questioning negative trends that show the intention of financial interests of physicians. (9 statements).

- *Unnecessary Demand Size*: It will be for various purposes such as providing material benefits to gain experience or sometimes considered unnecessary demand resulting from the creation of professional incompetence. (5 statements)

- *Bad Medical Treatment*: The perception of physicians and patients towards physicians resulted in medical faults' prevalence and species. (9 statements)

The statements for physicians and patients are evaluated with 5 Likert scale. Besides it is applied different questionnaire to patient and physicians, the sizes to measure perceptions towards physicians and the statements in these sizes are made up parallel, so that both the physicians' and patients' independent views are determined and it is tried to be understood the difference between the perceptions and the comparison of physicians and patients

Cronbach Alfa values which show the reliability in physician and patient questionnaires size change between 0.656 and 0.910. These results show that there isn't reliability problem in the questionnaire and sub-dimension used in research.

When it is examined the distribution of 124 physician according to their working institution, it is seen more than half of them work in university hospital. When it is examined whether physicians expert on surgical clinic or not, it is confirmed %47,6of them work in surgical clinic, and %52,4 of them work in other clinics. When it is examined the distribution of physicians in terms of age,

%27,0 of them are 29 years old and younger; % 35,1 of them are between 30-39 ages and %23,1 of them are 40 years old and older. In terms of total working period, the most percentile is about 9 years and less workers of physicians (%39,4). From the physicians of research, %71,8 of them are married and %71,7 is male. Nearly half of them (%49,4) have 3001-5000 income

From the patients which are reached %54,7 of them are female and %45,7 are married. It is seen %26,0 are 40 years old and above. In the research the patients whom the questionnaire applied to, more than half of them (%59,7) are graduated from university. In this concept, it is studied a highly educated patient group. More than half of patients (%55,6) have income below 1000 TL.

The patients, in the perception of physicians, is defined to participate in these size of problems in medium level by getting nearly 3 points from Unreliability to Physicians, Pecuniary Advantage, Unnecessary Demand and Bad Medical Treatment size. The patients only got points below average from Ethical Problems size, they agreed with experiencing ethical problems less other than the other problems.

As to physicians in the perception of their colleagues by getting points below the average 3 from Unreliability to Physicians, Ethical Problems, Pecuniary Advantage, Unnecessary Demand, Bad Medical Treatment size, they showed a tendency not to join these kind of problems. Physicians got the highest point in Unnecessary Demand Size (2.546±0.837).

4. Results and Suggestions

Points handled in all respects have been compared in terms of patients and physicians, and all differences have been found statistically meaningful. It was determined that perceptions related to the negative situations which appear as part of counsel relation are above at patients compared to physicians.

In research, patients showed reason physical dissatisfaction and drug companies' promotions, but the physicians showed reason lack of experience and professional illiteracy as an excuse for suggestions of unnecessary observation and treatment. It was expressed by patients and physicians that professional abuses are much more in surgical clinics than in other clinics.

It was determined that patients' age and education, but physicians' just income cause differences in perceptions related to the negations in patient-surgeon relations, and apart from that patients' income and the hospital's ownership that physicians work in and the clinic they work in is surgical or not don't cause any differences in perceptions.

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HEALTH OMBUDSMAN IN THE UNITED KINGDOM: ESTABLISHMENT, FUNCTIONS, AND EFFICIENCY

Kadir Caner Doğan[1]

[1]Gümüşhane Universitesi, İİBF, Kamu Yönetimi Bölümü

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ABSTRACT

Ombudsmanship is an institution of complaints acting against especially poor administration issues of public authorities per public complaints. Ombudsman, equally, is a public administration audit tool. Ombdusman, meaning representative person or attorney of the people, appeared for the first time in the 18th century Sweden. After the Second World War, it has spread to all continents. In present day, ombudsman has a field of application in 150 states in varying levels and formats. In the course of history, ombudsmen of different specialties have appeared due to increasing capacity and activities of the state and the public bureaucracy. The health ombudsmanship that constitute the main theme of this study is among them. This study aims to analyze the establishment, functions and efficiency of the health ombudsman in the United Kingdom. Accordingly, after general information about the concept of ombudsman is given, the historical establishment process of the health ombudsman in the UK, its functions and efficiency are assessed through the selected method of research. The scientific documents on the issue, such as books, articles, conference papers and official institutional documents in Turkish and English languages, are collected, analyzed through content analysis, the findings are deduced and a

conclusion is reached after discussion. The Health Ombudsman in the UK functions as an important tool of Parliament accountability, guarantor of the right to information, and a key democratic institution in charge general health quality in the country. Access to ombudsman for a complaint is extremely easy, fast and systematic.

INTRODUCTION

Ombudsman, as a public institution, is an institution of complaints that works for removing poor administration practices and human rights violation in bureaucracy. While the ombudsman is a public organization, it has field of application also in the private sector.

In the course of history, the ombudsmanship was employed for the first time in the 18th century Sweden, a Northern European country. One hundred years after having emerged in Sweden, after the Second World War, it has spread to all continents in different public levels. The main factors for the ombudsmanship to earn recognition in this period are the development of the state of law and the democratic gains. Equally in this period, the rapid expansion and growth of public administration, a structural and function mechanism of the state, created the need for its effective auditing. Ombudsmanship, an important tool for public administration auditing, from then on, has become active in different specialties and been implemented in different levels and sectors. The health ombudsmanship that constitute the main theme of this research is among these areas of specialty.

This study aims to analyze the establishment, functions and efficiency of the health ombudsman in the UK. In the study, the structural, institutional and functional aspects of health ombudsmanship's contribution in the UK are explained concisely. Thus, the probable effects of the health ombudsman to the UK democracy and public administration are identified. Therefore, in this study, primarily the theoretical information on ombudsmanship is given, then the data collected through the selected methodology and the findings are discussed to finalize the research.

1. OMBUDSMANSHIP AND THE HEALTH OMBUDSMAN: THEORETICAL FRAMEWORK

The ombudsman, the composition of the word (Ombuds) (representative) and man, has the meaning of representative person or attorney of the people. Principally, the ombudsman, as a public structure and function, may be defined as an audit mechanism or a mediation organization that examines, investigates and aims to resolve the complaints of persons and institutions claiming to have their rights and entitlements violated by the government and the public organs through defined procedures (Arslan, 1986: 157-158; Remac, 2013: 63).

The objective of the ombudsman is to remove poor administration practices in public administration organs and functions and to protect human rights and principal liberties (Remac and Langbroek, 2016: 88). Its principal aim is to minimize the shortcomings and the poor administration practices of the public bureaucracy, acting upon citizens' complaints or ex-officio (by own initiative). The main features of the ombudsman or the ombudsmanship are as below (Büyükavcı, 2008: 12):

- In relation with the legislative bodies,
- Independent and neutral,
- Acts according to defined functions and procedures,
- Based on a legal regulation,
- Acts upon a complaint or ex-officio,
- Always in interaction with the public bureaucracy,
- Gives recommendations on the resolution of issues,
- Presents a yearly report to the legislative bodies,
- Has an active relationship with the media and the public.

Ombudsman appeared for the first time in history in the 18th century Sweden (Esgün, 1996: 255) and had a rapid spread after the Second World War reaching a worldwide recognition. Among the factors on the expansion and gaining importance, there are; "*global economic and political crises, the expansion of public bureaucracy due to welfare state practices and the increase in poor practices, positive developments in the order of law and human rights and the transformation of the state through these factors and the restructuring of public administration"* (Doğan, 2014: 81-83). In this respect, ombudsman is a guarantor of human rights, democracy and the order of law through the transformation of the state and restructuring of public administration.

Based also on these aforementioned factors; economic, cultural and political developments of today, such as the globalization process and the restructuring of capitalism reshape the social field rapidly. Therefore, the changing social, political and economic demands create an important diversification of ombudsman specialties. Accordingly, ombudsmen specialized and focused in several different fields have appeared. These are (Gülener, 2013: 5-6; Reif, 2011: 300-301);

- Parliamentary ombudsman,
- Human rights ombudsman,
- Children's rights ombudsman,
- Armed forces ombudsman,
- Press ombudsman,
- Local authority ombudsman,
- Health ombudsman,
- Legal services ombudsman,
- Consumer ombudsman,
- University ombudsman,
- Banking ombudsman.

Among these, the Health Ombudsman is in charge of investigating citizens' complaints on the health sector and to protect their rights and liberties in this domain. The health Ombudsman in charge of citizens' complaints on the health sector, in cases they deem to be necessary launch an investigation on the case and resolves the complaint by taking advisory decisions addressed to concerned institutions. The health sector, which is indispensable for human life, day by day becomes a field necessary to be audited. The health ombudsman, the specialized ombudsman in this domain, attempts to fill this void (Özer, 2015: 83).

2. MATERIAL AND METHODOLOGY

The methodology of the research is based on a content analysis of the scientific documents such as books, articles, conference papers and official institutional documents in Turkish and English languages along with other scientific documents, and their treatment and discussion, in order to analyze the establishment, functions and efficiency of the UK Health Service Ombudsman. The principal objective of the research through its method is to inform on the establishment, functions and efficiency of the UK Health Service Ombudsman, and to assess the functional capacity and effectiveness of a health ombudsmanship in the United Kingdom. These assessments would also give hints on the UK democracy and the public (health) administration in the context of ombudsman.

3. FINDINGS

In order to resolve the complaints of citizens against the administration in the UK and to help the means of audit already in place, a report was commissioned to Sir John Whyatt in 1961, to constitute a ombudsmanship. In this report, the shortcomings of the means of audit already in place were identified, and the establishment of an ombudsmanship was suggeted to the parliament (Çakmak, 2008: 67; Abraham, 2011: 1; Gregory and Hutchhesson, 1975: 78). Ombudsmanship in the UK was established in 1967, by the "Parliamentary Commissioner Act" passed by the Parliament (Kirkhamn, 2006: 792).

The UK Ombudsman is known as the "Parliament Commissioner" (Altuğ, 2002:

99; Giddings, 2003: 139). They have been appointed by the Queen. They do not have a specific period of office, their tenure lasts until they are 65 years old. While they can leave their post of their own accord, they may be unseated by the Queen upon request of both houses of the Parliament. They are independent vis-a-vis both the Parliament and the government. The citizens do not have the right to apply direct to the Parliament Commissioner, and the Commissioner may not act ex-officio, however the wishes and complaints may be made via a Member of Parliament (House of Commons) (Soyupek, 2014: 23; Ataman, 1993: 224; Gay, 2010: 2; Giddings, 2008: 94). The Commissioner, after deciding to investigate the complaints under defined procedures, informs the concerned member of the House of Commons on the issue. The Commissioner prepares a report after the investigation is finished and presents the report to the concerned party and to both houses of the Parliament (Arslan, 1986: 170-171). In the United Kingdom, the Commissioner is also politically neutral, in order to fulfill their requirements, they have to stay away from partizanship. Therefore, the Commissioner may not have relations with the political parties (Fendoğlu, 2010: 11). Also, the decisions and suggestions of the Commissioner are in advisory capacity (Poole, 1983: 193).

Due to the successful works of the Parliament Commissioner in the UK; the health ombudsman, the local authority ombudsman, the police complaints ombudsman and the legal services ombudsman are commissioned (Ünal, 2008: 113; Adler, 2003: 327). Therefore, in the United Kingdom, in addition to the Parliament Commissioner, there are ombudsmen specialized in several fields (Soyupek, 2014: 22).

The Health Service Commissioner, among the aforementioned ombudsmen, was established in England, Wales and Scotland, according to the legislative regulations made in the 1970s to address the complaints against the National Health Service[1] (NHS) founded in 1948 (Giddings, 2004: 115; Seneviratne, 2002: 22-23). In the United Kingdom, the National Health Service is based on a regulation dated 1946 passed by the Parliament, as the foundation of basic health services (Tingle, 1993: 195). Accordingly, the UK Health Service Commissioner was established in 1972 along with a legislative regulation restructuring the National Health Service system (Kerrison and Pollock, 2001: 120; Anderson, 1979: 104; Ham, 2009: 23). Subsequently, in 1987, 1993 and 1996, the ombudsmanship was improved by legal arrangements (Gay, 2012: 3; Neff and Avebury, 2000: 671; Seneviratne, 2002: 162). The functions and activities of the ombudsman in the health services field were expanded, to the extent that the Parliament Commissioner and the Health Service Commissioner had a dual status known to be the "Parliamentary and Health Service Ombudsman-PHSO" (Esgün, 1996: 258; Eryıldız, 2006: 87) and its official website[2] was entitled accordingly (Parliamentary and Health Service Ombudsman, Resource Accounts, 2010-11: 5).

The UK Health Service Ombudsman examines complaints on poor administration issues on the National Health Service, such as poor services and failure to deliver a service (Perry, 2016; Seneviratne, 2002: 162; Gregory and

[1] The NHS in the UK was established by a law passed on 6 November 1946, and put into effect in 1948. Its principal features may be resumed in three articles; it covers all citizens regardless their affordability capacity and aims to deliver equal health services to everyone; people do not pay for health services or pay premiums as it is financed by general tax, and it aims to deliver health services through a holistic approach. The responsibility of the NHS is provided by the Secretary of State for Health (Kılıç and Bumin, 1993: 32-33). The NHS has a holistic structure and function in providing all citizens access and facilitation to basic health services (Webster, 2002: 1).

[2] http://www.ombudsman.org.uk/.

Giddings, 2002: 675; Tingle, 1993: 197; Kerrison and Pollock, 2001: 120; Parliamentary and Health Service Ombudsman, 2016).

The UK Health Service Ombudsman has been appointed by the Queen (Neff and Avebury, 2000: 671) and their tenure lasts until they are 65 years old (Giddings, 2000: 341). The Ombudsman may investigate the ineffectiveness or the lack of services by a health administration, the claims of an administration not delivering the required services properly or at all, and any other activity by an administration or on their behalf (Eryıldız, 2006: 87). However the UK Health Service Ombudsman does not have authority in cases below and cannot exercise its functions (Akıncı, 1999: 341; Seneviratne, 2002: 165):

- Cases taken to court or the independent judges' council,
- Complaints on the personnel affairs of the National Health Service, such as assignments, fees and disciplinary matters,
- Contractual and commercial matters other than the contract clauses on the services provided to patients,
- Complaints on the services given by hospitals and nurseries not affiliated with the National Health Service,
- Complaints on state bodies such as the Secretary of State for Health, the Wales Office, Scotland Cabinet Secretary for Health and Sport, and the National Health Service Executive Committee,
- Complaints on local authorities such as social services.

Prior to application to the UK Health Service Ombudsman, all other application means should be exhausted (Avşar, 2012: 153). All citizens (patients, patient relatives, and the NHS or National Health Council staff) may apply to the ombudsman (Seneviratne, 1994: 71; Perry, 2016). The UK Health Service Ombudsman may solely act upon a complaint. The complaints to the Ombudsman are made in general by a written petition, the case file goes through a preliminary examination to be decided whether an investigation can be carried out regarding time and other factors. The statute of limitation for cases is one year. The Health Ombudsman has all the authorities of the Parliament Commissioner. At the end of the investigation, the Ombudsman sends a copy of their report to the complainer, the Member of Parliament supporting them, along with the concerned health administration and the superior administration in charge of that administration, also to the Secretary of State if the complaint is on the regional health administration. The Health Ombudsman, in case the violation persists and is deemed to be resolved, sends a special report to the Secretary of State. The Secretary of State is obliged to present this report to the House of Commons and the House of Lords. The Ombudsman also presents a yearly report to the Parliament. Equally, there has been a close relationship between the House of Commons Select Committee and the Ombudsman through their reports. The reports are taken to the general assembly after being reviewed by the committee (Eryıldız, 2006: 87-88; Avşar, 2012: 153; Giddings, 2000: 341-352).

The UK Health Service Ombudsman may demand all the documents and information from the concerned institution. If required, they may carry out on-site investigation and commission experts. Their interviews and inspections are confidential. They may suggest that the concerned administration resolve the injury (Avşar, 2012: 153-154; Akıncı, 1999: 342; Seneviratne, 2002: 166).

The UK Health Service Ombudsman received 13,310 complaints in 1997-2002 (Seneviratne, 2002: 186; Giddings, 2000: 346), while the yearly report of the UK Health Service Ombudsman states that

26,583 applications were made in the 2012-2013 period. Among them, 6,924 applications were taken into examination. In the 2013-2014 period, 7,760 of 27,273 applications were taken into examination. In the 2014-2015 period, 29,000 application were made and 6,815 application were taken into examination (Parliamentary and Health Service Ombudsman-PHSO Annual Report and Account, 2014: 11-13 from transporter Gökçe, 2016: 757).

4. DISCUSSION AND CONCLUSION

The UK Health Service Ombudsman is not only involved with poor administration practices, but also the general quality of health services. Furthermore, the Ombudsman is the guarantor of the right to information in health services. In this regard, they have further powers compared to the Parliament Commissioner (Akıncı, 1999: 340; Seneviratne, 2002: 169). The Ombudsman has an important role on increasing the service quality of hospitals and institutions delivering public health service. Also, the concerned party, due to "Open Government Plan," is entitled to demand information on health matters. The Health Institution, Health Council and National Health Service Foundation are obliged to provide this information. In case this information is not provided or a fee is demanded, the process may be subject to complaint (Avşar, 2012: 152; Giddings, 2000: 343; Smith, 2002: 20-21).

The UK Health Service Ombudsman, as a key institution with the NHS and a functional process, is an important mechanism of Parliament accountability and the guarantor of right to information, in domains they are in charge of. Due to the independence and neutrality of the Ombudsman in their functions, the convenience and speed of access to the institution, their expanded field of assignment, the relations they establish between the Parliament and the administration, their function of informing the public and suggesting resolutions; it may be said that it is a highly efficient institution in increasing quality in health administration.

As a result of the discussion above, the Health Ombudsman in the United Kingdom is an efficient tool of auditing public bureaucracy in the health domain. Equally, the Ombudsman, with its expanded functional capacity along with their structural and functional features, has a role in improving democracy and the order of law.

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HEALTH ORGANIZATIONS' PERCEPTIONS OF THE SERVICE THAT IS SUBJECT TO THEIR COMPLAINTS

Bilsen ONAT[1]

[1]IMBL Health Management Institute Department of Health Sciences, IMBL 33a/47, Nagibina Ave Rostov-on-Don, Russian Federation, 344068.

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ABSTRACT

All health care organizations, patient-health worker satisfaction and participation with the Group is aiming to reach synergies that will be created. In the health sector because of to continue to exist, needs the support of all parties. This article in the study, health care organizations quality management practices that they follow to achieve their goals within the scope of the effects of demographic characteristics on patient's complaints were investigated.

In order to measure these effects in a State Hospital March –April 2006 period, 94 patients completed the questionnaire of 32 questions refer to. The results of the questionnaire were analysed with SPSS statistical analysis method and interpreted.

At the end of the study, it was seen that assessments differ in patient survey. Satisfaction levels of hospital care and Ambulatory patients from the meticulous attention to personal privacy from hospitalized patients was found to be higher. The height of this one-to-one service providers and the service recipients that is related to the time they spend on it is shown.

1. INTRODUCTION

Health service delivery, brokers are individuals who demand the service from anyone not contain his request or the continuation of the conduct in the legal representative of the direction of the process to approve life. processes for the generation of the resumed service quality standards in different branches of health service delivery in the health services of the business managers together with all employees should also be found in their personal responsibility. Quality level of service that made the presentation, is taken as the basis for articles covering these topics are not satisfied with the service quality and condition of the patient to be measured with the feedback they have made of the individual patient. The purpose of the study, in a state hospital patients complain that the way to achieve the quality of service to evaluate how effective and to provide suggestions for upgrading the level of dissatisfaction with the assessment made as a result of the correction of errors.

2. QUALITY OF SERVICE

Concepts that belong to an abstract concept, which is the level of service the detection of the phenomenon varies on an individual basis. The concept of service to encompass the very notion of a structural feature is a broad (Yalkın, 2010: 4).

The concept of service is expressed in the most simple way to do a job for anyone. Individuals and businesses or to both presentations can be made. Turkish Language Institution of Great Turkish Dictionary; "Seeing one's work or doing something for someone" is defined (Ardıç, 1998: 12).

In Economics terms dictionary (TDK, b.t.) service “has the characteristics that meet the requirements at the time it is produced and consumed in any activity” in the definition of are made.

3.MATERIALS AND METHODS

3.1. Purpose Of The Study

The objective of the study in a State Hospital in Turkey to assess customer perception has been identified as external.

3.2. The Universe Of The Research

The research of the universe in a State Hospital March –April 2006 during the period consists of the people who apply.

3.3. The Sample Of The Study

Sample Bursa/Turkey operating in a State Hospital March –April 2006 94 has been identified as the person to receive outpatient services in the period refer.

3.4.Evaluation Of Data

Entering the survey data obtained from participants computer containing descriptive analysis using SPSS 19.0 statistical software frequency and percentage distributions are made.

4. RESULTS

4.1 Age and “Is This Your First Application To The Hospital?” Expression Comparison

			Age					Total	Significance	
			18-25	26-40	41-50	51-65	66 and above		X^2	p
Is this your first application to the hospital?	Yes	Count	16	18	10	1	1	46	22,130	,005
		%	34,8%	39,1%	21,7%	2,2%	2,2%	100,0%		
	No	Count	7	10	13	11	7	48		

		%	14,5%	20,8%	27,0%	22,9%	14,5%	100,0%		
Total		Count	23	28	23	12	8	94		
		%	24,5%	29,8%	24,5%	12,8%	8,5%	100,0%		

When table 4.1 is examined, "Is this your first application to the hospital?" expression; patients between the ages of 18-25 (34.8%) yes, (14.5%) no, patients between 26-40 years of age (39.1%) yes, (20.8%) no, patients between 41-50 years of age (21.7%) yes, (27.0%) no, patients between 51-65 years of age (2.2%) yes, (22.9%) no, patients between 26-40 years of age (39.1%) yes, (20.8%) no, with age 66 years and older patients (2.2%) yes (14,5%) no answered in the form. Statistically significant differences according to the age of the patient whether or not individuals are first admitted to the hospital (p <.05) was found to reveal (p<.05).

4.2 Age and "How Many Times Did You Come To The Hospital For Inpatient Treatment?" Expression Comparison

			Age					Significance	
			18-25	26-40	41-50	51-65 and above	Total	X^2	p
How many times did you come to the hospital for inpatient treatment?	First	Count	18	21	12	5	56	34,335	,001
		%	32,1%	37,5%	21,4%	8,9%	100,0%		
	2 nd accesses	Count	3	3	7	3	16		
		%	18,7%	18,7%	43,7%	18,7%	100,0%		
	3 or 4 accesses	Count	2	3	3	12	20		
		%	10,0%	15,0%	15,0%	60,0%	100,0%		
Total		Count	23	27	22	20	92		
		%	25,0%	29,3%	23,9%	21,7%	100,0%		

When table 4.2 is examined, "How many times did you come to the hospital for treatment bed?" expression; Patients between 18 and 25 years (32.1%) were for the first time, (18.7%) of the 2 nd time, (2.0%) have 3 or 4 th time, patients between 26 and 40 years (37.5%) were for the first time, (18.7%) of the 2 nd time, (15.0%) have 3 or 4 th time, patients between 41 and 50 years (21.4%) were for the first time, (43.7%) of the 2 nd time, (15.0%) have 3 or 4 th time, patients 51-65 years of age and older (8.9%) were for the first time, (18.7%) of the 2 nd time, (60.0%) have 3 or 4 th time answered in the form. Statistically significant differences according to age how many times they came to the hospital to inpatient treatment (p <.05) had revealed.

4.3 Age and "I Did Not Expect Much For Analysis and Investigation" Expression Comparison

			Age						Significance	
			18-25	26-40	41-50	51-65	66 and above	Total	X^2	p
I did not expect much for analysis and investigation	Yes	Count	3	8	8	7	6	32	20,461	,009
		%	9,4%	25,0%	25,0%	21,9%	18,8%	100,0%		
	Partially	Count	9	14	11	1	1	36		
		%	25,0%	38,9%	30,6%	2,8%	2,8%	100,0%		
	No	Count	11	6	4	4	1	26		
		%	42,3%	23,1%	15,4%	15,4%	3,8%	100,0%		
Total		Count	23	28	23	12	8	94		

%	24,5 %	29,8 %	24,5 %	12,8 %	8,5 %	100,0 %

When table 4.3 is examined, "I did not expect much for analysis and investigation." expression; patients between the ages of 18-25 (9.4%) yes, (25.0%) partially, (42.3%) no, patients between the ages of 26-40 (25.0%) yes, (38.9%) partially, (23.%) no, patients between the ages of 41-50 (25.0%) yes, (30.6%) partially, (15.4%) no, patients between the ages of 51-65 (21.9%) yes, (2.8%) partially, (15.4%) no, with age 66 years and older patients (18.8%) yes (2.8%) partially, (3.8%) no answered in the form. Statistically significant differences according to the age of their responses that they expect a lot of patient and wait for the assay tests (p <.05) was determined to show.

4.4 Marital Status and "Is This Your First Application To The Hospital?" Expression Comparison

			Marital Status			Total	Significance	
			Single	Married	Widow		X^2	p
Is this your first application to the hospital?	Yes	Count	21	24	1	46	17,159	,002
		%	45,7%	52,2%	2,2%	100,0%		
	No	Count	9	25	14	48		
		%	18,7%	52,0%	29,1%	100,0%		
Total		Count	30	49	15	94		
		%	31,9%	52,1%	16,0%	100,0%		

When table 4.4 is examined, " Is this your first application to the hospital?" expression; single patients (45.7%) yes, (18.7%) no, married patients (52.2%) yes, (52.0%) no, widow patients (2.2 %) yes, (29.1 %) no answered in the form. Statistically significant differences according to marital status in perceptions about whether they refer patients to the hospital for the first time (p <.05) was determined to be.

4.5 Marital Status and "How Many Times You Come To The Hospital For Treatment Bed?" Expression Comparison

			Marital Status			Total	Significance	
			Single	Married	Widow		X^2	p
How many times you come to the hospital for treatment bed?	First	Count	22	32	2	56	30,434	,000
		%	39,3%	57,1%	3,6%	100,0%		
	2 nd accesses	Count	5	9	2	16		
		%	31,3%	56,3%	12,5%	100,0%		
	3 or 4 accesses	Count	2	7	11	20		
		%	10,0%	35,0%	55,0%	100,0%		
Total		Count	29	48	15	92		
		%	31,5%	52,2%	16,3%	100,0%		

When table 4.5 is examined, " How many times you come to the hospital for treatment bed?" expression; single patients (39.3%) were for the first time, (31.3%) of the 2 nd time, (10.0%) have 3 or 4 th time, married patients (57.1%) were for the first time, (56.3%) of the 2 nd time, (35.0%) have 3 or 4 th time, widow patients (3.6%) were for the first time, (12.5%) of the 2 nd time, (55.0%) have 3 or 4 th time answered in the form. Statistically significant differences according to marital status of the subject many times they come to the hospital for inpatient treatment (p <.05) was determined to be.

4.6 Educational Status and "How Many Times You Come To The Hospital For Treatment Bed?" Expression Comparison

	Educational Status	Total	Significance

			Patients with non-literacy and primary school	Middle School	High school and equivalent schools	University and higher		X^2	p
How many times you come to the hospital for treatment bed?	First	Count	5	4	16	31	56	35,437	,000
		%	8,9%	6,7%	28,6%	55,4%	100,0%		
	2 nd accesses	Count	2	2	7	5	16		
		%	12,5%	12,5%	43,8%	31,3%	100,0%		
	3 or 4 accesses	Count	8	3	5	4	20		
		%	40,0%	15,0%	25,0%	20,0%	100,0%		
Total		Count	15	9	28	40	92		
		%	16,3%	9,7%	30,4%	43,4%	100,0%		

When table 4.6 is examined, " How many times you come to the hospital for treatment bed?" expression; patients with non-literacy and primary school (8.9%) were for the first time, (12.5%) of the 2 nd time, (40.0%) have 3 or 4 th time, patients with secondary school graduates (6.7%) were for the first time, (12.5%) of the 2 nd time, (15.0%) have 3 or 4 th time, patients with high school and equivalent school graduates (28.6%) were for the first time, (43.8%) of the 2 nd time, (25.0%) have 3 or 4 th time, patients with university and higher school graduates (55.4%) were for the first time, (31.3%) of the 2 nd time, (20.0%) have 3 or 4 th time answered in the form. Statistically significant differences according to the educational status of the subjects they come several times to the hospital for inpatient treatment ($p < .05$) was determined to be.

4.7 Educational Status and " What Are Your Reasons For Forwarding Your Complaint?" Expression Comparison

			Training Status				Significance	
			Patients with non-literacy and primary school	Middle School	High school and equivalent schools	Total	X^2	p
What are your reasons for forwarding your complaint?	I thought that complaining doesn't work	Count	3	1	16	20	23,551	,023
		%	15,0%	5,0%	80,0%	100,0%		
	I don't know where to complain	Count	4	1	4	9		
		%	44,4%	11,1%	44,4%	100,0%		
	Thought I'd stop by and caused material damage by complaining	Count	2	1	7	10		
		%	20,0%	10,0%	70,0%	100,0%		
	I did not complain for other reasons	Count	1	3	17	21		
		%	4,7%	14,2%	80,9%	100,0%		
Total		Count	10	6	44	60		

	%	16,6%	10,0%	73,3%	100,0%		

When table 4.7 is examined, "You have come several times to the hospital for treatment bed" expression; patients with non-literacy and primary school (15.0%) those who think that complaining is useless, (44.4%) those who know where would complain, (20.0%) those who would suffer losses in the material sense complaining, (4.7%), patients with middle school graduates (5.0%) those who think that complaining is useless, (11.1%) those who know where would complain, (10.0%) those who would suffer losses in the material sense complaining, (14.2%), patients with high school and equivalent schools graduates (80.0%) those who think that complaining is useless, (44.4%) those who know where would complain, (70.0%) those who would suffer losses in the material sense complaining, (80.9%) answered in the form. Statistically significant differences according to marital status and the reason for forwarding the complaints of relatives of the patient group ($p < .05$) was determined to show.

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4.8 Educational Status and "Which Department Did You Complain To?" Expression Comparison

			Training Status			Significance	
			Patients with non-literacy and primary school - Middle School	High school and equivalent schools University and higher	Total	X^2	p
Which department did you complain to?	Patient relationship	Count	3	24	27	30,549	,015
		%	11,1%	88,8%	100,0%		
	Front Office	Count	5	8	13		
		%	38,4%	61,5%	100,0%		
	House keeping	Count	2	3	5		
		%	40,0%	60,0%	100,0%		
	Food and drink	Count	2	3	5		
		%	40,0%	60,0%	100,0%		
	Other	Count	2	4	6		
		%	33,3%	66,6%	100,0%		
Total		Count	14	42	56		
		%	25,0%	75,0%	100,0%		

When table 4.8 is examined, " Which department did you complain to?" expression; Literacy is not, Primary and Middle school graduate of patients (11.1%) patient relations, (38.4%) front Office, (40.0%) house keeping, (40.0%) food and drink, (33.3%) other, high school and equivalent schools, university graduates and older patients (88.8%) patient relations, (61.5%) front Office, (60.0%) house keeping, (60.0%) food and drink, (66.6%) other answered in the form. Statistically significant differences by education departments in which they made their complaints ($p < .05$) was determined to show.

4.9 Educational Status and "Patients Laughs Staff Are Friendly and Were Concerned In The Recording Section" Expression Comparison

			Training Status					Significance	
			Literacy is not - Primary	Middle School	High school and equivalent schools	University and higher	Total	X^2	p
Patients laughs staff are friendly and were concerned in the recording section	Yes	Count	10	1	7	9	27	20,730	,008
		%	37,0%	3,7%	25,9%	33,3%	100,0%		
	Partially	Count	1	7	10	18	36		
		%	2,7%	19,4%	27,8%	50,0%	100,0%		
	No	Count	4	1	11	14	30		
		%	13,3%	3,3%	36,7%	46,7%	100,0%		
Total		Count	15	9	28	41	93		
		%	16,1%	9,7%	30,1%	44,1%	100,0%		

When table 4.9 is examined, " Patients laughs staff are friendly and were concerned in the recording section " expression; Literacy is not, Primary school graduate of patients (37.0%) yes, (2.7%) partially, (13.3%) no, Middle School graduate of patients (3.7%) yes, (19.4%) partially, (3.3%) no, High school and equivalent schools graduate of patients (25.9%) yes, (27.8%) partially, (36.7%) no, University and higher graduate of patients (33.3%) yes, (50.8%) partially, (46.7%) no answered in the form. Patients rose and faced the personnel department in the patient records statistically significant difference according to whether they are related to the subject of education ($p < .05$) was determined to be.

4.10 Occupation Status and "Patients Laughs Staff Are Friendly and Were Concerned In The Recording Section" Expression Comparison

			Occupation status						Significance	
			Self-employed	Worker	working as civil servants and retirees	Housewife	Unemployed	Total	X^2	p
Patients laughs staff are friendly and were concerned in the recording section	Yes	Count	8	4	11	7	6	36	18,435	,048
		%	22,2%	11,1%	30,5%	19,4%	16,7%	100,0%		
	Partially	Count	9	9	9	4	4	35		
		%	25,7%	25,7%	25,7%	11,4%	11,4%	100,0%		
	No	Count	9	3	3	5	2	22		
		%	40,9%	13,6%	13,6%	22,7%	9,1%	100,0%		
Total		Count	26	16	23	16	12	93		
		%	28,0%	17,2%	24,7%	17,2%	12,9%	100,0%		

When table 4.10 is examined, "Patients laughs staff are friendly and were concerned in the recording section" expression; patient self-employed (22.2%) yes, (25.7%) partially, (40.9%) no, patients workers (11.1%) yes, (25.7%) partially, (13.6%) no, working as civil servants and retired patients (30.5%) yes, (25.7%) partially, (13.6%) no, patients housewife (19.4%) yes, (11.4%) partially, (22.7%) no, patients unemployed (16.7%) yes, (11.4%) partially, (9.1%) no answered in the form. The examination of patients during the time of the required inspection according to think about leaving the profession, they think of the topic statistically significant differences ($p<.05$).

4.11 Occupation Status and "The Hospital For Inpatient Treatment Which Time?" Expression Comparison

			Occupation status							Significance	
			Self-employed	Worker	working as civil servants	Retieres	Housewife	Unemployed	Total	X^2	p
The hospital for inpatient treatment which time?	Yes	Count	14	10	7	2	4	9	46	18,958	,041
		%	30,4%	21,7%	15,2%	4,3%	8,7%	19,6%	100,0%		
	No	Count	12	6	3	11	12	3	47		
		%	25,5%	12,7%	6,3%	23,4%	25,5%	6,3%	100,0%		
Total		Count	26	16	10	13	16	12	93		
		%	28,0%	17,2%	10,8%	14,0%	17,2%	12,9%	100,0%		

When table 4.11 is examined, "Is this your first application to the hospital?" expression; patient self-employed (30.4%) yes, (25.5%) no, patients workers (21.7%) yes, (12.7%) no, working as civil servants (15.2%) yes, (6.3%) no, retired patients (4.3%) yes, (23.4%) no, patients housewife (8.7%) yes, (25.5%) no, patients unemployed (19.6%) yes, (6.3%) no answered in the form. Patients to the hospital for the first time a reference regarding whether statistically significant differences between the perceptions of they according to profession ($p<.05$).

4.12 Occupation Status and "The Hospital For Inpatient Treatment Which Time?" Expression Comparison

			Occupation status			Significance	
			Self-employed Worker Servants and Retieres	Unemployed Self-employed	Total	X^2	p
The hospital for inpatient treatment which time?	First	Count	34	21	55	35,154	,002
		%	61,8%	38,1%	100,0%		
	2 nd accesses	Count	8	8	16		
		%	50,0%	50,0%	100,0%		
	3 nd accesses	Count	3	5	8		
		%	37,5%	62,5%	100,0%		
	4 nd accesses and above	Count	5	7	12		
		%	41,6%	58,3%	100,0%		
Total		Count	50	41	91		
		%	54,9%	45,0%	100,0%		

When table 4.12 is examined, " The hospital for inpatient treatment which time?" expression; patients self-employed, patients worker, patients servants and retired patients (61.8%) were for the first time, (50.0%) of the 2 nd time, (37.5%) of the 3 nd time, (41.6%) 4 nd accesses and above, Unemployed Self ve employed (38.1%) were for the first time, (50.0%) of the 2 nd time, (62.5%) of the 3 nd time, (58.3%) 4 nd accesses and above answered in the form. Statistically significant differences by occupation state how many times they come to the hospital for inpatient treatment of patients ($p <.05$) was found to show.

4.13 Social Security Status and "Did Your Complaint Through What Channel?" Expression Comparison

			Social security status				Significance	
			SSI Working and retired	Green card and private health insurance	Social security and other non -	Total	X^2	p
Did your complaint	Face to face	Count	29	7	4	40	49,058	,003

through what channel?	interview	%	72,5%	17,5%	10,0%	100,0%		
	Phone (toll free customer lines, etc.)	Count	3	1	1	5		
		%	60,0%	20,0%	20,0%	100,0%		
	In writing (letter, complaint form)	Count	1	3	4	8		
		%	12,5%	37,5%	50,0%	100,0%		
Total		Count	33	11	9	53		
		%	62,2%	20,7%	16,9%	100,0%		

When table 4.13 is examined, " Did your complaint through what channel?" expression; SSI Working and retired (72.5%) who complain face to face with the channel, (60.0%) Telephone (such as free customer lines) thanks to the channel, (12.5%) In writing (letter, complaint form), green card and private health insurance (17.5%) who complain face to face with the channel, (20.0%) Telephone (such as free customer lines) thanks to the channel, (37.5%) In writing (letter, complaint form), In case of patients with no social security and other social security (10.0 %) who complain face to face with the channel, (20.0%) Telephone (such as free customer lines) thanks to the channel, (50.0%) In writing (letter, complaint form) answered in the form. A patient's complaints through the channel according to the status of their social security subject in which statistically significant differences ($p<.05$).

4.14 Social Security Status and "Which Has Been Used To Improve Business Process Your Complaint?" Expression Comparison

			Social security status			Significance	
			SSI, Working and retired	Green card and private health insurance and do not have health insurance Other	Total	X^2	p
Which has been used to improve business process your complaint?	Anything has not been done	Count	19	12	31	49,921	,049
		%	61,2%	38,7%	100,0%		
	Apology and explanation are reviewed	Count	6	3	9		
		%	66,6%	33,3	100,0%		
	The mistake is corrected	Count	9	3	12		
		%	75,0%	25,0%	100,0%		
	The adjustment has been made	Count	1	2	3		
		%	33,3%	66,6%	100,0%		
Total		Count	35	20	55		
		%	63,6%	36,3%	100,0%		

When table 4.14 is examined, " Which has been used to improve business process your complaint?" expression; SSI, Working and retired (61.2%) anything has not been done, (66.6%) apology and explanation are reviewed, (75.0%) the mistake is corrected, (33.3%) the adjustment has been made, green card and private health insurance and do not have health insurance and other (38.7%) anything has not been done, (33.3%) apology and explanation are reviewed, (25.0%) the mistake is corrected, (66.6%) the adjustment has been made answered in the form. The company complained of were statistically significant differences according to the social security status of threads which implement improvement methods ($p <.05$) was determined to be.

4. 15 Social Security Status and "During The Examination, I Think That The Time Allocated The Necessary Examinations." Expression comparison

			Social security status						Significance	
			SSI Working	SSI retired	Green card	Private health insurance	No social security and Other	Total	X^2	p
During the examination, I think that the time allocated the necessary examinations.	Yes	Count	10	14	3	4	5	36	18,805	,043
		%	27,8%	38,9%	8,3%	11,1%	13,8%	100,0%		
	Partially	Count	18	6	1	3	7	35		
		%	51,4%	17,1%	2,9%	8,6%	20,0	100,0%		
	No	Count	12	1	4	3	2	22		
		%	54,5%	4,5%	18,2%	13,6%	9,0	100,0%		
Total		Count	40	21	8	10	14	93		
		%	43,0%	22,6%	8,6%	10,8%	15,0	100,0%		

When table 4.15 is examined, " During the examination, I think that the time allocated the necessary examinations." expression; SSI working (27.8%) yes, (51.4%) partially, (54.5%) no, SSI retired (38.9%) yes, (17.1%) partially, (4.5%) no, Green card (8.3 %) yes, (2.9%) partially, (18.2%) no, Private health insurance (11.1 %) yes, (8.6%) partially, (13.6%) no, not social security and other (13.8%) yes, (20.0%) partially, (9.0%) no answered in the form. During the examination of patients, a statistically significant difference when compared to the required examination of the issue of social security that they would consider leaving ($p < .05$) was determined to be. SSI Working, SSI retired, Green card

4.16 Social Security Status and "Inspection Were Provided Sufficient Privacy While" Expression Comparison

			Social security status				Significance	
			SSI Working, SSI retired, Green card	Private health insurance	No social security and Other	Total	X^2	p
Inspection were provided sufficient privacy while	Yes	Count	50	6	7	63	22,188	,014
		%	79,3	9,5	11,1	100,0%		
	Partially	Count	16	2	6	24		
		%	66,6	8,3	25,0	100,0%		
	No	Count	2	2	1	5		
		%	40,0	40,0	20,0	100,0%		
Total		Count	68	10	14	92		
		%	73,9	10,8	15,2	100,0%		

When table 4.16 is examined, "Inspection were provided sufficient privacy while" expression; SSI Working, SSI retired, Green card (79.3%) yes, (66.6%) partially, (40.0%) no, Private health insurance (9.5 %) yes, (8.3 %) partially, (40.0%) no, not social security and other (11.1%) yes, (25.0%) partially, (20.0%) no, answered in the form. During the examination of the patient sufficient privacy statistically significant difference according to whether adequate social security issues ($p < .05$) was determined to be.

5. CONCLUSIONS AND RECOMMENDATIONS

All services group active in the health care system should provide complete services to meet the needs of patients in health care demand. This full-service, but also within the philosophy of total quality management can be performed with high quality service. Total Quality Management, a leading manager approach, increasing the labor force and the quality of service unceasingly conscious of individual responsibility is based on the development goals to keep alive. These objectives will bring self-developed organization and staff is constantly kept alive. The services will always tried to be taken to better patient satisfaction and thus continuously raising the concept of quality in health services will be moved farther than ever.

What dissatisfaction as a result of health service delivery, according to the demographic situation of the participants to the hospital administration has tried to determine the way they transmit. In this context, the age of those surveyed; They did not make contact for the first time to the hospital, how many times they come to the hospital for inpatient treatment and analysis and tests conducted it was determined that they do not expect much wait associated.

Marital status; and making their first application for inpatient hospital was determined to be related to whether the number of times they come to the hospital.

Education; for inpatient treatment several times they came to the hospital, they did what their complaints department, laughs part of the staff that the patient records are friendly and they're not to be associated is about.

The professions; During the examination of the patient, time of examination that they would consider that to be separated, and whether to apply for the first time they have been determined to be related to inpatient hospital once they come to the hospital match.

Social security status of; They did through which channel their complaints, businesses which have implemented an improvement method, during the inspection, that they would consider that to be examined when the leave, during the inspection, it was determined that sufficient associated with not providing privacy assurance team.

All based on these results, patient training of health professionals in the analysis of the complaints contained in the development of health service delivery and the use of such claims in hospital is recommended.

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COMPARISION BETWEEN THE QUEUING SYSTEM AND APPOINTMENT SYSTEM IN HOSPITALS

Sedat BOSTAN[1]
Yıldırım AYDOĞAN[2]

[1]Gümüşhane University/Healty Care Management/Turkey/sbostan29@gmail.com.
[2]Gümüşhane University/ Healty Care Management/Turkey

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ABSTRACT

The Problem of the Study: Despite the globalization in health services and technological integrations, patients still face with uncalled-for waiting times in service encounter process. This waiting time cannot be limited to not only waiting physicians but also waiting for treatment, waiting for an emergency or waiting for an accident case. It is aimed in this study to understand the effects of these waiting times on psychological effects on patient satisfaction.
The Purpose of the Study: It is aimed in this study to evaluate the level of patient satisfaction by analyzing and evaluating waiting in queues and appointment system in policlinic units of State Hospital.
Method: This study mainly consists of the patients that are provided services from State Hospital. The study was conducted based on a survey system with 150 patients in 4 policlinics between 28.04.2014 and 09.05.2014.
Findings and Results : Even though waiting periods change in each polyclinics, the most intense times of queues are between 08:00-11:00 and 13:00 and15:00. Generally waiting periods in Otorhinolaryngology is 62 minutes, 45 minutes in General Surgery , 47 minutes in Ophthalmologic clinic and 68 minutes in Internal Diseases clinic. The highest contentedness level in appointment system is in Ophthalmologic clinic. Periods in waiting in queues are much more than those in appointment system. At the end of the study, it is

determined that appointment system is more efficient than waiting in the queues.

INTRODUCTION

Rapid developments in information and communication technologies, technological integrations and globalization process have created significant changes in health sector as in others. Hospitals are providing service in an integrated manner with technology by raising their quality of service, increasing accessibility to health services and enhancing level of health standards.

'Today, it is a reality that the number of health institutions cannot supply the needs of this raising population despite the positive developments in this sector. As a result of increasing level of income, a demand of more qualified service has emerged (Tekin, 2015:484). Lack of sources, ineffective use of the system, problems while providing service especially in policlinics and long queues become inevitable (Fedai et al, 2000:49).

One of the sectors that queue problems are mostly encountered is the health sector. Within this aspect, hospitals are thought as a system comprised of queuing networks (Luck1972). According to a research done by Ministry of Health , patients wait approximately 70 minutes after arriving to the hospitals to meet the doctor and this period reaches nearly two hours in university hospitals (Ministry of Health,1994). Patients are waiting on phones and on internet as well as in front of patient admission office. To solve waiting problems in hospitals, patients are provided health services speeded in time periods (Alagöz, 2003:2). However, ineffective planning of sources and the imbalances in supply and demand of services cause long waiting times. Determining the number of patients to be treated without an analytical model and serializing at the beginning of the clinic hours are the main reasons of long queues in hospitals. Under this circumstance, patients have to arrive hospitals early to get a sequence. Therefore there becomes stampede in lounges especially during these moments because these patients have to wait in queues (Gürpınar and Karahan, 2009:156). In order to reach health services in more active and productive ways, one of the most important projects studied by Ministry of Health within scope of Health Transformation Project is Central Appointment System (www.sisoft.com). Appointment system is a system used for planning the sources, effective and efficient workforce, increasing patient contentedness, shortening the long queues (mhrs.gov.tr). The two main performance indicators of an appointment system are waiting times and doctors' leisure times (Brahimi, 1991).

The purpose of appointment is minimizing the loss of time and extending the flow of patients in periods to regularize the work load. On condition that appointment system is carried out in an efficient way, undermanned waiting periods can be decreased to minimum level. In this context, the effectiveness of queue and appointment systems will be examined and these two systems will be compared and the contributions to patient contentedness and supplying service will be discussed in this study.

MATERIAL AND METHOD

The universe of the study is comprised of patients who are provided service by Gumushane State Hospital. The study is carried out on 150 patients in four polyclinics between 28.04.2014 and 09.05.2104 based on questionnaire system. Dates are collected with a sampling method through a survey and an enrollment form. Four polyclinics (interior diseases, Ophthalmologic, otorhinolaryngology, general surgery) are analyzed related to the efficiency of queue and appointment system in hospital.

The questions in the survey are about the treatment time, minimum waiting time, maximum waiting time, approximate waiting time (time spent), patient

contentedness and awareness of patients of appointment system. All the information about the number of appointed patient number, the number of patients in queue, the number of appointed patients that do not come, the number of queuing system patient that do not come, the number of treated appointed patient and the number of patient waiting in queue in each polyclinics are situated in the study. Besides, average waiting times and times for changing queues' periods are observed during the day in each polyclinic.

RESEARCH

The findings are given below obtained from the queuing system and appointment system applications of the study.

Table 1: Outpatient patient flow

Polyclinics (minutes)	The number of Patients Appointment	The number of Patients Queue	The number of patients coming by appointment	The number of patients coming queuing system	The number of patients cared for appointment	The number of patients cared for queuing
Internal Medicine	38	87	6	9	32	78
General Surgery	12	51	3	8	9	44
Otorhinolaryngology	25	95	4	15	21	80
Ophthalmologic	11	71	3	6	8	58

When studied outpatients flow statement with the number of patients coming from the queuing system it was found to be more than twice the number of patients the appointment system.

Table 2: Queue system indicators

QUEUE SYSTEM INDICATORS (minutes)	Internal Medicine	General Surgery	Otorhinolaryngology	Ophthalmologic
AVERAGE DURATION OF INSPECTION.	4.5	5	4.5	8. 5
AVERAGE DURATION OF QUEUE.	180	105	180	150
NUMBER OF DOCTORS	2	2	2	1
WAITING PERIOD AT LEAST	15	15	15	15

THE MAXIMUM WAIT TIME	150	75	120	120
THE AVARAGE WAITING TIME	68	45	62	47

The waiting time of the patients who want to be examined according to the queuing system service has been found to vary between 45-68 minutes.

Table 3: Appointment system indicators

APPOINTMENT SYSTEM INDICATOR	Internal Medicine	General Surgery	Otorhinolaryngology	Ophthalmologic
AVERAGE DURATION OF INSPECTION.	4	4,5	3.5	8
AVERAGE DURATION OF QUEUE.	–	–	–	–
NUMBER OF DOCTORS	2	2	2	1
WAITING PERIOD AT LEAST	10	5	5	5
THE MAXIMUM WAIT TIME	20	15	15	15
THE AVARAGE WAITING TIME	13	8	11	10

According to the patients' waiting time for service appointments system it has been shown to vary between 8-13 minutes.

Table 4: The effectiveness of queuing systems

Polyclinics	Spent time	The number of examination	Satisfaction
Internal Medicine	68	87	40%
General Surgery	45	51	60%
Otorhinolaryngology	62	95	50%
Ophthalmologic	47	71	59%

The level of satisfaction of patients from the queue after the inspection system has been found to occur between 40-60%.

Table 5: The effectiveness of appointment systems

Polyclinics	Spent time	The number of examination	Satisfaction%
Internal Medicine	13	38	75%
General Surgery	8	12	80%
Otorhinolaryngology	11	25	80%
Ophthalmologic	10	11	84%

After examination of the patients examined satisfaction with the appointment system has been found to vary between 75-84%.

CONCLUSIONS

The level of patient contentedness mostly based on not only to the treatment time but also to the time spent. The less time a patient spends for a treatment, the more contend s/he is. Although, waiting times change in each polyclinic, the most intense times are between 08:00-11:00 and 13:00-15:00. While the highest level of contentedness is in general surgery (%60), the least level of contentedness is in interior diseases (%40) which is the most time-consuming clinic. While the level of patient contentedness is %80 in general surgery which is in the best position of appointment system, in interior diseases which is the most time-consuming clinic the level is %75. While the waiting time in appointment system is mostly 20 minutes, it is 120 minutes in queuing system. Evaluated in approximate waiting time, one can wait mostly 13 minutes in appointment system; this period can rise to 68 minutes. When we consider the degree of satisfaction between these systems, the level of satisfaction in appointment system is higher than in queuing system. To shorten the queue and waiting times, patients should be encouraged to use appointment system. By means of this system, personal convergence will be decreased.

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