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JHMT Editorial

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NICHE MARKETS IN MEDICAL TOURISM

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Abstract

Medical tourism is a growing industry that appeared as a niche market around the globe. From a strategic point of view, niche markets result in environments that have high profits and are accessible to a smaller number of businesses. This study is primarily concerned with the various services offered within the scope of medical tourism and statistics regarding the global prevalence of such services. Thus, any services that are widely available with cost being the main driving factor for a patient to receive the service abroad are excluded. Surgical procedures that are deemed illegal in some jurisdictions, countries where confidentiality is valued, countries that can deal with complicated medical cases, and niche markets aimed at medical tourism in these countries are examined in this study with the goal of providing the businesses offering services related to medical tourism with a strategic point of view.

Keywords: Medical Tourism, Niche, Market, Marketing, Health Tourism

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Introduction

Although the medical tourism industry has existed for a long time, it has expanded significantly following the late 90s. As a subcategory of health tourism, medical tourism implies going abroad to access certain medical services as well as vacationing in the countries visited (Akbolat and Gülcin Deniz, 2017; Kim, et.al, 2019; Sayin, et.al, 2017).

Emerging as a niche market, medical tourism has advanced rapidly worldwide. Niche marketing is a segmentation of bottom-up marketing. Thus, it involves the fragmentation of the mass market (Güclütürk Baran and Ozogul, 2018). Medical tourism also represents a segment of health tourism and certain countries around the world are preeminent when it comes to different service areas of this market. Although there are numerous studies concerned with the practical applications of niche marketing, there are no widely accepted studies in the literature aiming to create a theoretical framework for niche marketing (Parrish, et.al, 2006; Toften and Hammervoll, 2013). In the existing literature, niche marketing is considered as a strategic variable from a strategic point of view (Choudhary, 2014; Dalgic and Leeuw, 1994; Stachowski, 2012) as well as market segmentation in a narrower framework (Ciftci and Ogretmenoglu, 2018; Güres and Akgül, 2014; Sert, 2017). In this study, the strategic point of view was taken into account while evaluating medical tourism as a niche market.

There are various problems regarding access to health services around the world. These problems have contributed significantly to the development of medical tourism. Some of the problems that contribute to the development of medical tourism include the medical practice being considered illegal in some jurisdictions, said operation posing a problem in terms of religious beliefs, social reasons, lack of technology to provide access to the requested service, the complexity of certain health problems requiring specific treatment (Altsoy and Tastan Boz, 2019). Areas of special interest have a tendency to attract demand (Güclütürk Baran and Ozogul, 2018) and these problems prevent access to much needed health care in many countries around the world. In countries that are capable of providing these services, a niche market where the needs of a special consumer group are met is created. Medical tourists can more easily access the treatments they need in distant countries where such problems do not exist (Sayin, et.al, 2017). This study aims to reveal the niche market areas in medical tourism by drawing attention to medical tourism

areas with these features. In addition, medical tourism is a commercial activity as well as a touristic activity carried out for the purpose of receiving health services (Ari, 2017). Therefore, ensuring profitability is essential. While the service areas with great patient potential and problems in accessing said services are included in the study, the services that are provided almost universally whose costs fluctuate between countries and are lower compared to other services (such as high-anesthetic aesthetics, hair transplantation, dental treatments etc.) are not included. The study is remarkable in terms of dividing medical tourism, which is considered a niche market, into niche markets within itself.

2.Medical Tourism

Medical tourism is defined as the act of traveling for the purpose of receiving medical care (Al-Shamsi, et.al, 2018; Kumar and Raj, 2015; Young, et.al, 2019; Zarei and Maleki, 2018) and there are two categories of medical tourists. The first category consists of those who travel from developed countries to less developed countries in order to receive treatment for health problems that incur high costs or are not included in the health services offered in their country of residence. The second category, on the other hand, consists of people who travel from less developed countries to more developed countries in order to access more advanced healthcare services that are not available in their home countries (Cannon Hunter, 2007; Fetscherin and Stephano, 2016; Hudson ve Li 2012). International patients among these tourists that come from developed or wealthy nations constitute an important financial opportunity for developing countries and institutions located in these countries (Benedetti, et.al, 2018). On the other hand, international medical traffic from underdeveloped countries to developed countries is due to the desire of these patients to receive advanced medical care that may not be available in their own countries (Young, et.al, 2019).

Josef Woodman, founder, and CEO of Patients Beyond Borders, a US-based company that provides consultancy services to medical tourists, makes a similar statement on the subject. Woodman states that citizens of the USA, Canada, the United Kingdom, and many European Union member countries, where health services are provided to a higher standard but access to these services incur higher costs, are looking for more affordable options. On the other hand, they state that the citizens of countries whose economies are developing such as China and Vietnam, create a wave of medical movement affecting countries where

they can access the best care, regardless of price. According to Woodman, international hospitals and clinics compete aggressively for global patients (Woodman, 2020).

Medical tourism is a growing industry thanks to developing health technology, decreasing transportation costs and innovative information technologies (Cesario, 2018; Fetscherin and Stephano, 2016; Heung, et.al, 2011; Xu, et.al, 2020). Some of the factors contributing to the growth of the industry are increasing health care costs in developed countries, long waiting times, lack of insurance coverage for some services, low wages in developing countries, aggressive marketing strategies, competitive health markets, low cost, fast transportation opportunities, the operation being considered illegal in the country, lack of confidence in the quality of the treatment provided, access to technology, expertise and generally better health services in foreign countries, the desire to get faster medical services from high-brand hospitals with better quality doctors and better equipment (Alsharif, et.al, 2010; Carabello, 2013; Dehdashti Shahrokh and Nakhaei, 2016; Foley, et.al, 2019; Glinos, et.al, 2010; Jang, 2017; Zarei, et.al, 2018).

The results obtained from several studies which describe the factors affecting the preferences of medical tourists are presented in the table below. Studies show that numerous factors affect what countries a medical tourist is likely to choose. It is understood that low costs, quality service, fast access, and service delivery to an international standard are the most important factors among the ones studied.

Table 1. Main Motivators in Medical Tourism

Author	Research Knowledge	Lower Price	Standby Time	Trained Staff	Legality	Spoken Language and Culture	Security	Insurance Coverage	No Service	Privacy	Travel	Being Accredited	Proximity to Country of Residence	Quality Service
Reddy, et.al. - 2010	Travel for treatment: students' perspective on medical tourism.	√	√	√				√	√		√			
Heung, et.al. - 2010	A Conceptual Model of Medical Tourism: Implications for Future Research.	√	√	√		√				√	√	√		√
Lunt and Carrera - 2010	Medical tourism: Assessing the evidence on treatment abroad.	√	√	√	√	√		√	√	√	√	√	√	√
Hopkins, et.al. - 2010	Medical tourism today: what is the state of existing knowledge?.	√	√		√			√	√			√		√
NaRanong and NaRanong 2011	The effects of medical tourism: Thailand's experience.	√										√		√
Peters and Sauer - 2011	A survey of medical tourism service providers.	√	√			√		√	√	√	√	√	√	√
Heung, et.al. - 2011	Medical tourism development in Hong Kong: An assessment of the barriers.	√		√		√	√					√	√	√
Wang - 2012	Value as a medical tourism driver.	√	√				√				√	√		√
Hudson and Li - 2012	Domestic Medical Tourism: A Neglected Dimension of Medical Tourism Research.	√	√					√	√	√	√			√
Musa, et.al. - 2012	Travel behaviour among inbound medical tourists in Kuala Lumpur	√	√	√	√	√		√	√	√	√	√		√
Lee, et.al. - 2012	Medical Tourism-Attracting Japanese Tourists For Medical Tourism Experience.	√									√			√
Runnels and Carrera - 2012	Why do patients engage in medical tourism?	√	√					√			√	√		√
Connell - 2013	Contemporary medical tourism: Conceptualisation, culture and commodification.	√	√		√	√		√	√			√	√	√
Fetscherin and Stephano - 2016	The medical tourism index: Scale development and validation.	√		√		√	√				√	√		√
Esiyok, et.al. - 2017	The effect of cultural distance on medical tourism.	√	√			√		√				√	√	√
Suess, et.al. - 2018	Perceived impacts of medical tourism development on community wellbeing.	√	√					√						
Cesario - 2018	Implications of Medical Tourism.	√	√		√			√	√		√			√
De la Hoz-Correa, et.al. - 2018	Past themes and future trends in medical tourism research: A co-word analysis.	√	√									√		√
Bagga, et.al. - 2020	Medical tourism: Treatment, therapy & tourism.	√	√	√		√	√		√	√	√	√	√	√

Apart from the factors mentioned in the table, it can be said that hospitality, regulatory policies of the country, political and economic situation, advice from other medical tourists and advertisements (Fetscherin and Stephano, 2016; Heung, et.al, 2011; Heung, et.al, 2010; Hudson and Li, 2012) ease of visa procedures (Bagga, et.al, 2020) presence of acquaintances in the destination country, service in accordance with the religious requirements of medical tourists (for example, providing halal food for Muslim patients), historical ties between the home and destination countries (Esiyok, et.al, 2017; Lunt and Carrera, 2010) and the continuity of the health service provided upon returning to their own country (De la Hoz-Correa, et.al, 2018; Lunt and Carrera, 2010) are also effective in choosing a country.

Jai Verma, the Senior Chief Executive Officer of a company that provides healthcare services on a global scale, cites, the rising healthcare costs in western countries, and the fact that some services are not covered by insurance as the reason behind the rapid increase in medical tourism. According to Verma, people are willing to travel to other countries for medical, cosmetic and surgical services that are not available or are unaffordable in the countries they live in. Healthcare costs are increasing around the world, and governments understand the importance of investing in healthcare to attract patients. They also cite the agreements health insurance companies have with quality and affordable medical centers as well as the geographical locations of the countries as effective factors in attracting medical tourists (Verma, 2020).

Gianrico Farrugia, the CEO of a US based hospital that provides services internationally, draws attention to the continuity of the service saying "We expect medical tourism to continue to grow. At the same time, we anticipate that patients will increasingly want and expect to receive care close to their home, or even in their own homes, thanks to advances in digital technology." (Farrugia, 2020).

Prahlad Singh Patel, India's Minister of State (Independent Charge) of Culture and Tourism, emphasizes the quality of health services as a factor increasing dynamism in medical tourism. Patel states that there currently are 34 Joint Commission International (JCI) accredited hospitals in India. According to Patel, the number of JCI-accredited hospitals in the country needs to be increased in order to attract more medical tourists and offer them more hospital options (Patel, 2021).

If we look at the reasons for international travel in the world, leisure travel takes the first place. This is followed by mobility for health purposes (Ferreira and Castro, 2020). However, the growth momentum of the health tourism market is higher than that of recreational tourism (Lautier, 2014).

The medical tourism sector is seen as a promising sector and is considered the highest value-added service sector in the Fourth Industrial Revolution. In this context, many governments around the world are willing to boost and develop the medical tourism industry (Seo and Park, 2018). Due to the increase in the number of countries providing medical tourism, it is possible to achieve high profitability by differentiating service provision or by focusing on niche areas (Fetscherin and Stephano, 2016).

CEO of the Health Regulation Sector at Dubai Health Authority (DHA), Dr. Marwan Al Mulla also draws attention to the quality of care and the services provided by the medical tourism centers in Dubai to improve the service conditions of medical tourists. Mulla states that 96 percent of hospitals in the emirate of Dubai are internationally accredited, employ highly skilled doctors and healthcare professionals, and provide world-class personalized healthcare. They also mention that the medical tourism industry in Dubai offers patients a variety of options for high-quality health services in their core areas of expertise, and guidance is provided to make the journeys of medical tourists smooth and comfortable (Dubai Health Authority, 2020).

Medical tourism as a growing industry offers many entrepreneurial opportunities. In Asian countries, where these opportunities were adopted at an early stage, competitive advantage has been gained thanks to the support and encouragement of governments. Medical and healthcare businesses in countries such as India, Thailand, Singapore, and Malaysia are constantly investing to attract tourists, placing particular emphasis on their positions as healthcare and wellness destinations. While the costs of medical treatment and waiting times for access to health care are increasing in Western countries, the demand for medical services in developing countries is expected to increase even more. As a result, Asian countries specializing in attracting medical tourists are creating new entrepreneurial activities in the region that can lead to a profitable and sustainable tourism industry (Carabello, 2013).

Looking at the statistics of the Medical Tourism Association for the 2020-2021 period, Canada is the country where health tourism occurs the most in the world. Singapore, Japan, Spain, United Kingdom, Dubai, Costa Rico, Israel, Abu Dhabi, and India follow up Canada in this respect (Medical Tourism Association, 2020). It is estimated that the annual number of medical tourists worldwide is 5.5 million, whereas the total value of medical travel expenditures is estimated to be US$ 10-15 billion (Rokni and Park, 2019). Considering the size of the income from medical

tourism, it is not surprising that some cities and countries (such as Dubai, Singapore, and Malaysia) are actively resorting to medical tourism (Dalen and Alpert, 2018).

A medical service is received within the scope of medical tourism (Young, et.al, 2019). However, the consumption areas in the care of international patients are not only related to medical care. Medical tourism also requires allocation of resources for different consumption areas. Therefore, it is said that medical tourism tends to be resource intensive. In medical tourism interpreters or cultural guides are needed more often compared to local patients. Treatment planning may take longer and require the use of auxiliary services such as physiotherapy (Benedetti, et.al, 2018). In addition, when people travel for medical reasons, they need accommodation and other related tourism services not only for themselves, but also for the family members who often accompany them (Carabello, 2013; Ferreira and Castro, 2020). This situation supports the view that medical tourism is an important market for the country where service is received and the necessity of making investments.

Annabelle Neame, the CEO of a UK based hospital, also draws attention to this situation. According to Neame, another important issue in medical tourism is the provision of family-centered holistic care to the families and loved ones accompanying patients. The treatment process can be stressful and in order to facilitate the treatment process of the patient as much as possible, it is necessary to consider the demands of the patients in service areas such as health concierge services, accommodation, rental and travel arrangements, interpreters, drivers, travel guides, hotel and restaurant reservations etc. No request is ever too small. In all matters, daily assistance should be provided to patients and their relatives (Neame, 2020).

3. Medical Tourism as a Niche Market

Medical tourism is a subset of health tourism and a new (Junio, et.al, 2016), rapidly developing global niche market where tourists often travel to foreign destinations for medical treatment and services (Ari, 2017; Buzcu and Birdir, 2019; Ile and Țigu, 2017; Zarei and Maleki, 2018). There is evidence that it has significant socio-economic impacts and strengthens as well as enhances the medical and tourism industries in various destinations. Medical tourism is considered an important niche for any destination that is potentially competitive in terms of price and services. It results in increased spending in cases where a longer stay is required (Cannon Hunter, 2007).

Medical trips can be carried out for minor cosmetic procedures (hair transplantation, botox, etc.), dental health (dentures, implants, etc.) and diagnostic tests where health risks are relatively low (Eltorai and Garimella, 2017). Apart from these, frequent medical trips abroad also include important interventions such as orthopedic surgeries (hip replacement, prone, knee replacement, joint surgery), bariatric surgeries (gastric bypass, gastric banding), heart care/surgeries, cancer treatments, organ transplantations, vascular surgeries, and fertility treatments (Bolton and Skountridaki, 2016; Cheng, 2015; Glinos, et.al, 2010; Hwang, et.al, 2018; Lunt, et.al, 2016; Young, et.al, 2019). Some countries fund patient mobility programs to direct services to a different country that provides more affordable and quality healthcare for rare or complex situations, rather than providing services domestically. In countries that do not have a well-functioning health system, people can go abroad even for basic health services (Glinos, et.al, 2010).

The countries that stand out in terms of the fields they serve in medical tourism are as follows: India cardiology, orthopedics, organ transplants; Singapore, cardiology, kidney and bone marrow transplant and plastic surgery; Malaysia obesity surgery; South Korea oncological surgery; Costa Rico dental health and some aesthetic applications; Thailand is at the forefront of gender reassignment, while Turkey is more prominent in areas such as hair transplantation, aesthetic surgery, eye, dental, orthopedics, oncology, and in vitro fertilization (Sayin, et.al, 2017; Tengilimoglu, 2020).

Sangita Reddy, the CEO of one of the major medical tourism centers in India, told the Press Trust of India that many of her international patients seek medical treatments for oncology, organ transplants, cardiac interventions, orthopedic problems, and neurosurgery. According to Reddy, cost-effectiveness, focus on advanced medical technology and availability of skilled medical professionals are some of the features that have helped India attract international patients. Indian doctors provide international standard care at a rate well below the international cost. However, Reddy states that India can take the upper hand in medical tourism through marketing campaigns (Reddy, 2020).

3.1. Niche Market Areas in Medical Tourism

3.1.1. Surgical tourism

There is an increase in the number of patients traveling to different countries to receive surgical care around the world. Due to the cost of surgical care, patients often travel to receive care that

they consider affordable and high quality (Eltorai and Garimella, 2017). According to The Lancet Commission on Global Surgery report, there is a significant increase in diseases requiring surgical intervention. Despite this, there are various problems in accessing safe surgical intervention (World Health Organization, 2015).

In the last few decades, the increase in non-communicable diseases such as diabetes, hypertension and ischemic heart disease brought together a surge in the rate of surgical intervention caused by these diseases, as these diseases sometimes require surgical intervention. Surgical operations such as advanced cancer surgery, organ transplantation and functional neurosurgery are now promising for these diseases, which until recently had an extremely poor prognosis. However, the complexity and high cost of most of these surgeries contribute to the fact that they form an important market for medical tourism, since they are not covered by insurance in some countries (Nagral, et.al, 2017).

Along with the increase in medical tourism, there is also an increase in medical tours related to orthopedic procedures in general (Eltorai and Garimella, 2017). Orthopedic procedures most commonly engaged in through medical tourism include knee arthroplasty, hip arthroplasty, joint arthroscopy, spinal laminectomy, spinal decompression, and spinal disc replacement. Complications that may occur after bariatric surgery can constitute an obstacle for operations to be performed in distant countries (Foley, et.al, 2019; Kowalewski, et.al, 2019). Cosmetic surgery, on the other hand, is widespread worldwide, and destinations where related services are offered are increasing. Instead of all the different kinds of cosmetic surgery, it may be more meaningful to turn to cosmetic applications that cannot be performed in different countries for various reasons. For example, face transplants require surgical treatment to correct deformities on the face of the individual and to improve functional or aesthetic results. Face transplant surgery, which became legal in 2004, is a new field worldwide (Ugras and Yüksel, 2014). The fact that the results of face transplantation are in the desired direction increases the interest of both patients and providers. However, the number of centers where these practices will be carried out is insufficient (Rifkin, et.al, 2018). Considering these situations, turning to more complicated cases in the medical tourism market regarding surgical interventions may create a niche market for service providers.

3.1.2. Transplant tourism

It is estimated that approximately 10% of organ transplants in the world are carried out through transplant tourism (Morris and Muller, 2019). Transplant tourism is the act of donors, recipients, or transplant specialists traveling or the organs being transferred for the purpose of transplantation in accordance with law (Rudge, et.al, 2012).

Organ transplant tourism involves any organ (eg. Kidney) being transferred from highly developed countries with long waiting lists to less developed countries where there are no prohibitive regulations on buying and selling organs (Broumand and Saidi, 2017; Hopkins, et.al, 2010). Organ transplantation is the best and sometimes the only treatment for many patients with end-stage organ failure (Rudge, et.al, 2012). The demand for organ transplantation all over the world is increasing much faster than the donation rate (Broumand and Saidi, 2017; White, et.al, 2014). According to the Global Observatory on Donation and Transplantation reports (2019), looking at the countries that stand based on organ types transplanted, Spain ranks first in kidney transplantation, Korea in first lung transplantation, the US in heart transplantation, Austria in lung transplantation, Finland in pancreas transplantation and England in intestinal transplantation (Global observatory on donation and transplantation, 2019). Although there is a demand for organ transplantation in some countries, it is seen that the demand cannot be met for various reasons. Among these reasons are legal problems, religious beliefs, lack of trained personnel, costly transplantation practices and insurance packages not covering transplantation costs in some countries (White, et.al, 2014). This is an important factor that causes people in need of transplantation to go to different countries and meet their needs. For this reason, it is an important niche market in the case of providing accessible quality service in this field.

Stem cell transplantation is another field of medical tourism along with organ transplantation. Although the health problems in which stem cell transplantation is applied are very diverse, it is often a treatment method used in incurable neurological diseases such as multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS) or spinal cord injury. Since it is not possible to treat these diseases, stem cell transplantation is seen as a beacon of hope. Desperate patients suffering from these diseases tend to seek radical treatments at all costs to regain their function. On the other hand, the therapeutic potential of stem cell research and future individualized treatment applications is seen as a turning point (Julian, et.al, 2018). The presented stem cell

procedures cost thousands of dollars (Julian, et.al, 2020) and are not covered by insurance (Julian, et.al, 2018). However, cost tends to be seen as an insignificant factor for people who want to receive the service. The fact that the patient profile requesting this service is indifferent in terms of cost and that this service is not accessible in every country can be seen as a driving force for countries to focus on providing services in this field. The leading countries in the market are the US, India, China, Mexico, and Thailand (Foley, et.al, 2019).

3.1.3. Fertility treatments, abortion, and sex-reassignment

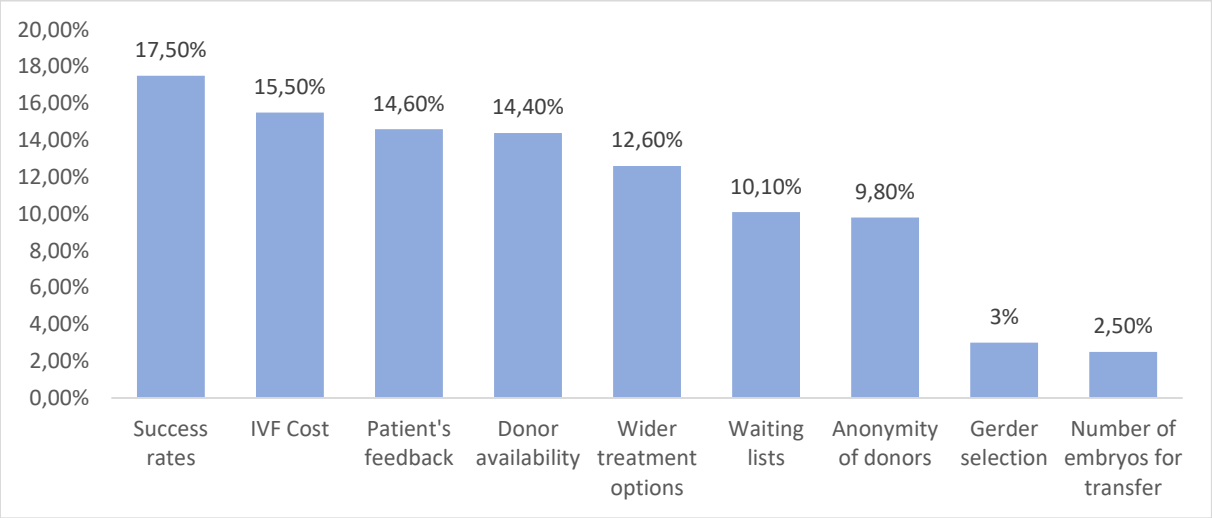
In many countries, egg donation, surrogacy, and even in vitro fertilization are prohibited by law. For example, surrogacy is illegal in Sweden, Norway, Austria, France, Germany, and various US states (Mikava and Vasadze, 2020). In this context, reproductive treatment has a number of motivations for cross-border travel, including legal restrictions on access to certain forms of treatment (e.g. surrogacy, restriction of access to treatment for certain categories of people (singles or same-sex couples), high treatment costs in the country of residence, desire for donor anonymity, choice of gender or trait, desire for treatments considered too experimental to be available in the country of residence, lack of specialists in the country of residence, lack of gamete (especially oocyte) donors, long waiting times, desire for culturally sensitive care, higher success rates abroad or higher quality of care) (Culley, 2011; Lunt, et.al, 2016; Mikava and Vasadze, 2020).

The demand for cross-border reproductive services is one of the growing niche markets within medical tourism, according to Keith Pollard, the Editor-in-Chief of the International Medical Travel Journal (IMTJ). It is estimated that approximately five million babies have been born through in vitro fertilization and other related reproductive techniques in the last 40 years (Pollard, 2015).

The International Fertility Company is an online platform with headquarters in the UK and the US providing information to anyone considering traveling for fertility treatments. A survey was conducted by the company in May 2020 to determine the factors affecting the fertility treatment choices of patients of different ages. In a 2017 report, cost remains the most important criterion for the majority of respondents (around 70%), while in the 2020 report, cost remains an important factor only for young respondents. On the other hand, for older participants, the availability of donors, wider treatment options, success rates, and feedback from previous travelers were found to be more important factors than cost. The company stated that clinics that want to promote international patients should develop different marketing strategies

for different age groups. In line with the opinions of 527 people, the factors affecting the choice of destination for fertility treatments are shown in the chart below (Fertility Clinics Abroad, 2020).

Graphic 1. Factors Affecting the Choice of Destination for Fertility Treatments



According to Julie Munro, the president of the Medical Travel Quality Alliance (an international independent organization established in 2009 to promote safety and quality in treatment and care for medical tourists), quality and access to services in accordance with international standards are the most important criteria for medical tourists in choosing a country and hospital. Although affordability also remains an important factor (Munro, 2019).

Surrogacy is another technique among reproductive techniques. The cost of surrogacy in India today is approximately $40,000. Surrogacy can be considered as an important niche market in that it is not legal in every country and is a service provided for a serious fee. On the other hand, it is seen that fertilization fees (egg donation only) reach approximately $11,000 (Health Tourism). However, reproductive therapy requires long-term treatment and care, including prenatal and postnatal processes. This makes fertilization services an important market in medical tourism.

Another area of reproductive medical tourism is abortion. In Europe, abortion is legal in most jurisdictions, but restrictions, gestational age limits, waiting times and procedures, cultural and religious stigma, and social pressures affect access to abortion care. In some European countries with ostensibly liberal abortion laws, such as Italy and France, women face legal barriers to termination of pregnancy after the first trimester, before which abortion is permitted, particularly in case of fetal anomaly or risk to a woman's health or life. Limited or insufficient clinical training

and conscientious objection among physicians lead to a lack of willing or trained service providers in many countries, particularly for second trimester abortions. Both legal restrictions and conscientious objection negatively affect the quality of abortion provision and create barriers to abortion services in many countries. In addition to legal restrictions and conscientious objection, cost of services, coverage, and reimbursement (or lack thereof) by the public health system, waiting times, complex referral or approval practices, limited facilities, uncooperative or untrained medical staff, anti-choice harassment, and lack of confidential services are reasons for women to select another country for an abortion. In countries where access to abortion is restricted, many women travel within or outside their home country to circumvent local laws and illegal barriers to abortion services (Gerdts, et.al, 2016).

3.1.4. Cancer

Cancer patients living in developing countries desire access to specialized care services such as sophisticated surgery or the latest advances in chemotherapy offered in developed countries (Awano, et.al, 2019). In some cases, they may want to get health services from a more developed country in order to get a second opinion on their own situation from service providers who are certified in the medical and surgical fields and have clinical and research experience (Al-Shamsi, et.al, 2018). Currently, the most used medical tourism field in the classification made according to treatment types is cancer treatment. In the coming years, the demand for medical tourism for cancer treatment is expected to increase more than for other types of treatment. Cancer treatment is an expensive and long-term treatment. For this reason, the demand for destination regions that provide lower-cost services is increasing and this situation affects the growth of the market. Apart from this situation, due to the lack of advanced treatment in some countries, patients turn to countries that provide advanced health services in order to receive a higher-quality service. This is the main element that highlights this treatment field (Allied Market Research).

Dr. Hamed Al Hashemi, Abu Dhabi Ministry of Health Strategy Director, and Dr Mohammed Al Khatib, Medical Director of the HealthPlus Diabetes and Endocrinology Center, emphasized on ensuring the continuity of cancer treatments offered to medical tourists. The duo stated that cancer is a complex disease and a patient's treatment process requires a series of tests and care performed in many different facilities, therefore the continuity and integrity of care is extremely important and has a direct impact on the success of the treatment (Al Hashemi and Al Khatib, 2021).

In the report published by the World Health Organization on non-communicable diseases, cancers form the second most common type of non-communicable diseases (World Health Organization, 2018), and according to the International Cancer Research Center Reports, breast cancer is the most common form of cancer per 100,000 of the population. The number of breast cancer cases is followed by prostate, lung, bowel, cervical and stomach cancer cases. In medical tourism planning, the most common cancer areas can be prioritized. In addition, considering the number of cases (19.292.789 cases) and deaths (9.958.133 deaths) around the world, it is clear that there are still areas that need to be improved in cancer treatment and that countries that will achieve effective treatment in this context will gain a serious niche market (International Agency for Research on Cancer) Among the cancer types, lung and stomach cancers are the most lethal cancers in both sexes, whereas liver cancer is the most lethal in men and breast cancer is the most lethal in women (Mattiuzzi and Lippi, 2019). On the other hand, while cancer cases, like facial cancers, are among the cancers with high mortality rates, it is a health problem that faces problems in its treatment worldwide (Esen, et.al, 2018; West, et.al, 2006). In this context, it is thought that turning to the treatment of complicated cases that other countries cannot perform in the field of health tourism in cancer cases or the treatment of cases that other countries do not wish to focus on will allow to obtain a niche market area and create an important source of income. Anadolu Medical Center, which ranks second in the list of the best medical tourism centers in the world, is renowned in cancer treatment (World's Best Hospitals for Medical Tourists).

4. Conclusion and Recommendations

Medical tourism is a rapidly growing new type of tourism and an international and political-economic phenomenon in the world, especially in Asian countries (Thailand, Singapore and India) (Tarabipour, et.al, 2016). The main targets of medical tourism are patients who have the potential to visit other regions or countries to meet their medical needs (Hwang, et.al, 2018).

The motivations these patients must travel to different countries in order to receive healthcare are different from each other. These motivations include being able to receive health care services at a lower cost (patients living in the US), waiting for a shorter time (patients in Canada and the UK), receiving health services that are deemed illegal in their home countries in countries where there are no legal obstacles, to avoid the technologically inadequate services provided in their own countries. There are also other factors such as the desire to receive a higher

quality service from a doctor who is considered more qualified. Some also apply for medical services such as elective surgery, including aesthetic surgery, in places they go on vacation (Tarabipour, et.al, 2016).

Among these motivations, cost and quality of care are important factors for medical travel, but they are not the only ones. Timely access to services, regardless of cost, appears to be the key driver of cross-border care (Alsharif, et.al, 2010). The main issues regarding access are long waiting times, the service to be received being considered illegal in the country of residence, and a lack of sufficient opportunities for providing the service even if it is legal. Regions with legal problems can be considered as regions with deficits, especially in terms of medical tourism. Some inconveniences are extremely lethal, and it is understood that there are problems with access to these services in many parts of the world. The fact that these diseases require advanced expertise and that many physicians and health institutions do not offer these services are also areas where there are gaps in medical tourism. It can also be said that the competition in these areas is weak (Karamustafa and Akin, 2017). It can be argued that the inadequacy of the number of centers providing services and the absence of centers to compete make these areas more profitable than other types of services. This study aims to offer market information and emphasize the strategic importance of the areas that are undervalued due to various reasons around the world and where access is problematic.

The driving force of medical tourism in countries its higher profitability and income provision compared to the other medical services offered. In this context, it is recommended that countries focus on services of this nature within the scope of medical tourism. On the other hand, there are uncertainties in the number of people receiving services related to medical tourism (Kowalewski, et.al, 2019). With more precise numbers of medical tourists available, it is thought that it will provide more reliable information in determining which countries are preferred for which types of services and market gaps. In addition, it is assumed that it will guide the medical service providers in terms of which areas they should operate.

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EVALUATION OF SATISFACTION LEVEL OF HOSPITALIZED PATIENTS AT THE CITY TRAINING AND RESEARCH HOSPITAL LOCATED IN THE SOUTH OF TURKEY DURING COVID-19 PANDEMIC

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Abstract

Aim: The purpose of this research study was to evaluate the satisfaction level of hospitalized patients with regard to healthcare services as well as physical conditions of the hospital and investigate the socio-demographic variables in relate to the satisfaction level of inpatients at Adana City Hospital.

Methods: This study was conducted with 150 randomly selected patients thru face- to- to-face using a standard inpatient satisfaction questionnaire. The research was conducted between March 13-23, 2021 when the Covid-19 pandemic was the most intense. For the statistical analysis, SPSS 21 package was used.

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Findings: About 40% of inpatients reported a decrease the in a number of their admissions to the hospital due to Covid- 19 pandemic. Forty- percent of the respondents reported not using any mobile applications while 40% indicated using Life Fits Home. About 85% used ALO 182 for a physician appointment. While the mean score of inpatient satisfaction with healthcare services was found to be 4.35 and satisfaction with physical conditions of hospital was found to be 4.30 on a 5-point Likert scale.

Conclusion: Mostly, our findings were consistent with the findings of other studies. In our study, the majority of the hospitalized patients who participated in the study reported "satisfaction" with the healthcare services and the physical conditions of the hospital.

Keywords: Patient Satisfaction, City Hospital, Healthcare Services, Mobile Health Applications

Introduction

Consumer satisfaction plays an important role in the quality of healthcare reforms and healthcare delivery, particularly in the United States of America and Europe. However, consumer satisfaction studies are challenged by the lack of a universally accepted definition or measure (Bleich, Ozaltin, Murray, 2009). While some researchers focus on patient satisfaction with the quality and type of healthcare services, others focus on the satisfaction of individuals with the healthcare system more generally (Bleich, Ozaltin, Murray, 2009). The importance of both perspectives has been demonstrated in the literature. For example, satisfied patients are more likely to complete their treatment regimens and to be more compliant and cooperative than those who are not satisfied. Conversely, if patients are dissatisfied, patients are less likely to seek care when needed or refusing to comply with the treatment (Hudak, and Wright, 2000).

With respect to measuring quality and type of health care services, typically three major factors play an important role. Those factors are the physical conditions of the hospital, attitudes, and behaviors of healthcare personnel, and socio-demographic characteristics of patients. Patient satisfaction is the output of the expected and perceived quality of care, meaning patients have upfront expectations of healthcare services and after they received healthcare services patients will develop their own perception based on their experience. As a result of the evaluation between the expected quality and perceived quality, the patient shapes her or his own decisions according to whether her or his expectations are met. Patient satisfaction may have a positive effect on patient compliance and outcome. (Tukel *et al,* 2004). Physicians who treat their patients with respect, take the time to get to know their patients and their concerns, and who listen to their patients' needs

may result in higher patient satisfaction (Moore, Wright, Bernard, 2009). If patients are satisfied with the physician and his or her patient interaction, they are likely to be more compliant with their treatment plan, to understand their role in the recovery process, and to follow the recommended treatment. Subsequently, improved health outcomes are more likely to happen (Cowing, *et al*, 2009). Carr-Hill (1992) defines patient satisfaction as "the basic criterion that gives information about the level of meeting the values and expectations of the patient and shows the quality of care, where the main authority is the patient". In general terms, patient satisfaction, which depends on how patients perceive the service provided, is a concept that is difficult to express and measure, based on many factors (Ataman and Yarımoglu, 2018).

The factors affecting patient satisfaction are divided into two as patient-related factors and service-related factors. Among the factors related to the patient, the patient's age, gender, education level, social security status, income status, place of residence, diagnosis, treatment and length of stay may affect patient satisfaction. Among the factors related to the service, the most important ones are the attitudes and behaviors of healthcare personnel (Talmac and Soysal, 2021).

Researchers generally agree that measure the ent of patient satisfaction fulfills several distinct functions. Fitzpatrick (1984) put forward four—understanding patients' experiences of healthcare, promoting cooperation with treatment, identifying problems in healthcare, and evaluation of healthcare. One of the important concepts used to reveal the quality, efficiency, effectiveness and therefore performance of health services is patient satisfaction.

One of the important concepts is patient satisfaction which evaluates the quality, efficiency and effectiveness of healthcare services. Recently, health institutions are acting on patient needs and expectations as well as results of satisfaction studies. Since hospitals have put patients in the center, patient satisfaction and evaluation of patient satisfaction studies have become a necessity (Kirilmaz, 2013). Patient satisfaction is an important part of quality. Determining the satisfaction levels of the patients is a very important indicator to improve the quality of service and provide more qualified services that are in line with patient expectations (Soylemez, 2009). Limited evidence suggests that satisfaction is largely the result of fulfilled expectations and values. The patient who has been involved in the evaluation of healthcare for the last ten years' satisfaction has begun to be considered as an evidence to decide on the right use of existing resources due to the increasing cost of healthcare services (Williams, 1994).

Donabedian (1980) proposed the healthcare quality theory, explaining (1) satisfaction as an integral component of a three-pronged structure of the medical market, (2) the process of provision of healthcare, and (3) the outcome of the treatment. Based on these studies, a comprehensive model of the patient satisfaction model was developed to incorporate all influences on satisfaction, thereby providing a holistic framework for exploring the interactions between variables that affect the evaluation of patients (Fig. 1)

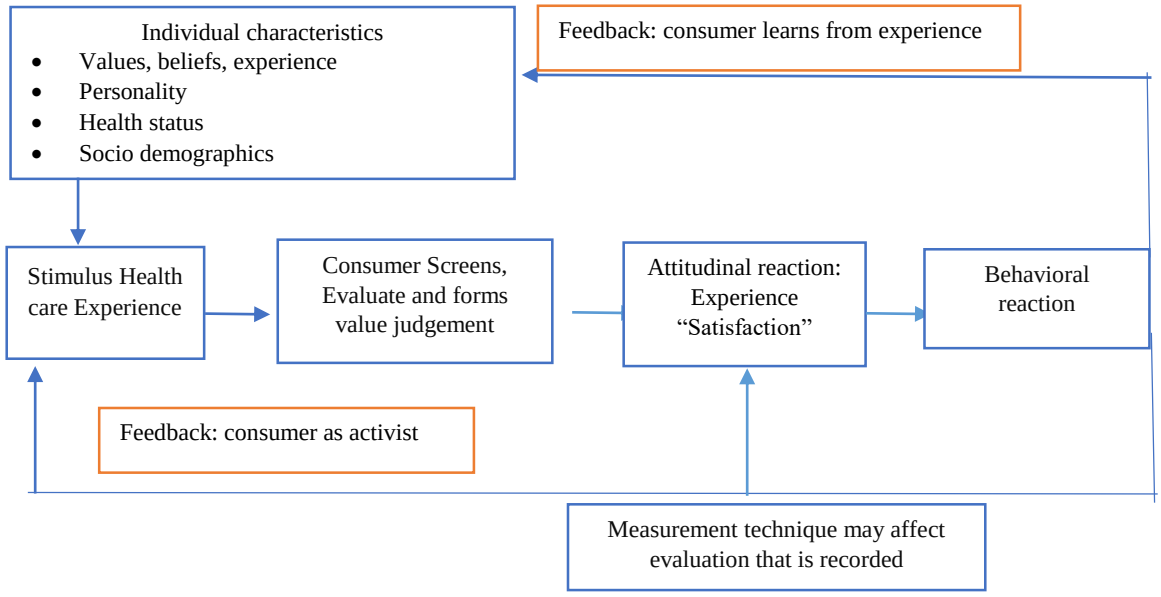

Figure 1: Comprehensive model of satisfaction with health care
Sources: Adopted from Strasser and Davis (1993), Strasser et al. (1993) and Crow, et al. (2002)

Patient satisfaction provides a baseline measurement for identifying patients, employees, and organizational outcomes. (Yildiz and Yalman, 2015). Therefore, patient satisfaction with healthcare services is an important measurement of performance (Cowing *et al*., 2009). It can be said that measuring the satisfaction of the patient with the health services periodically will contribute to the decision of how the healthcare services will be provided and increase the quality of service (Ahmad and Din, 2010). This measurement covers all the activities throughout the process from patient admission to the diagnosis, treatment, and care. The factors determining of quality of healthcare services are the environment of health care services, physical image of the hospital, timing of the service, the specialist who delivers health care services and the continuity

of healthcare services and the reality and flexibility of the healthcare services (Kidak and Aksarayli, 2008). Patient satisfaction is one of the important indicators in the measurement of health service quality. The main criterion that shows the quality of care in hospitals is patient satisfaction, and it is the main criterion that gives information about the level of meeting the needs and expectations of the patient. In this way, the quality of service in health institutions and the structure of the service process can be reviewed (Hekimoglu *et al,* 2015).

In addition to patient-physician interaction and attitudes of healthcare personnel towards patients, bureaucracy is also one of the factors affecting patient satisfaction. Patients always want to access healthcare services without long waiting times. As the number of formalities in health institutions increases, the time loss of patients increases ,and their access to service gets delayed (Kavuncubasi and Yildirim 2012). Long waiting times can lead to patient dissatisfaction (Oche and Adamu, 2014). Determining the satisfaction levels of the patients is important to increase the quality of service and provide more qualified service in line with patient expectations (Soylemez *et al.,* 2009,). Generally speaking, patient satisfaction measures have an important role in the health system because they integrate patients' views on the health system; identify potential issues arising in the health sector; contribute in evaluating the health services (Mpinga and Chastonay, 2011). Moreover, patient satisfaction appears to play an important mediating role in increasing the strength of the association between healthcare quality and patient trust in healthcare service provider (Alrubaiee,2011). Patients' quality perceptions of the service are believed to influence patient satisfaction positively, which in turn positively influences the patient's decision to choose a specific healthcare provider (Andaleeb, 2001; Taylor, S., 1994). In early study Donabedian (1988) indicated that patient satisfaction is a key outcome of care (Lin and Kelly,1995). Patient satisfaction could therefore be considered as a valuable indicator to health professionals and health authorities allowing them to define better strategies and management procedures as well as training priorities and resource allocation options (Batbaar, *et all.* 2016).

As a result of transformation in healthcare services, the number of City hospitals across the country is increasing. To date there are 15 city hospitals operating across the country and 5 more chospitals are in the construction phase. City hospitals are defined as a cooperation between public and private sectors. When the transition process to PPP projects in Turkey is evaluated in terms of taxes, which is the main source of income for the public, the pressure of resource shortage is clearly seen (Sozer, 2014). City hospitals were built to increase the quality of healthcare services, to

respond to the requests of patients to a large degree and to combine the polyclinics under one roof (Talmac and Soysal, 2021).

Hospitals that incorporate patient satisfaction into their strategic stance which in turn translates into increased market share and competitiveness (Andaleeb, 1988). Satisfaction studies will enable hospital management to identify areas and factors that need attention and improvement, leading to higher patient satisfaction.

Evaluating the extent to which patients are satisfied with healthcare services is clinically significant, as satisfied patients are more likely to comply with treatment (Valentine *et al*, 2015). In contrast, the effect of Covid-19 has been reducing procedure and treatment adherence, increase treatment dissatisfaction, and discontinue their treatment follow-up (Bragazzi, et al .2020). With keeping all this in mind, we decided to include questions to find out whether the number of admissions to hospitals was affected, and what mobile applications patients used to make an appointment with their physicians and whether the satisfaction level of inpatients was impacted due to Covid-19 pandemic. In order to answer these questions we conducted this research study at Adana City Hospital.

2. Research Methodology

2.1. Design, Sampling and Data Collection

For this study the screening model was used.

In order to determine the level of satisfaction of patients and the areas that need for improvement, the patient satisfaction survey was developed by taking several studies conducted with inpatients into consideration (Hekimoglu, *et al.* 2015), (Kıdak and Aksaraylı, 2008). For this study we received an approval from Adana Provincial Health Organization and the Ethics Committee of the University (17.06.2021,74).

The total bed capacity of the Adana City hospital was about 1,600. We targeted over 500 inpatients in various clinics except psychiatry, oncology, and pediatrics. Easy-sampling method was used. In spite of several attempts to reach out 500 hospitalized patients, only 150 inpatients voluntarily accepted to participate in our research study due the severity of Covid-19 pandemic between March 13-23, 2021. In order to determine the level of inpatient satisfaction, a standard

satisfaction questionnaire was used. Overall patients' satisfaction results from the summation of the scores of individual questions (1 = extremely dissatisfied to 5 = extremely satisfied).

2.2. Research hypotheses

When the literature on patient satisfaction were reviewed, the factors affecting patient satisfaction; patients, service providers and environmental factors were determined. When the results from different studies were examined, the satisfaction levels of the patients may vary according to socio-demographic characteristics of the individuals. In this study, we wanted to examine how the mean of patient satisfaction was differed according to gender, age, education level, monthly income and type of insurance, employment and number of admissions. The research hypotheses developed based on these assumptions were shown below.

H1: There is a significant difference between the genders of patients treated in city hospitals and their perceptions of patient satisfaction and its sub-dimensions.
H2: There is a significant difference between the ages of patients treated in city hospitals and their perceptions of patient satisfaction and its sub-dimensions.
H3: There is a significant difference between the education levels of patients treated in city hospitals and their perceptions of patient satisfaction and its sub-dimensions.
H4: There is a significant difference between the employments status of patients treated in city hospitals and their perceptions of patient satisfaction and its sub-dimensions.
H5: There is a significant difference between the monthly income status of patients treated in city hospitals and their perceptions of patient satisfaction and its sub-dimensions.
H6: There is a significant difference between the number hospitalizations of patients treated in city hospitals and their perceptions of patient satisfaction and its sub-dimensions.
H7: There is a significant difference between the type of insurance of patients treated in city hospitals and their perception of patient satisfaction and its sub-dimensions.

2.3. Statistical analysis

For the validity of the scale the factor analysis was used. For the factor analysis the sample size should be minimum of 50 although the sample size of 500 was better, and the sample size of 1000 was even much better (Cokluk *et al*, 2018). In this study the sample size of 150 was considered to be sufficient for the factor analysis. In addition, one of the methods used to

determine the suitability of the data set for factor analysis was the Kaiser-Mayer-Olkin (KMO) sample adequacy criterion. The KMO was an index that compares the observed correlation coefficients with the partial correlation size. The KMO ratio should be 0.50 minimum (Kalayci,2014).

Kaiser-Meyer-Olkin of sample adequacy of the scale was determined as 89.5%. In order to reveal the factor structure of the scale, factor analysis was performed on the 14-item scale. As a result of performing factor analysis, the item no 14 was removed from the scale because it was an adjoining item. For the remaining 13 items of the scale, an explanatory factor analysis was applied. As a result, the scale was grouped under 2 dimensions with a variance of 66.7%. Table 1 demonstrated the results of factor analysis of the scale.

Table 1: **Explanatory Factor Analysis of Patient Satisfaction Scale**

	Burden	Eigen value	Explanatory variance	Mean	Alfa
1.Satisfaction with healthcare services		5.701	43.857	4.345	0.941
Nurse to follow- up and inform your treatment process	0.863				
Supply and follow-up on drugs for treatment	0.831				
Physician follow-up on your treatment process	0.804				
Physician's interest and attitudes toward you	0.776				
Quality of health care services	0.757				
Hospital admission procedures	0.742				
Attitudes and kindness of support personnel towards you	0.675				
Attitudes of health care personnel	0.658				
2.Satisfaction with physical conditions of the hospital		4.061	31.235	4.299	0.923
Cleanliness of the patient room	0.895				
General cleanliness of hospital	0.853				
Quality of food service	0.763				
Satisfaction with pre-hospital prepayment services	0.658				
Technology level of the hospital	0.644				

Factor eliminating method: Principal component analysis; Rotation method: Varimax
Kaiser-Meyer-Olkin adequacy of sample size: 89.5%
Chi-Square analysis for Barlett's Sphericity index: 1970,212, s.d: 78 p<0.001
Explanatory total variance: 66.797%
Reliability coefficient for the entire scale: 0.957
Overall satisfaction: 4.327

As a result of factor analysis, 13 items were grouped under two dimensions. First dimension includes 8- items and explains 43.85% of the total variance. The second dimension includes 5-items and explains 31.23% of the total variance. For the reliability of the scale Cronbach's Alpha Coefficient method was used (Ural and Kılıc, 2011). Cronbach's Alpha gets a value between 0 and 1. If the value gets a score between 0.70 and 0.90, this indicates higher reliability. If the score is 0.90, it indicates the highest reliability (Ozdamar, 2011). The Cronbach's Alpha Coefficient of the 13-item Patient Satisfaction scale was found 0.957, indicating the scale is highly reliable.

3. Analysis

3.1 Socio-demographic variables

In order to understand the inpatient profile, the socio-demographic questions were asked and the frequencies of those were outlined in Table 2. Following socio-demographic questions the patient satisfaction questionnaire was randomly administered to 150 inpatients. Table 2 outlines the characteristics of the respondents in frequencies.

Table 2: **Socio-demographic characteristics of inpatients**

Variable	n	%	Variable	n	%
Gender			**Health institute admitted generally**		
Male	70	46.7	Public hospital	99	66.0
Female	80	53.3	University hospital	4	2.7
Age breakdown			City hospital	37	24.7
20-29	29	19.3	Private hospital	7	4.7
30-39	26	17.3	Family Practitioner	3	2.0
40-49	47	31.3	**Number of admissions to any hospital within last year**		
50-59	27	18.0	2-3	57	38.0
60 and above	21	14.0	4-5	43	28.7
Education			6-7	12	8.0

Illiteral	12	8.0	8-9	9	6.0
Literate	12	8.0	10 and above	29	19.3
Primary education	61	40.7	**Frequency of admission to the hospital during Covid-19 pandemic**		
High school	37	24.7	Never admitted	17	11.3
University	26	17.3	No change	57	38.0
Graduate	2	1.3	Decreased	58	38.7
Profession			Increased	18	12.0
Public sector	16	10.7	**Frequency of admissions to this hospital**		
Private sector	7	4.7	First visit	34	22.7
Self-employed	29	19.3	Several times (1-4)	70	46.7
Student	13	8.7	Multiple times (5-10)	26	17.3
Retired	26	17.3	Continually	20	13.3
Other	59	39.3	**The clinic patient admitted to**		
Income (TL)			Neurosurgery	10	6.7
1.500 below	10	6.7	Internal Medicine	11	7.3
1501-2000	10	6.7	Endocrinology	13	8.7
2001-3000	33	22	Gastroenterology	10	6.7
3001-4000	25	16.7	General surgery	44	29.3
4001-5000	12	8	Ophthalmology	17	11.3
Insurance			Others	45	30
SGI (SGK)	108	72	**First admission to this clinic**		
Green card	20	13.3	Yes	118	78.7
Private insurance	1	0.7	No	32	21.3
No coverage	21	44	**Length of treatment in this clinic**		
The tool used most to obtain health information			Less than 1 week	61	40.7
Computer	10	6.7	1 week	56	33.7
Smart phone	140	93.3	2 weeks	17	11.3
Tablet	0	0.0	3 weeks	1	0.7
Smart watch	0	0.0	4 weeks	1	0.7
			More than 1 month	14	9.3
Total	150	100		150	100

Regarding the profile of inpatients who participated in this research, about 53% were female, 31% were between the age of 40-49, 41% had primary education, nearly 20% were self-employed; 34% reported no income, the respondents were asked which health institution they generally preferred to go, 66% reported public hospitals. With regard to number of visits to any hospital within last year, 38% indicated 2-3 times. In terms of number of admissions to any hospital during Covid-19, 38.7% reported a decrease in number of hospital admissions while 38% reported no change. Nearly, 72% of the inpatients indicated having some sort of health insurance while 14% reported not having any insurance. When the respondents were asked how many times they admitted to this hospital, 46.7% indicated several times (1-4). Approximately, 30% of the respondents reported being under the care of general surgery and 78% reported being first time in the clinic. About 41% reported hospitalizing less than one week in the clinic where they received treatment. Nearly, 47.3% of patients reported hospitals for their source of health information. About, 93% reported using smartphones for getting information on health.

Table 3 outlines the type of mobile applications that inpatients mostly use and to make a physician appointment.

Table 3: **Mobile applications used by patients**

Variable	**n**	**%**
Frequently used mobile applications by patients		
Life Fits Home (HES)	61	40.7
Do not use application	60	40.0
e-pulse	45	30.0
Central Physician Appointment System (MHRS)	43	28.7
Applications used by patients for physician appointment		
ALO 182	128	85.3
Central Physician Appointment System (MHRS)	28	18.7
e-pulse	9	6.0

Among the mobile applications Life Fits Home (HES) was used by 41% of the inpatients; on the other hand, 40% reported not using any application. For the physician appointment 85.3% of patients indicated using ALO 182.

3.2. Findings from the patient satisfaction scale

In this section the findings from the patient satisfaction questionnaire were outlined in Table 4. Patients rated the healthcare services and physical conditions on a 5-point scale during their stay at the hospital.

Table 4: Descriptive findings on the patient satisfaction scale

Scale items	**Mean**	**SD**
1. **Satisfaction level with healthcare services**	**4.35**	**0.676**
Physician interest and attitudes towards you	4.44	0.596
Attitudes and kindness of support personnel towards you	4.44	0.607
Physician follow-up on your treatment process	4.37	0.660
Quality of overall healthcare services	4.35	0.581
Hospital admission procedures	4.31	0.677
Supply and follow-up on drugs for treatment	4.31	0.695
Nurse follow- up and inform your treatment process	4.28	0.770
Attitudes of healthcare personnel	4.26	0.823
2. Satisfaction level with the physical conditions of hospital	**4.30**	**0.712**
Quality of food service	4.32	0,669
Technology level of the hospital	4,32	0.669
Cleanliness of the patient room	4.30	0.758
Satisfaction with pre-hospital prepayment services	4.29	0.698
General cleanliness level of hospital	4.27	0.766
Overall satisfaction	**4.33**	**0.563**
n= 150		

According to the descriptive findings of the patient satisfaction scale, all items in the table above received above the score of 4.00, thereby overall satisfaction level was found to be 4.33, meaning patients were satisfied with the healthcare services and physical conditions of the hospital. Among the healthcare services, physicians' interest and attitudes as well as attitudes and kindness of the support personnel were rated 4.44 that was the highest score on the scale. Satisfaction level regarding the attitudes of healthcare personnel was rated lower (4.26) than other scale items. Considering the two- sub dimensions of the scale, the level of satisfaction with

healthcare services was determined as 4.35 that was slightly higher than the satisfaction level with the physical conditions of the hospital that was rated as 4.30.

Difference tests

In this section, it was tested whether hospital satisfaction differed significantly according to the demographic variables included in the research study questions. First of all, the T-Test was conducted to determine whether the dimensions of the Patient Satisfaction scale differ significantly according to the hospitalization status for the first time. The results from the statistical analysis were illustrated in Table 5.

Table 5: Comparison of hospital satisfaction dimensions according to first time hospitalization

Patient Satisfaction	First hospitalization in this clinic	n	Mean	Standard Deviation	t Value	Significance
Patient satisfaction with healthcare services	Yes	118	4.2574	0.57649	-3.751	**0.001***
	No	32	4.6680	0.43022		
Patient satisfaction with physical conditions of the hospital	Yes	118	4.2458	0.60956	-2.015	**0,046***
	No	32	4.4938	0.64655		

***** p<0,05

As it was shown in Table 5, there was a statistically significant difference according to the number of hospitalization of the patient. Patients who were previously hospitalized in the clinic had a relatively higher level of satisfaction than those who were admitted to the same clinic for the first time.

ANOVA test was conducted to determine whether the satisfaction levels of inpatients differed according to age. The results of this test were summarized in Table 6.

Table 6: Comparison of patient satisfaction dimensions by Age

Patient Satisfaction	Age	n	Mean	Standard Deviation	F Value	Significance level
Patient satisfaction with healthcare services	20-29	29	4.0313	0.70696	3.158	**0.010***
	30-39	26	4.4808	0.53232		
	40-49	47	4.2473	0.50101		
	50-59	27	4.3565	0.48870		
	60 and above	21	4.6429	0.51733		
Patient satisfaction with physical conditions of hospital	20-29	29	3.8800	0.89772	4.321	**0,001***
	30-39	26	4.4615	0.54778		
	40-49	47	4.1872	0.53634		
	50-59	27	4.3111	0.49407		
	60 and above	21	4.6286	0.52644		

*p< 0.05

Since the variances of the dimensions were homogeneous (p>0.05) we wanted to see which groups were differed according to the test of homogeneity of variances (Levene) and Gabriel test (Mayers, 2013) (Table 7 and 8).

Table 7: Homogeneity of Variances Test

	Levene's Test p Value
Satisfaction with healthcare services	0.346
Satisfaction with hospital physical conditions	0.496

Table 8: **Patient Satisfaction Multiple Comparison (Gabriel) Table by Age**

Patient Satisfaction	Age		Difference in Mean	Significance level
Satisfaction with health care services	20-29	60 and above	-0.61161	0.008*
Satisfaction with hospital physical conditions	20-29	30-39	-0.58154	0.017*
		60 and above	-0.74857	0.001*

***** p<0,05

As it can be seen in Table 8, patients between the ages of 20-29 had a lower mean satisfaction score than the patients who are over age of 60 regarding the level of satisfaction with

healthcare services. For the dimension of satisfaction with the hospital physical conditions, patients aged 20-29 had a lower mean of satisfaction level than those patients aged 30-39 and patients over 60.

ANOVA test was conducted to determine whether the satisfaction levels of inpatients differed according to their education level. The results of ANOVA test were summarized in Table 9.

Table 9: Comparison of patient satisfaction dimensions according to education

Patient Satisfaction	**Education**	**n**	**Mean**	**Standard Deviation**	**F Value**	**Significance level**
Satisfaction with healthcare services	Illiteral	12	3.9792	0.4050	4.012	**0.002***
	Literal	12	4.0938	0.47412		
	Primary education	61	4.5410	0.47965		
	High school	37	4.3750	0.51958		
	Undergraduate	26	4.1587	0.73447		
	Graduate	2	3.9375	0,44194		
Satisfaction with physical conditions of hospital	Illiteral	12	3.9833	0.44687	3.194	**0.009***
	Literal	12	4.1667	0.38925		
	Primary education	61	4.4918	0.54354		
	High school	37	4.3243	0.55046		
	Undergraduate	26	4.0154	0.88710		
	Graduate	2	4.3000	0.14142		

p>0.05

For both sub-dimensions of patient satisfaction presented significant differences according to the level of education. According to the test of homogeneity of variances, the variance of satisfaction level with healthcare services was found to be homogenous (p>0.05). In order to determine differences between groups, Gabriel Test (Mayers, 2013) was utilized. The variance of satisfaction with hospital physical conditions was found to be non-homogenous (p<0.05) and for

that reason Games Howell test (Mayers, 2013:180) was used to see the differences between groups. Results of homogeneity of variances were shown in Table 10.

Table 10: Test of homogeneity of variances

	Levene Test p Value
Satisfaction with healthcare services	0.152
Satisfaction with physical conditions of hospital	0.034

Results of hospital satisfaction multiple comparisons by education were summarized in Table 11.

Table 11: Satisfaction level Multiple Comparison by Education (Gabriel - Games Howell)

Patient satisfaction	**Education**		**Mean Difference**	**Significance Level**
Satisfaction with healthcare services	Primary education	Illiteral	0.56182	0.009*
		Undergraduate	0.38233	0.039*
Satisfaction with physical conditions of hospital	Primary education	Illiteral	0.50847	0.028*

As it can be seen in Table 11, for the dimension of satisfaction with healthcare services patients who had primary education had a higher mean of satisfaction compared to illiteral patients and patients with undergraduate degree. For the satisfaction with hospital physical conditions patients with primary education reported a higher mean of satisfaction compared to illiteral patients.

ANOVA test was used to determine whether the satisfaction levels of inpatients differed according to the most preferred source for obtaining health-related information. ANOVA test results were summarized in Table 12.

Table 12: Comparison of hospital satisfaction dimensions by health related information source

Patient Satisfaction	**Most preferred source to obtain health-related information**	**n**	**mean**	**sd**	**F Value**	**Significance level**
Satisfaction with healthcare services	Internet	46	4.2636	0.62651	1.394	0.239
	Hospital	71	4.4155	0.54763		
	Friends	23	4.4239	0.53928		
	Do not need information	7	4.0893	0.44904		
	Others	3	3.9167	0.62915		
Satisfaction with physical conditions of hospital	Internet	46	4.2348	0.58318	4.204	**0.003***
	Hospital	71	4.3944	0.52478		
	Friends	23	4.4261	0.57935		
	Do not need information	7	3.7143	1.25357		
	Others	3	3.4000	0.52915		

As it was shown in Table 12, the dimension of satisfaction level related to healthcare services did not differ according to the source of health-related information ($p>0.05$), while the other dimension satisfaction related to hospital physical conditions, differed according to the source of health-related information ($p<0.05$). According to the homogeneity of variance test (Levene), the variance of dimension of satisfaction with hospital services was found to be homogenous ($p>0.05$). In order to identify the differences among groups, Gabriel test (Mayers, 2013) was conducted. Homogeneity of variances was outlined in Table 13.

Table 13: Homogeneity of variance test

	Levene Test p Value
Patient satisfaction with physical conditions of hospital	0,182

Summary of multiple comparison of satisfaction with hospital physical conditions according to source of health-related information was outlined in Table 14.

Table 14: Multiple comparisons of satisfaction with hospital conditions according to source of health- related information

Patient Satisfaction	Most preferred source to obtain health-related information		Mean Difference	Significance Level
Patient satisfaction with physical conditions of hospital	Hospital	Do not need information	0.68008	0.015*
		Other	0.99437	0.009*

P<0.05

As it was displayed in Table 14, regarding the dimension of satisfaction of hospital physical conditions, the most preferred source by the patients to obtain health-related information was hospital. Patients who used hospitals for the source of health information had a higher mean of satisfaction with physical conditions of the hospital than those patients who do not need information.

In other tests of difference conducted within the scope of the study, the satisfaction of the inpatients did not show any statistical differences for other demographic variables (p>0.05).

4. Conclusion and Recommendations

Covid-19 pandemic has become a major concern of countries due to its severity and burden of the disease. World Health Organization (WHO) announced the ways of minimizing the community transmission of Covid-19 thru social distance, frequent hand washing, and reduced population density in a healthcare setting in March 2020. In our study these issues were not addressed, assuming this was a more concern of outpatients than inpatients. We only asked the questions regarding cleanliness of the hospital and the patient room. Patients reported satisfaction with these items.

Deriba et al. (2020) studied satisfaction of patients who have chronic diseases, in their study, only 44.6% of the patients reported satisfaction. They concluded that in their country patients satisfaction who have chronic conditions decreased due to the number of factors including ordering drugs, social distancing status in the healthcare facility, availability of alcohol, and

sanitizer for hand cleaning at the healthcare facility entrance to prevent and control Covid-19. In our study more than 50% of inpatients reported satisfaction despite the risk of Covid-19 associated with being in the hospital.

In our study the majority of patients who were hospitalized at Adana City Hospital reported "satisfaction" with healthcare services as well the physical conditions of the hospital. Patient satisfaction with healthcare services was determined as 4.35 while satisfaction with physical hospital conditions was determined as 4.30. In spite of Covid-19 pandemic, the level of inpatient satisfaction level was comparable to other satisfaction studies that was run in non-pandemic periods.

According to the study that was conducted in the same hospital by Talmac and Soysal (2021), inpatients reported higher satisfaction with the healthcare services as compared to ours. The reason of this difference may be the result of the satisfaction scale used by Almac and Soysal.

Although various patient satisfaction studies showed a significant difference in satisfaction with respect to gender of patients, we did not observe any significant difference with respect to gender in this study. Accordingly, it could be said that satisfaction of the patients was generally similar to each other in terms of gender, that was, close to each other. Other research studies conducted by Talmac and Soysal (2021), Kidak and Aksarayli (2008) and Gokkaya, *et al.* (2018) indicated that there was no significant difference in patient satisfaction according to the gender. The results of our research were consistent with the findings of those researchers listed above. Therefore, H1 Hypothesis was rejected.

There was a significant difference between the ages of patients treated in city hospitals and their perceptions of satisfaction. When the findings related to the hypothesis were examined, it was concluded that there was a significant difference according to the age variable. According to the study that was run by Talmac and Soysal (2021), it was concluded that the significant difference determined in terms of patient satisfaction between the patients aged 46 and over, and patients who were younger than those. The level of satisfaction was found higher among the patients who were aged 46 and younger patients. In the same study, when the satisfaction of the patients according to the age was evaluated, it was observed that the satisfaction of the younger patients was lower than the other age groups. In conclusion, the level of satisfaction of the younger patients was moderate and above, while the satisfaction level of the older patients was at the level

of very satisfied and completely satisfied. In the studies of Kidak and Aksarayli (2008) and Kirilmaz, (2013), satisfaction of the patients differed statistically according to the age variable. In these studies, it was determined that the level of patient satisfaction increased with increasing age. In the same studies, it was observed that satisfaction of the patients aged 60 and over was higher than those in the other age groups, and satisfaction of the patients in this age group differed significantly compared to the patients aged 30 and under. In the study of Gokkaya *et al*. (2018), it was determined that satisfaction of the patients differed statistically according to the age variable. Additionally, satisfaction level of elderly patients was observed higher than younger patients. In our study regarding healthcare services, patients between the ages of 20-29 had a lower average satisfaction score than the patients over the age of 60. For the dimension of satisfaction with the hospital physical conditions, patients aged 20-29 had lower satisfaction levels than both patients aged 30-39 and patients over 60. Our findings were consistent with the results of the studies mentioned above. Therefore, the Hypothesis 2 was accepted.

Talmac and Soysal (2021) observed a statistically significant difference between satisfaction level and education level in their study. Patients with a lower level of education had higher perceptions of patient satisfaction than those with other education levels. In the study conducted by Kirilmaz (2013), it was determined that the level of satisfaction of the patients differed significantly according to the education level; the patient satisfaction increased as the education level decreased. In the study of Gokkaya et al., (2018), it was shown that the satisfaction of the patients did not differ statistically according to the education level, but the level of satisfaction of the patients with a lower level of education was higher than those with higher education level. When the study data describing the relationship between education level and patient satisfaction was examined as a whole, it could be said that there was an inverse correlation between patient satisfaction and education level. In other words, it can be summarized as the education level increases, patient satisfaction decreases or as the education level decreases, patient satisfaction increases. In our study, for the dimension of satisfaction with healthcare services patients with primary education had a higher mean of satisfaction compared to patients with university degree. Although a significant difference was obtained between illiteral patients and patients with primary education on the same dimension of satisfaction, the means of illiteral and primary education were close to each other. In term of satisfaction with hospital physical conditions, patients with primary education reported a higher mean of satisfaction compared to

illiteral patients. Therefore, H3 hypothesis was accepted except for the dimension of healthcare services for university students.

With respect to employment type, our study did not show that the satisfaction of inpatients differed statistically according to the type of employment. Therefore, Hypothesis 4 was rejected.

In the study of Talmac and Soysal (2021) it had been concluded that satisfaction of the patients earning low monthly income was lower than those patients who earned higher monthly income. It had been concluded that the level of satisfaction of patients with low monthly income was moderate and above, while the patients with high monthly income was very satisfied. Gokkaya *et al.,* (2018) found that the satisfaction of patients did not differ statistically according to level of monthly income; However, they determined that the level of satisfaction of the patients with a moderate monthly income (1500-2499 TL) was higher than the patients in other monthly income groups. In our study patient satisfaction did not differ statistically according to the level of monthly income. This could be explained that most of the patients who were hospitalized had some kind of social security coverage. Therefore, H5 Hypothesis was rejected.

Our study showed that the satisfaction of patients differed statistically according to the number of admissions to hospital. Patients who were previously hospitalized in the clinic had a relatively higher level of satisfaction than those who were admitted to the same clinic for the first time. This finding was very consistent with the study of Hekimoglu, *et. Al* (2015). Therefore, H6 hypothesis was accepted. With respect to type of insurance, the satisfaction of patients did not differ statistically and therefore H7 hypothesis was rejected.

City hospitals were built in order to increase the quality of the healthcare services in respond to the requests of the patients to a large extent, and to combine units that provide services for patients under one roof. In the past, some hospitals in Turkey had problems with disorganization of service units, lack of bed capacity, parking area, technological equipment, and number of personnel. It could be said that the construction of city hospitals in order to eliminate these problems had contributed to the increase of patient satisfaction. However, there is a need for further studies to assess City Hospitals with respect to efficiency and its cost to the society since government have entered into contracts with several private companies to pay a rent to the private company based on number of patients who are being treated on a yearly basis for the term of 25 years. To increase level of satisfaction there is always a room for improvement. Therefore, the mean of level of satisfaction can be raised from satisfaction to extremely satisfaction. Considering

the significant cost of public-private partnership the level of patient satisfaction is expected to be higher at the City Hospitals compared to public hospitals.

Limitations

We have several limitations. First, this study was limited to the number of inpatients who had voluntarily participated in our research. Second, our study was a part of a complex study that included technology assessment and satisfaction of inpatients and outpatients who were treated at the City Hospital. Therefore, we had to limit the number of questions to measure satisfaction of inpatients.There is a need for a widely used standardized questionnaire to measure patient satisfaction across the hospitals.

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Conflict of Interest

The author does not have conflicts of interest to declare.

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TURKEY'S HEALTH TOURISM DEMAND FORECAST: THE ARIMA MODEL APPROACH

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Abstract

Aim: A large number of people around the world travel abroad to get health services at more affordable prices. In terms of travel, Turkey is among the countries with a high potential to attract foreign patients. The development of health tourism has accelerated due to many advantages such as the work quality of the services provided in Turkey, the affordable price policy, the presence of specialist physicians, and the geographical location. The actualization of future plans by making health tourism demand forecasting depends on the decisions taken today. From this aspect, it is of great importance to forecast the demand for health tourism. This study aims to predict the future status of patients who come to Turkey to receive health services and to examine them within the scope of health tourism.

Methods: In the study, the data obtained within the scope of "Visitors Leaving by Reason of Arrival" in TUIK Tourism Statistics were used. Data refers for quarters period of 2003q1-2019q4. ARIMA models

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were used to predict the future of health tourism. Analysis and estimation equations were obtained using Eviews 10.0 package software.

Findings: ARIMA (3,0,1) was obtained as the most suitable model for the study. It is predicted that the number of health tourists arriving in Turkey will be 734,860 in 2022 and 780,754 in 2023.

Conclusion: In the next years, Turkey has high growth potential in terms of health tourism. Considering the expected increase in the demand for health tourism, it will be seen that Turkey has a rising trend in terms of attracting foreign patients. The results of the study will make it easier for policymakers to make decisions on critical issues.

Keywords: Health Tourism, Time Series Analysis, Tourism Demand Forecasting, Arima Model

Introduction

It is not possible to make a single definition of health tourism, but in the most general terms, health tourism can be defined as travels made to improve the health of individuals. Both spa visits for resort and relaxation and hospital visits for cosmetic surgery or diagnosis can be considered in this context (Ross, 2001). Visits by individuals to another country are classified into three groups such as thermal and spa-wellness tourism, advanced age and disabled tourism, and medical tourism (Aydın et al., 2011). Health tourism is explained within the scope of the services provided and handled as elderly care services, health promotion services, rehabilitation services, and therapeutic services (Tontuş, 2016). In addition to the diversity of elements such as well-being, renewal, and relaxation that health tourism offers to people, developments in communication and technologies at the global level also ensure the diversity of health services, facilities, and destinations (Akın, 2021). The relevant variety includes individuals traveling outside of their environment for the purpose of mental or physical recovery and health improvement (Carrera and Bridges, 2006). These trips require leaving the place of residence for the purpose of maintaining and promoting health and treating diseases. In addition, It includes staying at the destination for at least 24 hours and benefiting from health or tourism opportunities (Ministry of Health, 2013). The common point of the definitions is that individuals visit different countries from their own countries in order to maintain, improve and get treatment. In this respect, health tourism can be considered as a basic concept covering both medical and healthy life. Health tourism is defined as regular tourist attraction initiatives supported by health services in addition to the regular tourism opportunities of a touristic destination or facility. The health

services mentioned here include medical check-ups and surgical procedures; within the scope of health tourism, there are medical procedures, special diets, vitamin complex treatments, herbal medicines, and treatment forms provided by thermal swimming pools (Goodrich and Goodrich, 1987). Health travels present the existence of a mature perception of health travel that includes encouraging elements such as beauty, tolerance, and regeneration, and rewarding elements of beauty, tolerance and renewal (Laesser, 2011). On the one hand, the fact that countries provide services in different types of tourism ensures that health tourism activities become increasingly widespread due to improvements in quality, accreditation, technology, and lifestyle changes, on the other hand, countries have more intense competition due to their economic return has created awareness about health tourism and countries have focused on health tourism.

The convenience of Turkey's geographical location, the improvement of health services, the increase in the quality of health services, the increase in the number of private health institutions, the relatively cheaper health services compared to other countries in the world attracts many tourists to our country for treatment purposes. It can be said that Turkey has reached an important position in health tourism among the countries of the world as a result of providing services to the citizens of many countries both in medical tourism and thermal tourism and earning significant income through these services (Özer and Sonğur, 2012). USHAS (International Health Services Inc.), established under the Ministry of Health, is among the strategic steps Turkey has taken in the field of health tourism in recent years. It is aimed to promote the services offered in Turkey, to support the activities of the institutions providing services, and to make Turkey a brand by making its name more known in health tourism. In this way, it is aimed for Turkey to preserve and develop the position it has achieved.

When the scientific studies written within the scope of health tourism are examined, there are some studies for demand forecasting, but none of them includes the ARIMA model for Turkey’s health demand forecasting. With this aspect, the study is considered important in terms of estimating the patients who will come to Turkey in the next two years to receive health services. In addition, the estimation of health tourism demand is an important parameter in determining the economic strategies of Turkey when considered at the macro level, and of health tourism stakeholders when considered at the micro-level.

1. Research Methodology

Cross-border patient mobility for treatment is becoming more and more common around the world. Countries that want to get a share from the health tourism market are trying to distinguish with competitive policies and in this regard, they expand the scope of services they can provide. This study aims to predict the future status of patients who come to Turkey to receive health services and to examine them within the scope of health tourism. For this purpose, the data obtained for the people who came to Turkey from abroad to receive health services in the 2003q1-2019q4 period were analyzed. In this context, the data obtained within the scope of "Visitors Leaving by Arrival Reason" for the quarter period of 2003q1-2019q4 in TUIK Tourism Statistics (2020) were used. The data of 2020, which could not be surveyed due to the pandemic, are excluded from the scope. The data includes foreign patients coming to Turkey from other countries for health and medical reasons and Turkish citizens residing abroad. Economic models will be derived by using ARMA (p, q) models with the relevant data and estimation equations will be obtained. According to Namini (2018), the ARIMA model demonstrates its superior overperforms in precision, and accuracy in estimating the next delays of the time sequences. Also, Cuhadar (2014) states that the model's versatility and accuracy have long been accepted for use of short and medium-term forecasts. Analysis and estimation equations were obtained using Eviews 10.0 package software. The number of foreign patients or citizens residing abroad for health and medical reasons is considered as a quadrans.

2. Analysis

Unit Root Test

Although different unit root tests have been developed, all tests measure the stationary of the series. The unit root results of the series to be used in the analysis are given in Table 1. If the series to be used in the analysis are not stationary, the series should be made stationary by taking the variation. If the stationarity condition is still not achieved after applying the first variation operation to the series, the series should be made stationary by taking the secondary variation of the series. According to unit root tests, whether the series in question contains a unit root at 1%, 5%, and 10% significance level is given in the table below.

Table 1. Unit Root Dickey-Fuller Test

Total Number of Tourists Arriving in Turkey		
H_0: The Total Number of Tourists Arriving in Turkey has a Unit Root		
	t-Statistic	Prob.
Augmented Dickey-Fuller Test	0.515480	0.9860
Test Kritik Değeri: %1	-3.538362	
%5	-2.908420	
%10	-2.591799	
Augmented Dickey-Fuller Testi (1st difference taken)	t-Statistic	Prob.
	-4.583697	0.0004
Test Kritik Değeri: %1	-3.538362	
%5	-2.908420	
%10	-2.591799	

As seen in Table 1, according to the Dickey-Fuller unit root test result, it is seen that the probability value is greater than the critical value and the series contains a unit root. Besides, the fact that the t statistical value of the series is lower than the t statistical value of all significance levels is another proof that the series contains a unit root. Since the series has a unit root, it is made stationary by taking the variation. The general graphic structure and stagnation of the series are shown below.

Number of People Arriving in Turkey for Health Tourism Purposes

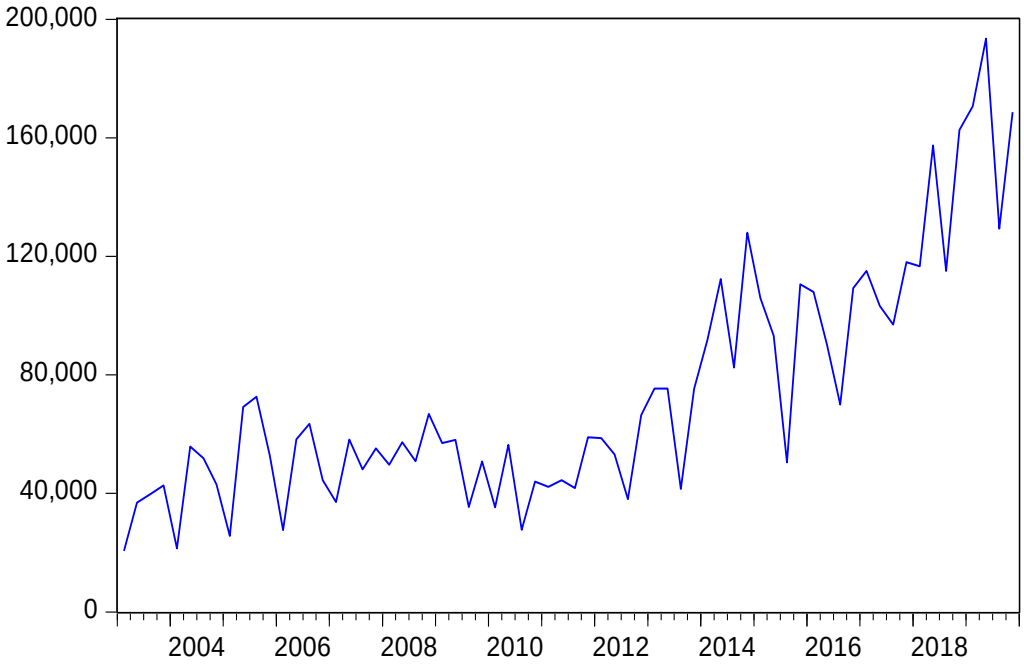


Figure 1. Progress of Persons Arriving in Turkey for Health Care by Years

Figure 1 shows the course of the series formed over the years in the number of people arriving in Turkey for health and medical reasons. When the graph is examined, it is seen that there has been a constant increasing trend since 2013, although it fluctuated at a certain level until 2013. In 2019, it is seen that the level of 2003 has reached almost five times. It can be said that the series has a unit root and shows seasonality when the graph is examined. For this reason, firstly, the series will be made stationary by taking the natural logarithm of the series and then taking the variation in the next process.

DLN Total Number of People

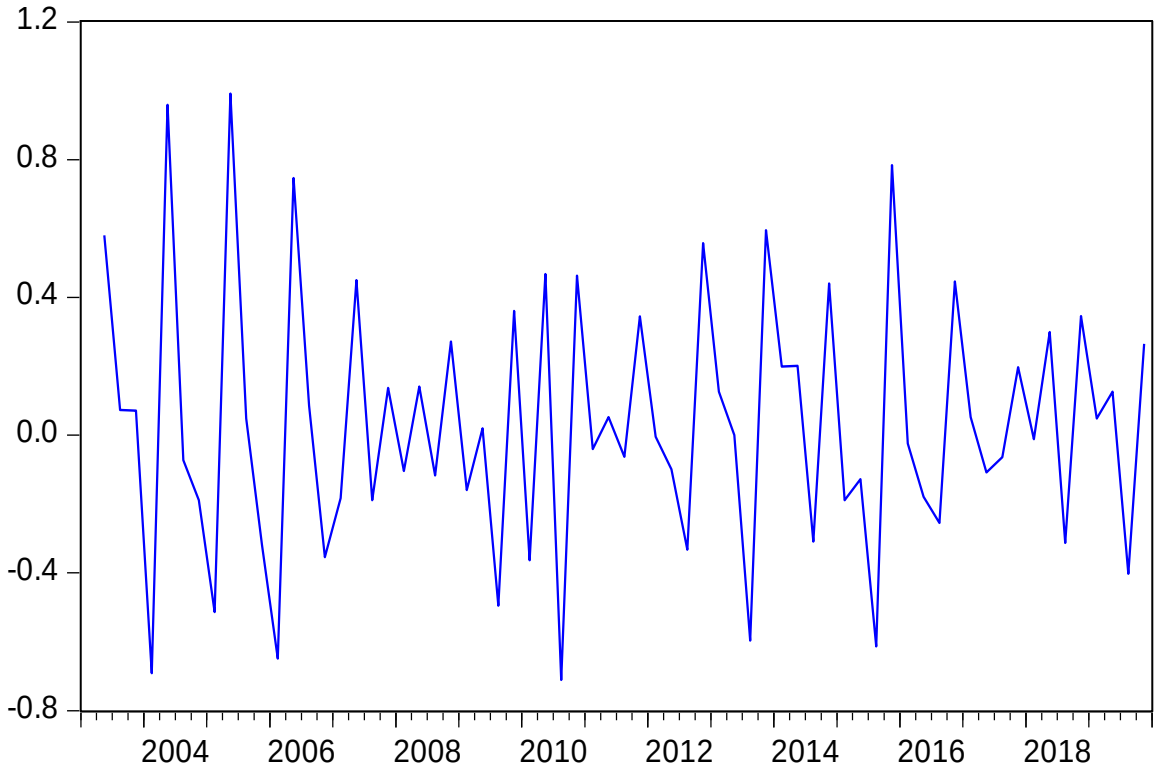


Figure 2. Series Graph with Logarithmic Transformation Applied

First, the natural logarithmic transformation was applied to the series analyzed in Figure 2, and the series was made stationary by taking the 1st variation. The series has been made stationary and converted to the required format for modeling the series. After the variation process in the series, the autocorrelation (ACF) and partial autocorrelation (PACF) graphs of the series were examined. It has been observed that the relations in the graph gradually decrease as the delay numbers increase. According to the study of Cicekgil and Yazıcı (2016), it is seen that the appropriate model is ARIMA due to the relevant situation.

In the ARIMA (p,d,q) model, there are criteria to be considered in order to determine the appropriate p, d and q values. In these criteria, parameter estimators should be meaningful therefore firstly, the smallest information criteria, especially SIC and AIC information criteria, should be preferred, and attention should be paid to the F probability value, which indicates whether the model is meaningful as a whole. Considering relevant criteria, different alternative

models were developed, and it was seen that the most suitable model was ARIMA (3,0,1). The estimation result of the model is shown in the table below.

Table 2. Results on the ARIMA (3,0,1) Model for the Total Number of Health Tourists Visiting Turkey

Variables	Parameter	Standard Error	t statistics	Probability Value
C	0.024668	0.010736	2.2977	0.0250
AR(1)	-0.995751	0.090730	-10.9749	0.0000
AR(2)	-0.850651	0.109723	-7.7527	0.0000
AR(3)	-0.802845	0.077284	-10.3882	0.0000
MA(1)	0.442352	0.159422	2.77	0.0073
R^2:0.7186	F Prob.: 0.000	Akaike Information Criterion: -0.135698	Shwarz Information Criterion:0.061737	
AR ROOTS:	-.01-.91i	-.01-.91i	-.97	
MA Root:	-.44			

When the results of the model created in Table 2 are examined, it is seen that all parameter estimators are significant. It is seen that the F probability value is also significant and the model has significance as a whole. Another point to be considered in the developed model is whether there is autocorrelation in the model. It was determined that there was no autocorrelation problem at the 5% significance level in the tests performed to the 28th delay value in the model. Theil's U value of the model was found to be 0.28 and the related value was below 0.50. Thus, it has been understood that the model is suitable for making predictions. On the other hand, it can be said that the average absolute percentile error (MAPE) value of the model is 16% and therefore it is a predictable model. The graph of the surplus values of the model is shown below.

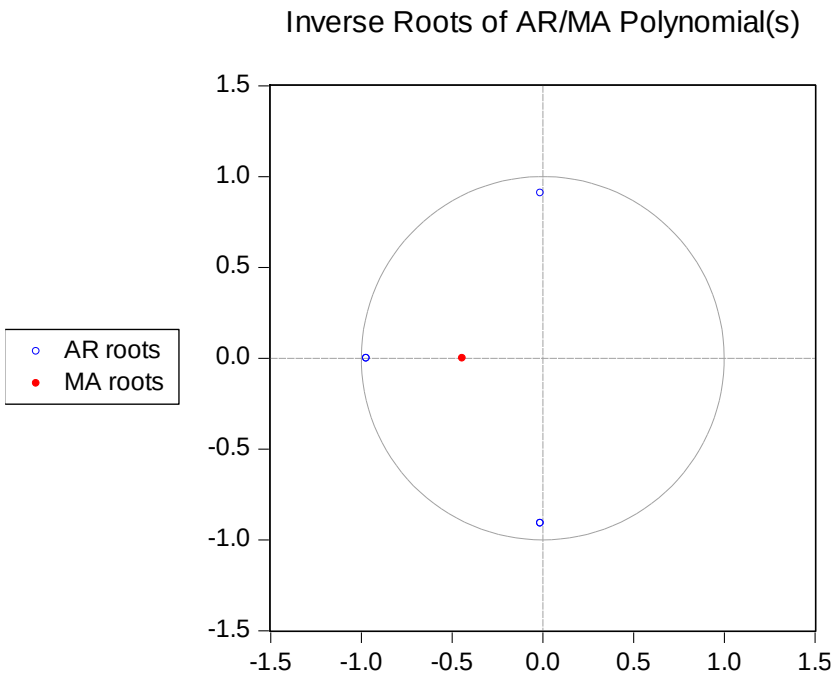
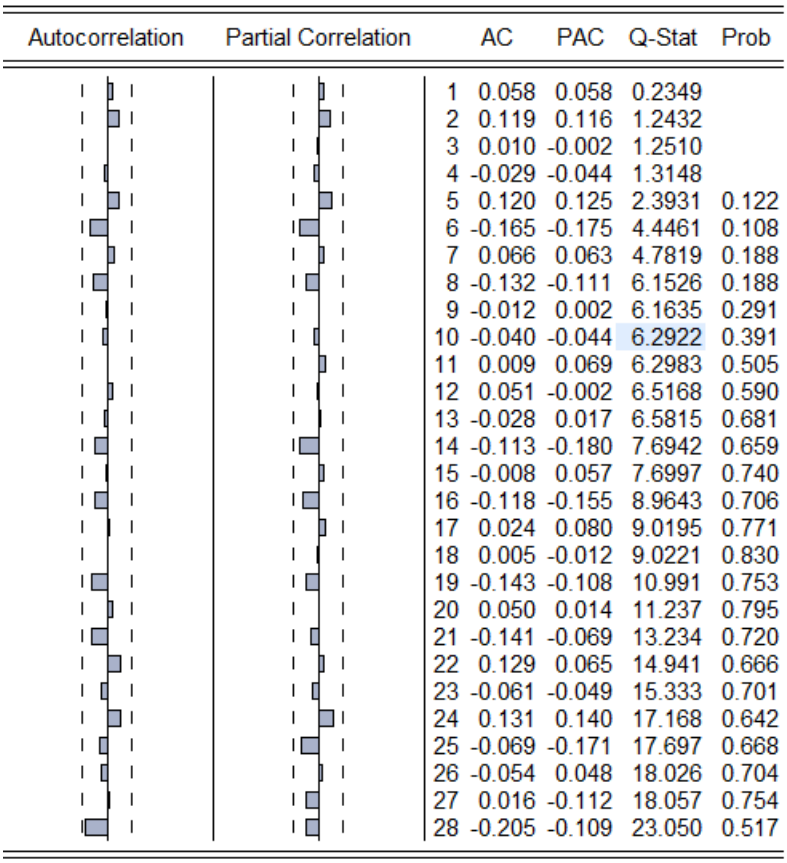


Figure 3: Representing the Roots of the Model on the Unit Circle

In a model created within the scope of the analysis, the roots are required to be inside the unit circle. The fact that the roots are inside or on the unit circle obligates different transformations. As seen in Figure 4, the roots of the model are in the unit circle.



Autocorrelation	Partial Correlation		AC	PAC	Q-Stat	Prob
		1	0.058	0.058	0.2349	
		2	0.119	0.116	1.2432	
		3	0.010	-0.002	1.2510	
		4	-0.029	-0.044	1.3148	
		5	0.120	0.125	2.3931	0.122
		6	-0.165	-0.175	4.4461	0.108
		7	0.066	0.063	4.7819	0.188
		8	-0.132	-0.111	6.1526	0.188
		9	-0.012	0.002	6.1635	0.291
		10	-0.040	-0.044	6.2922	0.391
		11	0.009	0.069	6.2983	0.505
		12	0.051	-0.002	6.5168	0.590
		13	-0.028	0.017	6.5815	0.681
		14	-0.113	-0.180	7.6942	0.659
		15	-0.008	0.057	7.6997	0.740
		16	-0.118	-0.155	8.9643	0.706
		17	0.024	0.080	9.0195	0.771
		18	0.005	-0.012	9.0221	0.830
		19	-0.143	-0.108	10.991	0.753
		20	0.050	0.014	11.237	0.795
		21	-0.141	-0.069	13.234	0.720
		22	0.129	0.065	14.941	0.666
		23	-0.061	-0.049	15.333	0.701
		24	0.131	0.140	17.168	0.642
		25	-0.069	-0.171	17.697	0.668
		26	-0.054	0.048	18.026	0.704
		27	0.016	-0.112	18.057	0.754
		28	-0.205	-0.109	23.050	0.517

Figure 4. ACF and PACF Distributions of the Total Number of Tourists Arriving in Turkey Model

When the figure above is examined, it is seen that the residuals are within the determined limits. As can be seen from the figure, the suitability of the model has also been confirmed here. Through providing all the conditions, the following table shows the predictions of the number of people who will arrive to Turkey for the 2022q1-2023q4 periods to receive services within the scope of health tourism.

Table 4. Forecasts of the Model for the Periods of 2022q1-2023q4

Periods	**Predictive Value**
2022q1	177.405
2022q2	199.755
2022q3	163.914
2022q4	193.786
2023q1	186.041
2023q2	208.150
2023q3	178.878
2023q4	207.685

Forecasts of the ARIMA (3,0,1) model for health tourists coming to Turkey for 2-year and 4-quadrans periods are shown in Table 4. According to the table, the lowest and highest forecast values in 2022 vary between 177,405 and 193,786. It is expected that 186.041 health tourists will visit Turkey in the 2023q1 period and 207,685 people in the 2023q4 period, with a total of 780,754 health tourists. Thus, it can be said that an increase is expected in the number of health tourists expected to arrive to Turkey for health and medical reasons between 2022 and 2023.

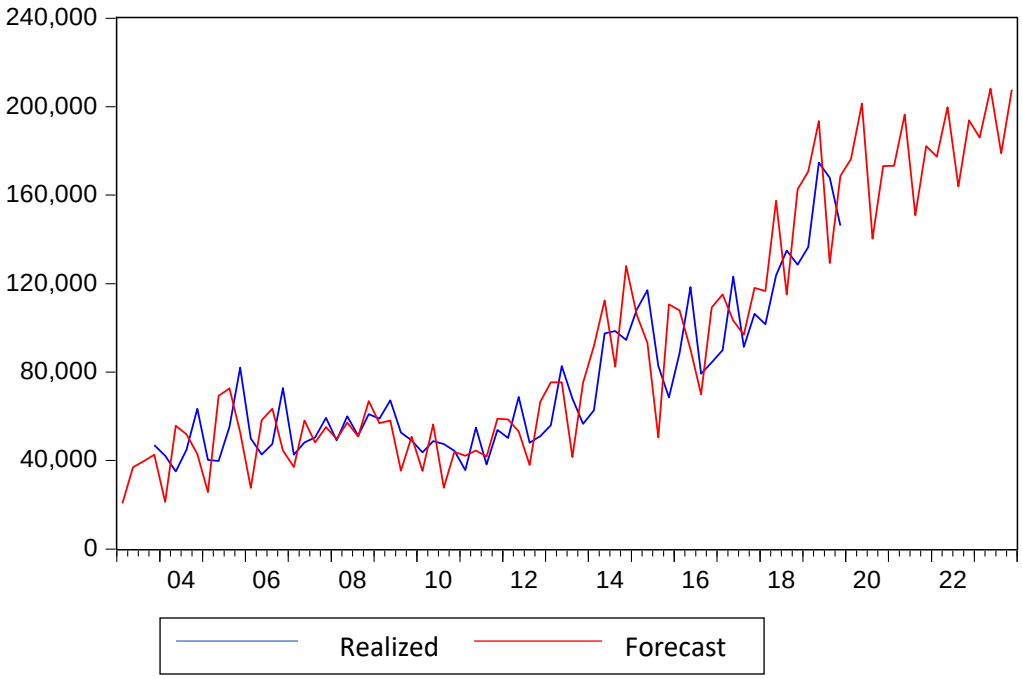


Figure 5: Forecast Graph of the Number of People Arriving in Turkey for Health Tourism Purposes

As seen in both Figure 5 and Table 4, although certain values show a decrease in quarterly, it is seen that there is an increasing trend in general. While the blue line in Figure 3 shows the people who arrive to Turkey for health tourism purposes, the red line shows the forecast graph until 2023q4. Although the values decrease at certain ranges, it is predicted that the number of people who will come to Turkey for health and medical reasons will be 780,754 in the q1-q2-q3-q4 quarters of 2023. The obtained time series has an upward trend. Thus, it can be said that number of the health tourists will increase in the long term. Obtained findings are considered as important for policymakers, decision makers and health sector stakeholders and it is thought that it will guide the investments to be made in health tourism. It is thought that it will be beneficial

for the stakeholders in the health tourism presentation, such as public and private health institutions, intermediary institutions, health tourism agencies, hotels, construction, finance, travel and communication-information sector, to consider such empirical research results in the future planning.

3. Conclusions and Recommendations

This study was performed to predict the number of people arriving in Turkey to receive health care services from different countries by using the ARIMA model, which is one of the time series methods. While developing the model, different alternatives were tried, and it was seen that the most suitable model was ARIMA (3,0,1). It is predicted that the number of health tourists arriving in Turkey will be 734,860 in 2022 and 780,754 in 2023. Quarterly forecasts for 2022 (q1-q2-q3-q4) and 2023 (q1-q2-q3-q4) show that Turkey has growth potential in terms of health tourism. Turkey is in an increasing trend in terms of attracting foreign patients from abroad in the next 2 years. The increasing number of foreign patients shows that Turkey will generate more income through health tourism. Hence, the literature (Connell, 2006; Cortez, 2008; Bennett et al., 2004; Özer and Sunğur, 2012) shows that health tourism is among the fastest growing markets, that it is the fastest-growing service sector of our time, and it supports the national economies and has significant economic contributions in many countries.

In the literature, there are many studies in which the ARIMA model is used, apart from health tourism. In Tay Bayramoğlu and Öztürk's (2017) study, the ARIMA model was used to estimate the Consumer Price Index, and the inflation rate was estimated for Turkey. In another study, the estimation of stock prices was performed with ARIMA, which has common use in modeling economic and financial time series. It has been determined that the ARIMA model is a powerful method for short-term forecasting (Ariyo et al., 2014). In a study using Johns Hopkins epidemiological data to predict the evolution of the COVID-2019 pandemic (Benvenuto, 2020), the epidemiological trend of the prevalence and incidence of the disease was estimated with the ARIMA model. It is known that the ARIMA model is used to predict the prevalence and incidence of diseases such as Tuberculosis (Zheng et al., 2015), SARS (Earnest et al., 2005), Malaria (Gaudart et al., 2009), Influenza (He and Tao, 2018) and Brucellosis (Cao et al., 2020) in the literature. In addition, using the ARIMA model in the literature, the relations between the average daily patient stay in the emergency room and various independent variables were examined (Rathlev et al., 2007), and there are also studies in which the daily number of patients

presented to the hospital is estimated (Kam et al., 2010) and the patient densities of a private hospital are estimated (Irmak et al., 2012).

In the literature, while the studies on demand forecasting on health tourism or medical tourism, which is a sub-branch, are limited, there are few studies on forecasting with the ARIMA model. The ARIMA model was used in the study (Rai et al., 2014), which was performed to estimate the medical tourism demand in India using data from the years 2009-2014. Again, demand forecasting analysis was performed in the study (Ahire and Fernandes, 2020), in which the ARIMA model was used to analyze and predict the medical tourism mobility seen in India between the years 2014-2017. In the study of Kumar and Sharma (2016), in which the SARIMA model was used, the tourist flow of Singapore from South Asian countries was estimated monthly for the next 2 years. Considering that Singapore is a country at the forefront of medical tourism, which is one of the main earning sectors, the forecast for tourism is also considered important. In the study of Isikli et al. (2020), Turkey's medical tourism demand forecast was performed by using the Least Squares Regression method. In Bayir and Isikli's (2019) study, data of health tourists who applied to a dental clinic (foreign patients from abroad and Turkish expats living abroad and coming to Turkey for health care) between 2013-2019 were used and a prediction study has been made to find an estimation at the future through four different models. According to the results of Sen's (2020) study, it is seen that the number of foreign patients who will demand health services from the Gynecology and Obstetrics, Cardiology, Orthopedics and Traumatology departments, which were estimated for 2020, 2021, 2022 and 2023, is increasing. This situation increases the belief that there is an increase in health tourists expediently with Turkey's 2023 targets and in reaching the target (Sen, 2020). According to the results of this study, an increase in the number of patients who will demand health services from Turkey is expected in 2022 and 2023.

In the literature, there are also forecasting studies on the field of health tourism with the Gray System Model, which is one of the demand forecasting models. The GM (1,1) estimation model was applied to estimate the demand for Thailand's medical tourism services and revenues from these services (Lin et al., 2009). The Gray GM (1,1) model was also used in the study on medical tourism forecasting in Bermuda (La Foucade et al., 2019). In the thesis study practiced by Sen in 2020, the demand forecast for the medical departments of a private hospital serving in Istanbul between the years 2015-2019 was performed with the Gray System Model GM (1,1).

Huang's (2012) study used the GM (1,1) model, which is the Gray forecasting model, to predict the health tourism demand in Asian countries. In this study, the existing secondary and primary data of the "Opportunities in Asian Health Tourism" report covering the period 2002-2009 were used. Dang et al., (2016) conducted a study on estimating the number of patients coming to Thailand, Singapore, Malaysia, South Korea, Taiwan, and India for health tourism purposes.

Considering the forecasts for 2022 and 2023, it is essential that health tourism stakeholders, especially the Ministry of Health, must set targets and take steps in this direction to actualize these forecasts. In order to achieve these goals, the Ministry of Health can act together with health tourism stakeholders. Hereby, Turkey needs to increase its efforts on its strengths to become a world brand, especially in medical tourism.

Especially Turkish immigrants living in Europe, in other words, diaspora Turks, receive health services from Turkey due to some chronic diseases and to spend more time in their homeland after retirement (Yazıcı et al., 2018). The relevant immigrant citizens residing abroad have great potential for Turkey. It can be said that the brand strategies that can be developed for diaspora patients who are close to Turkey in terms of cultural distance play a facilitating role in reaching the predicted target. Marketing activities to be performed in Germany, which is one of the countries where the number of citizens of Turkish origin living in Europe is high, is of great importance in terms of medical tourism.

With all the estimation models to be made, it will be possible to forecast the demand for health tourism and its sub-branch, medical tourism. Thus, the basis for the emergence of improvement ideas for countries in the health tourism sector will be prepared. In addition, the results of the study will make it easier for policymakers to make decisions on critical issues.

Through its potential and strengths in health tourism, Turkey will be able to attract more patients in the next years. In this study, it is pointed out that Turkey's health tourism industry will grow rapidly in the next years. For this reason, both the institutions affiliated to the Ministry of Health and the private sector stakeholders have to make the necessary investments in health tourism and take strategic steps in order to develop the health tourism industry.

Demand forecasting is important for the planning and strategic steps to be taken for health tourism. For the said planning, it is necessary to estimate the number of foreign patients who will come to the country. In this study, it has been tried to predict the number of foreign

patients who will come to Turkey in the next two years. However, the difficulty of estimating due to political, health, socio-economic and technological developments should not be ignored.

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THE MEDIATING ROLE OF PATIENT SATISFACTION IN THE EFFECT OF CORPORATE REPUTATION ON PATIENT LOYALTY

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Abstract

Aim Ensuring patient loyalty is among the priority issues for all health institutions in ensuring sustainability and gaining competitive advantage. In order to contribute to the literature in ensuring patient loyalty, the effect of hospital reputation on patient loyalty and the mediating role of patient satisfaction in this effect were tried to be determined.

Methods:200 patients were reached using easy sample management. In addition to demographic characteristics, patient loyalty, patient satisfaction, and corporate reputation scales were used in the study. The research analysis Regression and correlation analyzes were performed in the Smart Pls program.

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Findings: According to research findings, corporate reputation positively affects patient loyalty, and patient satisfaction plays a positive increasing role in this effect.

Conclusion: As a result of the research, it can be stated that hospitals should prioritize reputation and patient satisfaction to ensure patient loyalty. These variables play an essential role in ensuring patient loyalty.

Keywords: Corporate Reputation, Patient Satisfaction, Patient Loyalty

Introduction

One of the issues that private health institutions have focused on in recent times has been patient loyalty (Rashid et al ., 2022; Akob et al., 2021). Among the main reasons for this is the opening of private and city hospitals, which have increased rapidly in recent years (MoH, 2021). In the last twenty years, private hospitals have increased by 111%. The number of new private hospital establishments in the market increases every year. The increase in competitors creates a more competitive environment for institutions. In order to ensure their sustainability, it is essential in this respect that private hospitals first ensure the loyalty of their existing patients (Hoşgör and Hoşgör, 2017). With the pandemic, individuals prefer hospitals less than in previous periods (Amarat, 2021). Both the increase in competitors and the shrinkage of the market in this sense increase the pressure on hospitals to provide patient loyalty. In the literature, patient loyalty is defined as a willingness to re-purchase the same product and service from institutions that they have experienced before instead of purchasing them from other institutions. Re-service of patients occurs at the end of the psychological processes. Personality factors, along with habits, curiosity, culture, hospital experiences, and interactions with other customers, can be influential in these psychological processes (Derin and Demirel, 2011). In the literature, different perspectives are encountered in studies on loyalty. These perspectives are shaped on loyalty, behavioral loyalty, attitudinal loyalty, and mixed approaches covering both approaches. Behavioral loyalty creates repetitive buying behavior, while attitudinal loyalty mostly includes making positive conversations about the company that he bought before and making recommendations to those around him, even if the purchasing behavior does not continue. The mixed approach, on the other hand, covers both dimensions together. Consumers both prefer the same institution again and recommend the institution to their environment (Huang and Zhang, 2008). Hospitals that have achieved a high level of patient loyalty will be able to gain strategic advantages in a partially shrinking market and

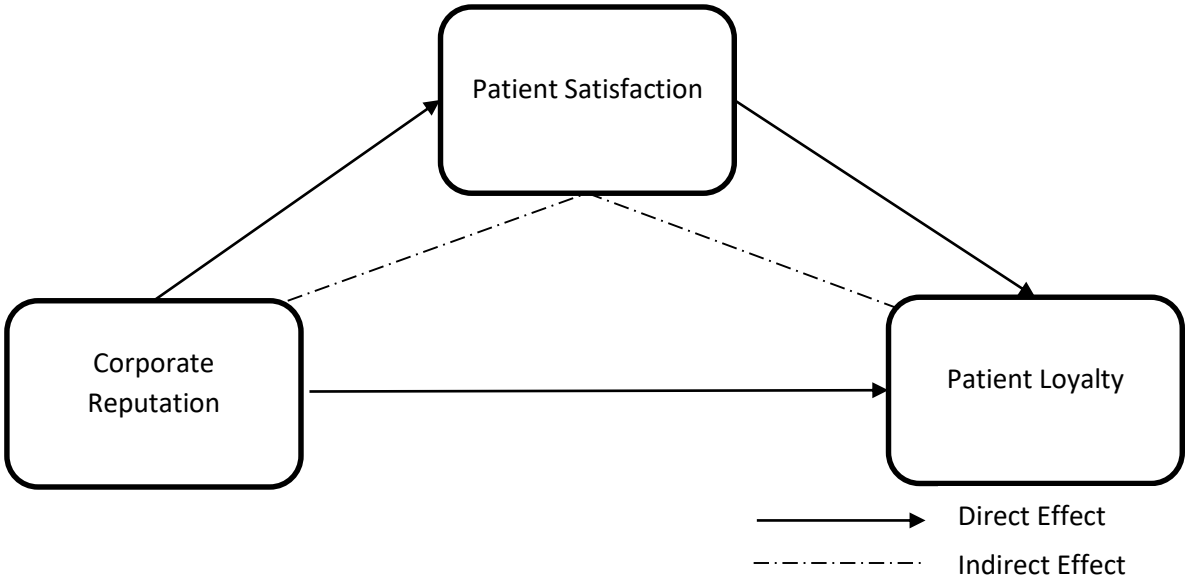
in an increasingly competitive environment. At the same time, it plays a vital role in recruiting new patients and reducing patient complaints about hospitals with high patient loyalty. It is stated that adherence among patients provides advantages in several aspects. The first of these advantages have been identified as the desire to know the institution and service providers in diagnosis and treatment, to comply with the treatment, and to continue the treatment (Torres et al ., 2009). In the literature on patient loyalty, patient satisfaction, perceived price appropriateness (Hoşgör et al ., 2017), relationship marketing (Nakip and Özçiftçi, 2015), hospital image (Ramli, 2019), service quality (Aladwan et al., 2021), patient-physician communication (Unal et al.,2018), lean hospital management approach (Yalman et al.,2019), patient complaints (Zhou et al., 2017), doctor reputation, trust, satisfaction (Torres et al., 2009). essential factors are known to be effective. Corporate reputation has a more important position on patient loyalty among these essential factors.

Corporate reputation is one of the concepts that there is no consensus in the literature and that finds itself a multidisciplinary field of study. This may be due to the lack of sufficient empirical evidence in the antecedents and conclusions of the concept. In addition, while there is a general definition of the concept, that is, a general evaluation of the stakeholder groups about the institution, in the recent discussions, some researchers argue that the concept, namely reputation, can vary and differ for each stakeholder group (Fombrun, 2012; Taskirmaz, 2015). Regardless of the definitions and discussions, this study will only consider the evaluation of patients within the stakeholder group of the hospital in determining corporate reputation. Thus, it will be possible to obtain information about the previous behaviors of the hospital (social responsibility, service quality, etc.) and how the signals it sends are perceived by the patients. Considering the competitive conditions in which these hospitals are located, it shows how they will position themselves and how they are. In this respect, hospitals need to protect and develop their corporate reputations. In addition, hospitals with a high corporate reputation increase the possibility of attracting potential patients and ensuring that they have preferred again (Unal, 2022). It is known that many different factors affect corporate reputation. However, in this study, rather than the factors affecting corporate reputation, the effects of corporate reputation and especially its relationship with patient loyalty will be emphasized.

Patient satisfaction has been another critical issue that has been emphasized recently. Among the reasons for this can be shown in the TUIK life satisfaction survey results. It can be

shown that the satisfaction rate of private hospitals between 2012 and 2020 did not exceed the 70% threshold (TUIK, 2022). Patient satisfaction is defined as the feeling that a patient's experience of the health service they receive meets their expectations (Simorangkir et al., 2021). Satisfaction of patients is effective in choosing a hospital (Ataman and Yarımoglu, 2018), patient loyalty (Kessler and Mylod, 2011), being more likely to comply with the treatment offered to them (Agosta, 2009), and suing for malpractices (Stelfox et al., 2005). Also, satisfied patients tended to recommend their healthcare provider to others (Akbolat et al., 2021). These results related to patient satisfaction can provide a competitive advantage in the competitive situation of hospitals. The factors affecting patient satisfaction can be examined in three groups. These factors can be related to the patient (age, socio-economic status, etc.), service providers (courtesy of the servers, communication, etc.), and related to the institution (physical facilities, policies, etc.) (Özer and Cakıl, 2007).

In light of this information, in our research, the effect of hospital reputation, which plays an essential role in hospitals' sustainability and competitive advantage, on patient loyalty and how patient satisfaction plays a role in this effect are investigated. For this purpose, a research model (Figure 1) was created.



2. METHOD

2.1. Sample

The population of the research consists of individuals over the age of 18 who have received service from health institutions operating in Sakarya, Turkey at least once in the last year.

Since the research universe has not been determined precisely, it has been determined as all individuals who have completed the age of 18 in 2020 in Sakarya province. Accordingly, 837.504 people constitute the research population. However, the next condition for participation in the research is to have received health care within the last year. For this reason, the research population cannot be calculated precisely. It is aimed to reach the maximum number that can be reached between 01/05/2020 and 30/05/2020 on a voluntary basis. Although a total of 278 people were interviewed, the participants who met the conditions were determined as 200 people.

2.2. Scales

The questionnaire method was used to collect data. The form used in the questionnaire consists of four parts:

(1) It consists of questions about the patients' age, gender, marital status, educational status, income, and the type of hospital they last used.

(2) Patient satisfaction, the scale developed by Erdem et al., (2008), was developed to measure patients' satisfaction with health services. The scale consists of four sub-dimensions: satisfaction with medical services, interest and courtesy, satisfaction with administrative services, and general satisfaction, and includes a total of fifteen statements. In this study, the sub-dimensions of the scale were not taken into account, and the whole scale was used.

(3) Corporate Reputation, Torres et al. (2009) consists of three statements and measures the overall reputation assessment of the institution. Original version Cronbach's alpha was 0.830.

(4) Patient Loyalty, Torres et al. (2009) Loyalty Scale was used. The scale consists of 4 items and measures patient loyalty.

The study used a five-point Likert-type scale, and the participants were asked to mark the most appropriate option ranging from 1 = strongly disagree to 5 = strongly agree.

2.3. Research Practice and Statistical Analysis Method

The questionnaires were collected from the participants in May 2020 by the researchers. The participants were given sufficient time to complete the questionnaire anonymously. Questionnaire forms were collected in sealed envelopes to ensure the confidentiality and anonymity of the participants. In addition, during the application of the questionnaire forms, the researchers followed the ethical rules by the Declaration of Helsinki at all stages of this study. Data were analyzed using SPSS version 22.0 and Smart PLS version 3. SPSS version 22.0 was used for descriptive statistical analysis and validity and reliability analysis. Smart PLS version 3 was used for structural equation modeling (SEM). This is because PLS is more suitable than alternative statistical analyses for data from non-normal or unknown distributions (Falk and Miller, 1992). PLS estimates the model parameters using the original sample and applies the resampling method to determine the confidence interval. Resampling is a method of validation using random subsets of data, such as bootstrapping. Statistical inferences are among the more robust alternatives when the preload data do not show the correct distribution (Aibinu et al., 2011; Mooney and Duval, 1993).

2.4. Validity and Reliability

First of all, reliability analyzes were made in the research. The Cronbach Alpha value for patient satisfaction was 0.927, the Cronbach Alpha value for corporate reputation was 0.848, and the Cronbach Alpha value for patient loyalty was 0.887.

Table 1 shows the SEM analysis results. Accordingly, the average explained variance (AVE) for each construct in the model was calculated in the range of 0.508 - 0.767, and the combined reliability values (CR) were calculated in the range of 0.908 - 0.937. Considering this result, it can be stated that the model established within the scope of the research supports the reliability and structural validity.

Table 1. Mean Explained Variance (AVE) and Combined Reliability (CR) Values of the Scales

Variables	CR≥0.700	AVE≥0.500
Corporate reputation	0.908	0.767
Patient Satisfaction	0.937	0.508
Patient Loyalty	0.922	0.749

In order to increase the validity of the model, discriminant validity was used. In order to ensure this validity, the black root of the average explained variance values calculated for each variable should be greater than the correlation values of that variable with other variables (Cengiz & Ozkara, 2016). In Table 2, the square root of the mean explained variance values of the variables, and the correlation values are presented. Accordingly, each variable used in the model has a moderate positive correlation with each other, and these values are not more significant than the square root of the mean explained variance values of the relevant variables. As a result of these findings, it can be stated that the factors in the study have sufficient discriminant validity.

Table 2. Differential Validity and Correlation Analysis Findings

Variables	Patient Loyalty	Corporate reputation	Patient Satisfaction
√ **AVE**	0.865	0.875	0.712
Patient Loyalty	1		
Corporate reputation	,726	1	
Patient Satisfaction	,581	,655	1

3. FINDINGS

After the validity and reliability results, the distribution data of the participants were examined first. Accordingly, 60.5% of the participants were women, 76% were singles, 55.5% were undergraduates, the average age was 29.70, and the standard deviation was 9.155. The average income was determined as 5808. The average of the corporate reputation scale was 3.44 +- 0.88; the mean of the patient loyalty scale was 3.19 +-0.77; the average of patient satisfaction was determined as 3.41+-0.74. In line with the participants' answers, the average corporate reputation was 3.44 +-0.88, patient satisfaction 3.41+-0.74, and patient loyalty 3.19+-0.77. Then, path analysis was performed by the research hypotheses.

The results of the structural equation model applied to reveal the effect of corporate reputation on patient loyalty and the mediating role of patient satisfaction are shown in Figure 2. Institutional reputation positively affects patient loyalty (β = 0.616) and patient satisfaction (β = 0.667). Patient satisfaction also positively affects patient loyalty (β = 0.261). In addition, patient satisfaction plays a mediating role in the effect of corporate reputation on patient loyalty (β = 0.174), and this effect becomes stronger (β = 0.790).

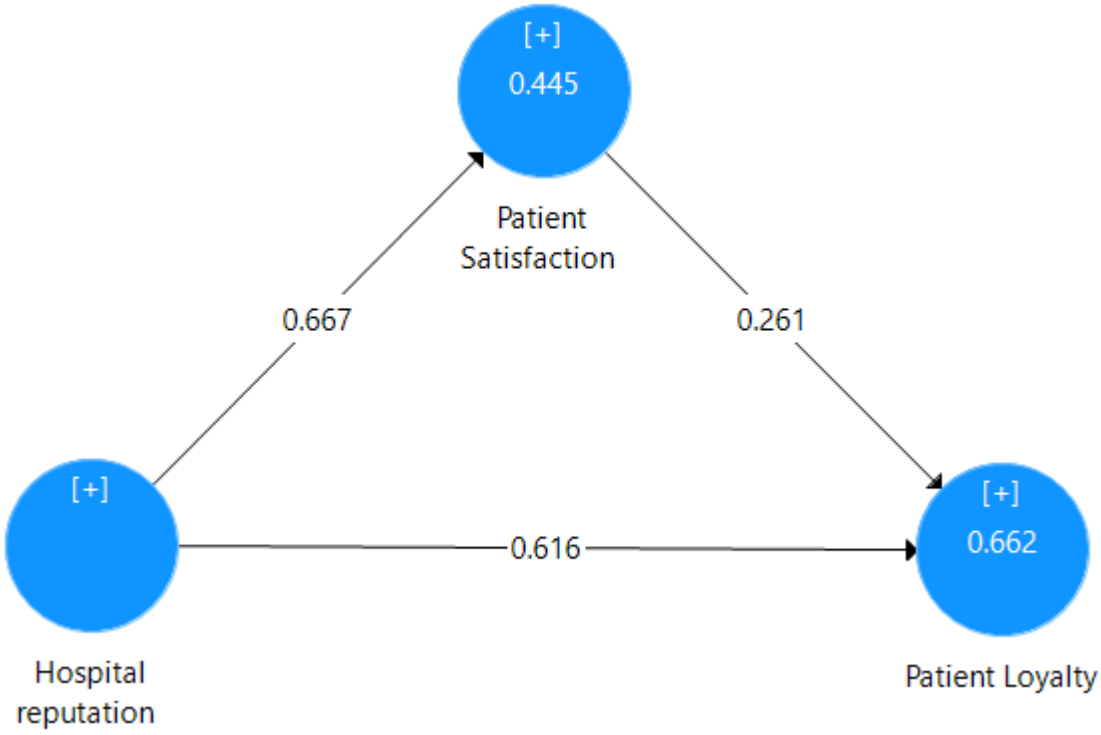


Figure 2. Path Analysis

4. CONCLUSION AND DISCUSSION

Patient loyalty is one of the critical factors in ensuring the sustainability of hospitals and gaining a competitive advantage in the changing health sector in Turkey. As patients' loyalty increases, they can be more resistant to the strategies of competing companies, and they can be more successful in attracting potential patients to their institutions. For this reason, in this research, the answer to the effect of hospital reputation on patient loyalty and how patient satisfaction plays a role in this effect is sought.

The averages of the scales used to answer the research question are included in the findings section. According to this, it is seen that the values of all three variables are at a medium-high level. However, the patient loyalty scale has a lower mean value than other variables. As a result of the research findings, corporate reputation positively affects patient loyalty. This finding is similar to both studies conducted in Turkey (Bicer, 2020; Saygin et al ., 2020) and international studies (Ramli,2019; Ondang and Syah,2018). Although the degree of effect obtained in the studies differs from each other, it is seen that hospital reputation directly and positively affects patient loyalty in all studies.

Another research finding is the positive effect between corporate reputation and patient satisfaction. When the results in the literature (Choi, 2020; Ramli, 2019) are examined, it is possible to come across similar results. The high reputation of the hospital will positively affect the satisfaction perceptions of the patients. The lowest accepted degree of impact in the research findings is patient satisfaction and patient loyalty. Although the degree of impact varies in other studies, similar findings are found (Sip and Ali, 2019; Hosgor et al ., 2017). Statistically, although researchers say that the loyalty of satisfied patients will increase, very few researchers in the literature have focused on whether this effect occurs (Kessler and Mylod, 2011). For this reason, it is not known to what extent the results obtained turn into a behavior. It is recommended that more research be done on the subject.

The last finding of the study is about how patient satisfaction plays a role in the effect of hospital reputation on patient loyalty. Research findings indicate that the mediating effect of patient satisfaction increases positively. In summary, it plays a role in increasing the impact of hospital reputation on patient loyalty. Since there is no similar finding in the literature, it can be stated that the research results have a unique value in this sense.

As a result of all the findings, it is recommended that the hospitals that want to increase their sustainability or gain a competitive advantage should first measure the current status of the hospital's reputation and make the necessary changes. Although hospital reputation has a multidimensional and variable structure, it is defined as transforming patients' experiences and sensations into a holistic perception. This perception's low, medium, and low levels will negatively affect patient loyalty. In addition, at this point, patient satisfaction should be increased. Patient satisfaction is directly related to both hospital reputation and patient loyalty. In this direction, it is

recommended that hospital managers take on roles that will strengthen the hospital's reputation with continuous improvements and measurements.

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HEALTH INEQUALITIES AND COGNATE INEQUITIES IN AMERICAN SOCIETY; RACISM, NEOLIBERALISM, AND FREEDOM FROM INDIGNITY

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Abstract

The paper re-examines neoliberal societies' essential characteristics and dignity exposition, arguing that racial injustice represents and inaugurates a systemic culmination. By proceeding with the theoretical framework of neoliberalism's impact on inequality, the study presents racism and its relevance in health and cognate inequalities and association to human security- freedom from indignity. Racial inequality in health and cognate inequities can not be transformed unless the power of neoliberalism is simultaneously contested. The COVID-19 has exposed the adverse effects of a system that has dominated and disproportionately impacted racialized US communities. It confirmed long-standing structural variations pointing out inadequate policies, budget discrepancies, jeopardizing human security conceptualization. Thus, the rationale for a neoliberalism reversal within the alternative hybrid order. The phenomenon's roots and current issues lie in the realization of capitalism, the morphology of the nation-state, and the generative order of colonialism. The discrimination and unequal access to healthcare, education, and employment construct a paradoxical paradigm - the affluent US society contains disputable human security, welfare, and general prosperity. With an ideal approach to skepticism and confusion regarding critical race theory, the legal history, doctrinal race development, and the International Convention on Racial Discrimination, a contemporary racial foundation needs to be developed, reaffirmed, improved,

and protected to incorporatethe democratic content of the US's principles of legal equality. A rational approach to assess the social welfare system is to examine its significant impact on poverty and racial discrimination. The moral criterion and compulsory economic logic of direct financial benefits associated with poverty policies require considerable determination. The right to health is a fundamental precondition for achieving freedom from indignity contributing to non-violent behavior, legalism, and community improvement. Theconsolidation of wealth and power in one society could be ground for racial and other exclusivist discourses, and the improper system of governance and, ultimately, society become. Institutional racism, whether implicit or explicit, is often unnoticed or disregarded. Ethnic sensitivity, empowerment, and cultural competence should constitute anti-racism tools of liberation policies to constitute a dignified culture of equality and equity.

Keywords: Health inequalities, Racism, USA, Human Security, Freedom from Indignity, Neoliberalism,Inequities, Human Rights

Introduction

Although less visible, racial inequality's historical and structural roots are broad and lie beneath the surface. It takes more than confrontation and condemnation to eradicate them. Racism, in its myriad forms, continues to flourish despite the spread of equal opportunities and the formal denial of racist actions. No theory gives a complete illustration of why prejudices and stereotypesarise. Stereotypes are deeply embedded in US culture and often influence acts of prejudice and systemic racism that have contributed to the inequalities of African-American males. (Taylor et al., 2019) Although (institutional) racism as a social problem is not new, its importance has undoubtedly increased with the advent of capitalism. Some authors have argued that the prevalence of racism is also closely related to the emergence of neoliberalism. According to Theodore and Brenner (2002), as a regime policy, neoliberalism leads to the formation of a multicultural, transnational elite class on the one hand, while on the other hand, there is a visible increase in poverty around the world. George (1999) argued that neoliberal practices and placing public wealth in private hands, granting tax breaks for the rich, cause inequalities reflected in interpersonal violence and racist behavior. Harvey (2003, 2005) similarly blames the capitalist nature of neoliberalism as the main reproducer of inequality that contributes to the uneven development of different states, increasing tension between certain groups of people. Hohle (2018) argues that neoliberalism results from the latest elite white strategy to maintain political and economic power. Hohle focused on how the origins and expansion of neoliberalism depended on language or semiotic assemblage of the white-private and black public. The language of neoliberalism explains how

the white racial frame operates as a web of racial meanings that connect social groups with economic policy, geography, and police brutality (Hohle, 2018).

Neoliberalism is a controversial issue and depends on the social context, and primarily neoliberal doctrines are based on open, competitive, and unregulated markets, free from all forms of state interference. Covid-19 manifested how vital healthcare and particularly public health-designed investments are. However, neoliberalism and racism as the associated phenomena must be treated at the root, not only current- pandemic circumstances. Biopolitics and necropolitics cannot exist without each other, but the specific imbalance between them depends on the specifics of racial capitalism and ethnonationalism in each state. These two dynamics have always provided a much more central place for necropolitics in the capitalist system. "Colonialism of power" ensures that the same violent, racist, and necropolitical dynamics at the heart of colonial rule are adopted in both metropolises and "former colonies" after formal decolonization (Quijano and Ennis, 2000).

The incapacity of the US, one of the most developed countries, was best demonstrated during the pandemic. In times of the pandemic, neoliberal capitalism has confronted the consequences of its policies on people's lives. Though African-American (Black) and Hispanic (Brown) communities share many of the experiences that make them more susceptible, significant differences between them need to be understood to combat the virus's adverse economic and health effects effectively. The Economic Policy Institute report focused specifically on black workers is the first to explore how racial and economic inequality leaves workers of color with few good options for protecting their health and economic well-being. Another companion report highlighted conditions for Hispanic workers. (Gould et al., 2020) Economic effects are that devastating job losses are hitting black workers and their families, especially hard. There are three main groups of workers in the COVID-19 economy: those who have lost their jobs and face economic insecurity, those who are classified as essential workers and face health insecurity as a result, and those who can continue working from the safety of their homes. Unfortunately, black workers are less likely to be found in the last group. They have suffered record numbers of job losses over the last two months (March 2020–May 2020), along with related economic devastation. They are also disproportionately found among the essential workers in the economy today—continuing to go to their workplaces, risking their health and their families because they cannot sustain adequate social distance from their co-workers and

customers (Gould and Wilson, 2020) .Drawing on over a decade of research on epidemics, the origins, unfolding and effects of the COVID-19 pandemic require analysis that addresses structural political-economic conditions alongside far less ordered, "unruly" processes reflecting complexity, uncertainty, contingency, and context-specificity. This structural-unruly duality in the conditions and processes of pandemic emergence, progression, and impact provides a lens to view three key challenge areas. The first is how scientific advice and evidence are used in a policy when conditions are rigidly 'locked in' to established power relations and yet so uncertain. The second is how economies function; the COVID-19 crisis has revealed the limits of a conventional economic growth model. Third, new forms of politics can become the basis of reshaped citizen-state relations in confronting a pandemic, such as those around mutual solidarityand care (Leach et al., 2021). The US paradox is the existence of inequality within all sectors. Onthe one hand, it indicates that American health research centers represent the world's reference centers and, on the other hand, a flawed health system assails the health care of ordinary American citizens.

The post-pandemic economy's representation illustrates Joseph Schumpeter's words: "there is a schedule when capitalism will experience complete disappearance." The data show that African-American and Latino communities have collectively faced some of the COVID-19 pandemic's most damaging economic and health effects. (Gould and Wilson, 2020). The US is one of the wealthiest, most powerful, and most technologically innovative countries globally, but its wealth, power, and technology do not address a condition where 40 million people live in poverty. The US exceptionalism has been a constant theme in the discussions. However, the US is exceptional only in highly problematical policies that are inoffensive contrast to the infinite wealth and formal commitment to human rights. As a developed country, the US originates paradoxical indications of population inequality within access to health, education, uneven workforce, with additional legal discriminations. The inequality of life prospects or opportunities (social mobility) of today's American generations is influenced by several factors, in addition to differences in income and wealth. Lack of a general health care system (children from more impoverished families are often uninsured and will have significant health problems), poor nutrition (poor children eat poorly and will get sick more often), a weak social network (parents' life difficulties are reflected in their children) and a markedly uneven quality of primary education. (Wilkinson and Pickett, 2009) The lack of adequate education has much more significant social consequences than the difference itself in income. The unemployment rate of

African-Americans in today's time is probably a fundamental cause of their role in the illegal sale of drugs, fatal cases, and crimes arising from it. The employment rate of African-Americans in 2016 was 61.8%, which means that more than one-third of the community does not contribute with its work but relies on government social programs, the black market, drug trafficking, other goods, and services, or a combination of all of these (Whalin and Block, 2017).

Observing health inequalities through the prism of the health system, the availability of healthcare, and social determinants that affect the whole context designate that synergy need to be achieved with other policies to work and health inequalities to work and health inequalities be minimized. Inequalities create differences in health status, and an increasing number of stagnant and impoverished, sick and uneducated people have no life chances to live materially, gain work skills and life experiences. Research on the relationship between income inequality and the number of people with mental illness has shown that the incidence of mental illness is strongly linked to income inequalities in the US and the United Kingdom (UK). At the same time, there isno correlation between the two data in continental European countries. (Phillips, 1991) The US health care system, the most expensive in the world, is, like education, accessible only to certain strata of society. As race and poverty often overlap, the most disadvantaged are racial minorities. They were also more exposed to the COVID-19 because they do jobs that cannot be done from residence and had fewer opportunities to be treated on time or adequately because hospitals in Africa-American districts were unprepared. The irony is that the virus, which was initially spread by people who could travel for work or as tourists, infected those forced to live in places and conditions from which it was impossible to escape. In addition, African-Americans often suffer as a percentage of so-called predispositions for critical illness from COVID-19, such as diabetes, obesity, heart, and respiratory diseases. These diseases are always exacerbated by the conditions people live and the lack of health care. So the pandemic exclusively brought to knowledge the issues caused by inequalities that could generally be ignored. The mortality among African-Americans has discarded new knowledge on long-standing structural and social inequalities inthe US, the focal point of global protests against social injustice. For a continued time, it is a factthat racial inequality is a severe problem in the US. However, it was a peripheral issue that sought a solution but cannot jeopardize the view of the US as a country of equal opportunities for progress for all.

Political, social, and economic events in the 1980s, such as the election of Ronald

Reagan as President, and the deregulation of the economy, the enthronement of neoliberalism as the unquestionable course of contemporary American society, led to a 2008 crisis. It revealed a sequence of the historical logic of the US society. At the end of the last century, the unrestrained logic of capital no longer knew any limitations favored the rise of neoliberal culture and a class of economic elite. From that period, the processes of mutation of capital began, the celebration offinancial capital eventually led to a crash that, as we know, was not its end but only a moment of crisis. After the financial crisis and the devastating wars in Iraq and Afghanistan, Obama's victory did not indicate victory over racism, leading to resentment. Racial capitalism is a fundamental cause of the racial and socioeconomic inequities within the novel coronavirus pandemic in the US. The overrepresentation of Black death reported in Detroit, Michigan was a case study for this argument. (Pirtle, 2020) Liberal America had not overcome its most significant issue; it was reflected in Donald Trump's election. Even before Trump came to power, racial riots occurred, such as a series of clashes between white police officers and African-Americans during Obama's term in which several people were killed. If some lives are insignificant, they cannot be called lives because life is assumed to be valuable in itself. So what we see here is that some lives are more valuable than others, that is, they are so valuable that they should be protected at all costs, while on the other hand, there are those lives that are not worth much or not worth at all. When this kind of thought becomes a reality, lives that are not worth much or are not worth anything can be killed or exposed to conditions of poverty and indignity without any bitterness. Under the influence of the latest social movements, citizens have started to perceive racial injustice and other forms of injustice as a systemic problem. It represents a significant ideological change. Racial discrimination and legal inequalities have a long history - but the ideological lens was considerably different, events and facts are the same, but interpretations differ. As Cornel West has well observed, this is a problem we cannot solve by "putting a few black people in high positions." Historically, each stage of increased rights for minorities in the US, principally for African-Americans, was accompanied by new forms of discrimination.

Lynchings followed the Civil War, monuments to the Confederacy and its generals were erected decades later, African/American soldiers in World War II were not given the right to study for free like other veterans, and the abolition of segregation in the 1960s resulted in the flight of white population from cities and tax areas inhabited by African-Americans. Systemic

racism is institutionalized through property and residence ownership, determining the tax base and education and health systems. As schools in the US are paid for from local budgets, more impoverished areas where African-Americans live have a lower tax base and thus fewer opportunities to fund education adequately. Differences in real estate ownership thus become the cause of other differences. In Minneapolis, for example, where George Floyd was assassinated, which is otherwise considered a progressive city, only a quarter of African-Americans own homes as opposed to 76% of the white population. Anti-immigrant sentiments are also part of American history. Just as periods of increased rights for African-Americans led to new forms of discrimination, each new wave of migration provoked new prejudices.

Neoliberal social and economic system by targeting individualization and minimal state interference in the economy makes it difficult to fully implement the human rights that the state needs to guarantee. For example, revenues from contributions and taxes should finance the welfare state and investments in affordable and affordable housing, quality education, a fair pension system, and comprehensive, quality, and affordable health care. The new global economy contributes to new forms of race, class, and gender inequality by widening economic disparities, displacing people from land which provided self-sufficiency, and eroding accustomed ways of life that cannot be addressed in a strictly domestic context. Struggles for economic justice and human rights, thus, need to be moved to the transnational level. (Glenn, 2000) To develop and improve human rights, we need to rethink the current economic system and make it a factor for improvement, not endangering or abolishing human rights. Article 28 of the 1948 Universal Declaration of Human Rights states that "everyone has the right to a social and international order in which the rights and freedoms outlined in this Declaration can be fully exercised, and since the current social, economic, and international order does not appear to be the ideal system for exercising the rights and freedoms guaranteed to us on paper should be re-examined. Thus, a thorough re-examination of the essential characteristics of capitalist societies is needed. In the search for a model of sustainable development, it is necessary to consider the fact that neoliberalism represents harm. However, anti-market fundamentalism or dogmatism is harmful as well. Capitalism is hard to replace, especially in the Western world, because it has simply entered into people's consciousness and became an inseparable part of their lives, but it is not disputed that it has its flaw and needs to be adjusted. First, it needs to be adapted to become more socially sensitive to suggest designing a hybrid system.

There is no doubt that neoliberalism is experiencing the zenith of its evolution characterized by the abuse of the notion of power. In the book, "People, Power and Profit: Progressive Capitalism for an Age of Discontent," Joseph Stiglitz (2019) describes the term "power" as "powerlessness," that is, the political powerlessness of large groups, which the capitalist system uses. Derogating the government forty years ago, attacks collective action undermines market equilibrium and abolishes financial resources that should be the backbone of developing sectors that resemble devastated after a pandemic. Despite massive $ 2.7 trillion in government assistance and poorly designed measures against the spread of coronavirus adverse effects, the US's economic system has failed to preserve US jobs, making the unemployment rate more progressive than other advanced countries. (Stiglitz, 2019) When a contemporary economic book written in today's intelligible language becomes a world bestseller - despite numerous objections on the one hand (too much advocacy of antitrust policies) and high praise on the other (creates an image of progressive capitalism) - then we comprehend how to understand economic trends after a pandemic it still requires the opinion of the profession. In the last three decades, the neoliberal belief in free-market effectiveness marked the mainstream economy. As distribution relations within the most developed Western countries were predominantly determined by ideological and political reasons and transformations from the late 1970s, the neoliberal paradigm of socioeconomic development prevailed and soon stopped and reversed, the prevailing trend of reducing inequality in Western societies. Unemployment rates by race, and by race and gender, from February–April 2020 show that, while unemployment skyrocketed for Black and white workers in the COVID-19 labor market, the unemployment rate is higher for Black workers (Gould and Wilson, 2020).

The production, technological, and globalization changes that have taken place in parallel with political changes have a much smaller impact on the return of asymmetric social distribution, if not marginal. The essential change in the character of social distribution came about due to the emergence of a new and different political will. It aimed to grow the wealth and power of individuals rather than the wealth of society and the preservation of uniform distribution. By accepting the neoliberal socioeconomic model to varying degrees, many European and other countries have also allowed the growth of economic and other social inequalities, but to a much lesser extent than Anglo-Saxon societies. Even in the UK, the country of most significant inequality after the US, neoliberal welfare state reforms have not led to the complete

disappearance of the principle of solidarity and the abolition of post-market measures to reduce income inequality. Conventional welfare economics states that the accurate response depends on the strength of propensity for income equality and the distortions in incentives that the system creates. A society that wants to be stable and prosperous must not allow itself to abolish mechanisms and reduce funds for social interventions of the state, because in addition to economic inequalities, other social problems such as demographic aging, low fertility rates, high youth unemployment, high pension and health expenses, and environmental pollution. Dramatically, people of "color" are exposed to more air pollution than whites from industry, vehicles, construction, and other sources. The most recent research showed that disproportionate numbers of non-white people were exposed to potentially hazardous fine particle pollution from nearly all primary US emission sources, regardless of where they live or how much money they make. African-Americans were the only group disproportionately exposed to each pollution source examined. Moreover, Black, Hispanic and Asian people were exposed to higher than average levels of fine particle pollution, while white people were subjected to lower than average levels. (Costley, 2021) It is the principal reason why they are more susceptible to chronic diseases. David Harvey, in "Short history of neoliberalism," problematize neoliberalism like a theory that explains the practices of political economy, a which claims to human well-being can be best promoted by allowing the freedoms of entrepreneurial activities of individuals and skills within the institutional frameworks, which are characterized by solid rights private property, free market, and free trade. However, that the theory is one a practice secondly, is confirmed by the data on significant economic inequalities, chaotic reforms, and uneven development of state institution, which imposes on us the conclusion that: "the neoliberal state is unstable and contradictory political form." (Harvey, 2007) Total privatization would undoubtedly eliminate the need for a state and collective decision-making, democracy, which are explicit anti-democratic beliefs. Neoliberalism was taken for granted, and its teachings and recommendations were so clear and shared understanding that it promptly qualified for the role of the best ideology. Many economists saw neoliberalism as the essence of all the best and most sensible ideas. Defending the Washington Consensus, John Williams wrote that it was "the core of wisdom accepted by all serious economists." (Williams, 2004).

Given the parameters addressed by socioeconomic rights, it is essential to highlight that the world's state currently finds itself. Today, the world is divided by the owners of capital who,

instead of primarily serving the economy, become its great masters. The neverending paradigm confirms the evidence that in the 2000s, 33 % of the gross domestic product was owned by them. Although it has been several years since the World Economic Forum debated economic inequality with a debate on "Has 20th Century Capitalism" characterized the main threat to socialstability, world powers have failed to stem the growing inequality trend. The poorest sections of global society are routinely forced to choose between healthcare and other household necessities, including food and education. More than 122 million people worldwide have to live on a daily wage of only $ 3.10, which is the threshold of moderate poverty due to healthcare costs. A total of 800 million people worldwide spend over 10 & of their household budget on healthcare costs not covered by health insurance. Women belong to the most vulnerable group. (World Bank, 2017) Minimum healthcare proclaims the right to be healthy, although one aspect of the right to health is a fundamental precondition for achieving a quality of life and enjoying other rights that contribute to the progress of society. The right to health is only one of the collective rights arising from international solidarity, of which it is the protector and foundation for realization. It is the essential tool of man for personal progress, development, and dignified life, and thus indirectly for the development of the whole community. The right to health encompasses the right to be healthy and is closely related to all those rights that provide the individual with the minimum to achieve a dignified life and personal progress.

Ensuring adequate healthcare is an obligation of a state arising from Article 12 of the International Covenant on Economic, social and cultural rights. In order to fulfill their obligation, states are obliged to ensure the availability of the healthcare system. Its accessibility and acceptability, and equal quality for all, should be based on the principle of non-discrimination. It includes public health institutions and health services in sufficient numbers at the state level, provision of fundamental medicines, physical accessibility of health services (health institutions and care within a reasonable distance from the place of residence), social insurance system, and coverage of basic costs of treatment and medicines, information on health and all factors that affect it, quality service based on scientific achievements and medical ethics. By ensuring a minimum of healthcare and hygiene conditions for all citizens, states create a basis for the personal progress of their citizens. Thus the progress of the whole society. Primary healthcare is specifically regulated by the 1978 Alma-Ata Declaration, which emphasizes the crucial role of primary healthcare in addressing the most common health problems in each community through

preventive, curative, and rehabilitative care. (Declaration of Alma-Ata, 1978)

Socioeconomic inequalities in health are differences in prevalence or the incidence of health problems among populations of different socioeconomic statuses. These inequalities should not be confused with health inequalities protection. Socioeconomic status is measured based on three indicators: occupation, level education, and property status, and it is the broadest sense of the word, which means a position in the social hierarchy expressed through the above three indicators. Socioeconomic inequalities in health are among the most critical public health issues today, as are differences in health status or the distribution of health determinants among different population groups. Today's range of these inequalities is surprisingly broad and indicates differences between different population groups (e.g., members of different regions, different ethnic groups, different social groups, races, and genders). Through their impact on health, many social factors lead to health inequalities. Health inequalities directly affect poverty, environmental and living conditions, unhealthy diet, risky behavior, or indirect, through insufficient education or inaccessible healthcare. (Mastilica, 2010) Income and income inequalities, social cohesion, and social capital significantly affect health and disease occurrence at the population and personal levels. (Sacker et al., 2000) The link between poverty, poor education, and even neurological consequences in the US is neglected. Effective poverty reduction can improve this complexity. Analyzing data (e.g., OECD Data, 2019 on the "Confronting Poverty" platform*)* from various countries, we can conclude that child poverty is far lower in other wealthy countries, i.e., European countries, not because their economy provides higher wages for lower-income workers, but because of more robust social programs. Like many in Latin America, most of these countries provide direct cash benefits to parents with children.

In the current global circumstances, the nation and race become an invincible stronghold of the disputed individual. With COVID-19, attributing responsibility to an "other" is somewhat indirect because, ultimately, the responsibility lies with a virus rather than human actors. COVID-19 is an "invisible enemy," as Donald Trump stated. In this regard, the pandemic is akin to a natural disaster. However, even natural disasters typically provoke efforts to attribute responsibility to human actors—to lay blame at the feet of an individual, group, or institution for failing to act appropriately. This process of attributing blame can be highly conflictual. As the conflict takes shape, it aligns with and amplifies existing cleavages. For example, after Hurricane

Katrina, an emotional struggle over responsibility ensued that ultimately enflamed a longer-running conflict over the place of African Americans in America. (Woods et al., 2020) Ana Bradley advances a long-overdue claim: racism should be affirmatively and explicitly recognized as a human rights violation under international law. (Bradley, 2019) A significant obstacle with the internationalization of human rights is the impossibility of prosecuting states that do not abide by signed pacts and declarations. Even though the affinities between critical race theory and Third World approaches to International Law, social justice, and critical legal pedagogy, anti-racism has little influence over how critical legal scholars teach international law. (Al Attar, 2020) The International Convention on the Elimination of All Forms of Racial Discrimination remains the principal international human rights instrument defining and prohibiting racial discrimination in all sectors of private and public life. While the principle of non-discrimination appears in Article 1 of the Charter of the United Nations and is enshrined in the Universal Declaration of Human Rights, it was felt that this crucial rule of international law should receive due prominence in a legal instrument that elaborates the definitions and obligations in stemming from it. (McDougall, 2021) Furthermore, the social and socio-economic potential of minority groups is often limited and severely disrupted, so empowerment is crucial—importance toprevent their abuse by more powerful groups. Multidimensionality is reflected in what happens within sociological, psychological, economic, and other dimensions and also occurs at different levels such as an individual, group, or community.

The critical race theory emerged out of postmodernist thought, which tends to be skeptical of the idea of universal values, objective knowledge, individual merit, Enlightenment rationalism, and liberalism—tenets that conservatives tend to hold dear. Fundamentally, though, the disagreement springs from different conceptions of racism. Critical race theory emphasizes outcomes, not merely on individuals' own beliefs, and it calls on these outcomes to be examined and rectified. Critical race theory also has ties to other intellectual currents, including sociologists and literary theorists who studied links between political power, social organization, and language. Moreover, its ideas have since informed other fields, like the humanities, the social sciences, and teacher education. However, this academic understanding of critical race theory differs from representation in recent popular books and, significantly, from its portrayal by critics—often, though not exclusively, conservative Republicans. The theory says that racism is

part of everyday life, so people—white or nonwhite—who do not intend to be racist can nevertheless make choices fuel racism. The critics charge that the theory leads to negative dynamics, such as focusing on group identity over universal, shared traits, dividing people into "oppressed" and "oppressor" groups, and urging intolerance. Thus, there is a good deal of confusion over what Critical race theory means and its relationship to other terms, like "anti-racism" and "social justice," with which it is often conflated. The term "critical race theory" is often cited as the basis of all diversity and inclusion efforts regardless of how it has informed those programs (Sawchuk, 2021).

New paradigms in security study have been developed within the framework of multidisciplinary and interdisciplinary "critical security studies." It is an umbrella term for various security approaches to problematize the dominant neo-realistic, state-centric and militaristic understanding of security and develop alternative security views in a broader political context, historically and sociologically. Their goal is to determine security's historical, political, and social content by questioning its meaning and value. Existing definitions of human security tend to be unusually expansive and vague, encompassing everything from physical security to psychological well-being. If realism is supposed to explain why states compete in a competitive anarchical system, human security could be making value judgments on whether this behavior is morally acceptable. The human security concept protects the vital core of all human lives from enhancing human freedoms and human fulfillment. Human security notion is focused on people. It deals with the way people live in society, universally, rich or developing countries, how freely they exercise their numerous choices, how much access they have to market and social opportunities, and whether they live in conflict or peace. In a space ruled by politics, political and academic arenas converge, spilling much ink in defense of a simple idea. Human security integrates freedom from fear, freedom from want, and freedom from indignity. Freedom from fear refers to protecting individuals from threats directed at their security and physical integrity and includes: various forms of violence that may arise from external states, the acts of a state against its citizens, the acts of one group against others, and the acts of individuals against other individuals. Freedom from want refers to the protection of individuals to satisfy their basic needs and the economic, social, and environmental aspects of life and livelihoods. Freedom from indignity refers to promoting an improved quality of life and enhancing human welfare that

permits people to make choices and seek opportunities that empower them (United Nations, 2021).

There is a need for a dignified life and imperatives like Kant's, which sound simple but are violated even more simply when we accept them in principle, and that all this should be taken into account when talking about human rights that belong to everyone. Plato, Aristotle, and their contemporaries advocated for the rights of citizens, their equality before the law, and freedom of association and speech in public places, which is represented the norm of social life, but only for a short time and only for the privileged strata. In fear of change, socio-political systems produce spiritual and undignified citizens kept in subjection. Subjects, followers, and observers cannot secure the power of reason. Such power today is no longer just a condition of progress but survival. If dignified people have been desirable for the development of the human community, they are necessary for human security concepts and social equity and justice. Inequality in the US begins at birth and even earlier for those whose mothers were ill during pregnancy or without adequate prenatal care. A quarter of American children start late without any guilt, while another quarter grows up in families that earn only twice the poverty line - about $ 48,000 a year for a family of four. Science has long shown that children were growing up in poverty face more significant barriers to social development and health, which often accompany them for life. They are more likely to suffer from chronic illnesses such as asthma or hyperkinetic disorder, less finish high school, work for lower pay, and often on non-utilitarian welfare. In addition, poverty-stricken African-American teenagers are more likely to give birth to undesired.

This paper re-examines neoliberal societies' essential characteristics and dignity exposition, arguing that racial inequalities negatively impact marginalized groups within the United States (US) healthcare, education, employment, and legal process. First, the paper briefly analyzes the main features of racism as a social construction and dynamic force as profoundly influenced by political, economic, and social forces. Subsequently, the paper seeks to locate its different types in neoliberalism legislative, political, and economic institutions. Finally, it presents the significant consequences of human security conceptualization (freedom from indignity and corresponding values) and neglect of human rights in reducing this phenomenon. The racial injustice in the US represents and inaugurates a systemic culmination.

2. Research Methodology

The general scientific method of analysis, synthesis, deduction, within the theoretical and legislative discussion, and critical considerations was used in the study. The methodology follows an in-depth academic literature review and examination of a range of other sources such as primary documents relating to phenomena (NGOs, experts, institutes, media accounts, and others). By proceeding with the theoretical framework of neoliberalism's impact on inequality, the study presents racism and its relevance in health and cognate inequalities and association to human security- freedom from indignity and related subjects. As empowerment is a constitutive element of anti-racism, health inequalities insights' are analyzed within neoliberalism critique, human rights - freedom of indignity, aiming to provide more precise insights into the research gap. The aim is to form reasoning used in pursuit of understanding and knowledge, establishing arelationship between actual representations and theories.

3. Analysis

3. 1. Neoliberalism, racism, and health inequalities

Racism presents a relatively modern phenomenon that has spread with the development of capitalism. However, there are indications that specific racist ideas go deeper into history and are present in classical or ancient thinkers, e.g., Hippocrates in "Airs, Waters, Places" (5th century BC) claimed that dark-skinned people were cowards and white people were brave fighters. Contemporary problems of racial inequality in the US and beyond are primarily analyzed in terms of radical politics, economic and ideological reorganization of society that occur in the logic of neoliberal globalization. Contemporary racism and structures of inequality manifest within neoliberalism authorizations. It has severely emptied society and privatized human rights and human security. Social policy constantly opposes all forms of racism in socially relevant institutions. Racism is built into society even if it does not identify specific cases and they do not eliminate; only part of the concern is solved, not the complete mechanism of the reproduction of racism. When the US was racially segregated, elites consented to political pressure to develop and fund white-public institutions. The black civil rights movement eliminated legal barriers that prevented racial integration. In response to black civic inclusion, elite whites used the language of white-private/black-public to deregulate the Voting Rights Act and banking. It created the

privatization of neighborhoods, schools, and social welfare, creating markets around poverty. They oversaw the mass incarceration and systemic police brutality against people of color. Citizenship was recast as a privilege instead of a right. Neoliberalism results from the latest elite white strategy to maintain political and economic power. (Hohle, 2018) Moreover, some critics claim that the critical race theory advocates discriminating against white people to achieve equity. However, they mainly aim those accusations at theorists who advocate for policies that explicitly take race into account. There are many disagreements among lawyers, teachers, policymakers, and the general public about how precisely to do those things and to what extent race should be explicitly appealed to or referred to in the process. For example, in a 2007 US Supreme Court school-assignment case on whether race could be a factor in maintaining diversity in K-12 schools, Chief Justice John Roberts' opinion famously concluded: "The way to stop discrimination based on race is to stop discriminating based on race." Nevertheless, during oral arguments, then-justice Ruth Bader Ginsburg said: "It is tough for me to see how you can have a racial objective but a nonracial means to get there." All these different ideas grow out of longstanding, tenacious intellectual debates (Sawchuk, 2021).

Neoliberalism sees the state as its opponent, the state is shown as wasteful, bulky, partisan, and corrupt, while on the other, foreign private property is efficient, frugal, rational, and honorable. Of all the forms of neoliberal destruction, the effect of the long-term corporate blow on health and the environment is the most visible. In addition to providing daily evidence of the ambiguity of the main concepts, it also testifies to the incredibly biologically dangerous consequences of neoliberalism in postcolonial regions. Mainly, neoliberal strategies have been blamed for catastrophic health underfunding in Africa. The final mechanism of destruction is easy to diagnose because the countries affected by it are also the countries that, we can freely say, announce the arrival of the need to introduce the age of physiological rights. In these countries, it is not surprising that the state of non-existent health and healthcare keeps in mind decades of pressure on increasing loans, aggressive, free-market creation, destruction of public sector support for all utilities, health services, and public goods. Moreover, it challenges local autonomy, turning incentives into individually created charitable actions and programs. For the countries of other continents, the most glaring examples relate to Guatemala. (Verdugo, 2004) Meanwhile, the World Bank continues to promote its "Maximizing Finance for Development" project, which forces countries, especially in the global south, to address their development

problems, for example, in the field of health, through private financing. The World Bank and the International Monetary Fund announced that they would make emergency loans available for the COVID-19 crisis, especially in developing countries where the health system is inferior and people are particularly vulnerable. Due to accumulated debts in healthcare costs, nearly 100 million people worldwide fall into poverty each year, according to the latest report by the World Health Organization (WHO) and the World Bank. (World Bank, 2020) Some international economic organizations' activities induce the insecurity and instability emerging in the current geopolitical order. At the same time, only 0.1% of the wealthiest people in the world today have combined wealth equal to the total wealth of as many as 50% of the most inferior part of the global population, showed the latest report on global inequality, "World Inequality Report "in 2018. (Alvaredo et al., 2018) Research shows how much social factors and status have an impact on health. Social inequality has the most significant impact on health, i.e., objective and subjective criteria imply social status. Higher social status, i.e., the subjective understanding of higher social status, also means a higher level of health (Braveman and Gottlieb, 2014). The gap between the world's most affluent population, which now accounts for only 0.1% of the global population, and 50% of the world's most impoverished population, has widened dramatically and shows no signs of declining.

The US has the highest level of health care inequality, which causes even more prominent economic inequalities. Stiglitz's (2019) thesis "we must save capitalism from itself" has two meanings. First, it criticizes the right-wing populism, believing that their disastrous economic policies result in enormous enrichment for corporations that did not profit from innovation and business progress because of the exploitation and consolidation of monopolies. The second is a call to the "Western leftism," believing that they have homework to create social programs that are not just "sugar rubbish" but should "strengthen and strengthen society. The basis of the neoliberal order was privatization and deregulation. The private economy often had an advantage over the state, where there were often no funds for state hospitals and public schools. We can ask whether the neoliberal ideal of freedom is a condition in which the private owner decides everything because of neoliberalism ideologies of privatization, not markets. Inthe 19th and 20th centuries, evangelicals took the side of those on the margins of society - women, the poor, workers, people of other skin colors.

The Trump 2016 election, along with the religious right's anemic response to racism and

white supremacism, suggests that this once noble and proud tradition has gone morally and ethically insolvent. Amid the global health crisis, Trump signed a law that envisages budget cuts for the Centers for Disease Control and Prevention (CDC) by 16% and the Ministry of Health by 10&. Reducing funding like this leads to people in the US not getting tested due to high costs. According to the WHO, "knowledge of the epidemic is the first step in eliminating it." It includes tests to know where the virus is spreading and can be controlled accordingly. However, Trump is a symptom and not the cause of many of these policies. In some cases, $ 1,000 is charged for the test and even more for quarantine. That is why many people do not test and thus contribute to the spread of the virus. In addition, many working relationships in the US do not provide for the payment of sick leave, so those who earn little with flu-like symptoms cannot stay at home. People show, meanwhile, that they are not satisfied with the political rhetoric on refugees but are asking their governments to take on the task of saving human lives and jobs. After the collisions of the world crisis in 2007/2008 and COVID-19 in 2020, it is evident that neoliberalism is under severe challenges. COVID-19 demonstrates that we face an uncertain future, where the anticipation of and resilience to major shocks must become the core problem of development studies and practice. Where mainstream approaches to development have been top-down, rigid, and orientated towards narrowly-defined economic goals, post-COVID-19 development must have a radically transformative, egalitarian, and inclusive knowledge and politics at its core (Leach et al., 2021).

The COVID-19 pandemic might accelerate specific historical movements. It led to the restructuring of the world economy within the weak democracy and failed policy, marking a historic turning point in racial capitalism with racial and economic inequalities. Neoliberalism, containing distinctive racial and revanchist forms of politics, has divided people culturally, politically, and economically, manifesting itself through a pandemic of economic and racial crises. The definite point that emerged from the complexity of the pandemic and its sociopolitical impact is that black African-Americans and some other ethnic minorities in the USare at greater risk of dying from COVID-19. Racial capitalism is a fundamental cause of the racial and socioeconomic inequities within the novel coronavirus pandemic COVID-19 in the US. The overrepresentation of Black death reported in Detroit, Michigan was a case study for this argument. Racism and capitalism mutually construct harmful social conditions that fundamentally shape the COVID-19 disease. They shape multiple diseases that interact with

COVID-19 to influence poor health outcomes. They affect disease outcomes through increasing multiple risk factors for poor people of color, including racial residential segregation, homelessness, and medical bias. They shape access to flexible resources, such as medical knowledge and freedom, which can minimize both risks and the consequences of the disease. Replicate historical patterns of inequities within pandemics, despite newer intervening mechanisms that ameliorate health consequences. Moreover, interventions should address social inequality to achieve health equity across pandemics (Pirtle, 2020).

The US is considered the home of neoliberalism. In particular, the health sector has been reformed according to neoliberal standards. The "neoliberal turn" began as a reaction against the welfare state as it expanded during the New Deal and post-World War II period. Historically, after a new US healthcare regime was in place and market theory became a dominant ideology, special interest groups, such as organized medicine, began their struggle for control and influence over legislation as an advantage. Health policy circles can be seen in a rising emphasis on "moral hazard," overuse, and cost-sharing above concern with universalism and equity. It wasmanifested by the corporatization of the health maintenance organization and the rise of the "consumer-driven" healthcare movement. (Gaffney, 2015) Thus, the capitalism we have been following for the last 40 years has not served most people by putting people's dignity ahead. Hybrid and progressive capitalism is required serving society. People should not serve the economy, but the economy should serve the people. The move out of the current crisis may be a significant global rearrangement that needs some trigger. "We need a new social contract between voters and elected officials, between workers and corporations, between the rich and thepoor, and between those who have jobs and those who are actively looking for work" (Stiglitz, 2019). Liberal and conservative economic theorists have directed much of their critique at the disorder in the complex existing system. Some programs assist in money, others in kind, some are relatively easy to achieve, others are inaccessible even for people whose income is significantly below the poverty line. Administrative responsibility and funding are randomly divided between the federal, state, and local governments. Most of the expenditure for the poor isearmarked for raising their current level of spending. On the other hand, some programs are designed to enhance their ability to earn independently in the future. It includes education and in-service education programs. Federal allocations for medical care for lower-income families increased in 1997, passing a law that redistributed $ 24 billion to states over five years to insure uninsured children. States can use

this money to expand Medicaid or buy private insurance for children. In light of the advantages and disadvantages of cash transfers and in-kind transfers, we may wonder why the US opted for such large transfers in the form of medical services. Rosen (2013) believes that one explanation is egalitarianism in goods and services: the existence of a tremendous social consensus that everyone should receive essential medical services. (Rosen, 2013) Elements of paternalism may also be present. It is believed that the poor, even if there were affordable health insurance options, would lack knowledge about obtaining adequate insurance. Individuals who are entitled to financial assistance also use Medicaid. In addition, the 1996 reform of the social security system requires states to provide Medicaid and Medicare to families who are no longer entitled to cash benefits because they earn higher incomes through work. The state's goal is to reduce the implicit tax rate on the earnings of individuals leaving the welfare system. African-Americans, who comprise 13.4 % of the population, carry the impact of these healthcare challenges. Most of them have some form of health insurance coverage. However, African-Americans still experience illness and infirmity at excessively high rates and have lower life expectancy than other racial and ethnic groups. They are also one of the most economically disadvantaged demographics in this country (The Century Foundation, 2019).

High rates of racial inequality, poverty, and social exclusion are closely linked and negatively affect the right to work and adequate working conditions, a dignified life, housing and education, and participation in cultural life. The US poverty policies are reduced to obtaining food or conditioned by finding employment, which is especially difficult for many experimental groups; Congress even requires cutting vouchers. New poverty policies need to begin introducing a federal cash benefit system for low-income families with children, as is currently being done in many countries worldwide. Although the rich are often thought to bear most of the tax burden, in real life, they often find legal ("loopholes," tax breaks, "tax havens") and illegal (tax evasion, corruption) ways to reduce their taxes or were wholly freed from them. The US Internal Revenue Service estimates that it accounts for about 99% of the money issued in the name of salaries, but only about 70% of the money goes through business or investment, which also increases income inequalities. In addition, the rich find it easier to bear the usual indirect taxes that the lower classes cannot avoid because they spend their small income on necessities of life burdened by these taxes. The neoliberal economic logic on which the doctrine of supply is built and the "trickle-down" argument argue that tax relief for the wealthy is an economically correct course of action for two

reasons. The first reason is that it helps the most productive part of the population without whose engagement there would not be enough investment and economic growth, and the second is that it indirectly helps economically weaker and enterprisingsections of the population to which some material progress will drip. Everything that was theoretically conceived in reality has been implemented, as can be seen from the example of the US within the marginal tax rate on companies and capital gains. In the early 1970s, up to 70% reduced from 1978 to the present from 48 or 40 to 35%. (Wade, 2011) It was confirmed by the economists of the Congressional Budget Office in 1987 based on an analysis of a ten-year change in actual general tax rates (on personal income, social security, corporate income, and excise duties) and their impact on the formation of income classes after 1977. The families belowthe top 10% paid higher tax rates because they were disproportionately more burdened by social security, raised excise taxes, and were less exempt from income tax cuts (neoliberal doctrine generally advocates reducing tax burdens on all incomes). In contrast, wealthier families paid lower rates because there was a significant reduction in rates on property income (capital gains, annuities, and dividends). Such a new tax policy has undoubtedly contributed to rising income inequalities, and the 5% of the wealthiest Americans (especially the 1% of the richest) were its biggest winners. (Phillips, 1991) It is necessary to put the worker back in focus and give him more freedom and importance in organizations and companies. Some pioneers are trying to adapt capitalism to a more complementary system. Holacracy is a new way of running an organization that removes power from the hierarchy management and distributes it through clear roles, which can then be performed autonomously, without the head of the micro company managing. Companies like Zappos and Medium are in different stages of applying the management system. Valve Software in Seattle is going even further and allows employees to choose the projects. Employees move their desks to the most comfortable office space to collaborate with the project team. These are small steps toward a system that values the employee more than what the employee values can produce. By giving employees a more significant power in decision making, corporations will make decisions that will ensure the future of the planet and its inhabitants." (Hansen, 2016).

The US is a complex and infinitely vital country in which the demographic paradigm is balanced by assimilation and new migration. "American Dream" is an infinitely powerful ideology in which even those who have never benefited from it participate. There are fears that immigrants will take jobs, but the fear is much more significant that jobs "go" elsewhere. For

years, American production and even services have been moving to Asia, Mexico, and even Canada. Immigrants certainly harm wages as well. However, in the last few years, unemployment in the US has been deficient, and the number of illegal migrants from Mexico, for example, has been declining, so economic explanations are not enough. Moreover, Trump has fueled latent fears of newcomers, of refugees. He skillfully used vocabulary that includes terms such as "invasion," "criminals," and "terrorists," as well as some European leaders, to protect white supremacy that may be most afraid of its demographic decline and projections of losing that status in the future. The US spends more on defense than China, Saudi Arabia, Russia, the United Kingdom, France, and Japan. In 2013, infant mortality was highest in the developed world; Americans live shorter and sicker lives compared to people in any other prosperous democracy; America has the most obese people in the world; in terms of access to water and sewage is the 36th country of the world; its rate of prisoners is the highest in the world and five times higher than the OECD average; 25 % of young people live in poverty, while the OECD average is 14%; The US is 35th out of a total of 37 OECD countries in terms of poverty and inequality and has the highest Gini inequality coefficient of all Western countries, and is also 28th out of 37 OECD countries in terms of voter turnout (Alston, 2018).

There is an evident link between the ideals of neoliberalism and rising inequality rates. Moreover, neoliberal policies have contributed to rising inequality and deteriorating living conditions worldwide. Neoliberal economic doctrine sees high taxes and a generous welfare state as a threat to entrepreneurship, innovation, and economic growth. Krugman (2009) refutes such reasoning, citing the example of France, which about the US has significantly higher taxes for the upper-middle and wealthier class and rich social programs that reduce post-market inequalities in society. Although France also has a significantly lower GDP per capita than the US, France's GDP per employee is only 10% lower mainly because it employs a smaller population. The difference results from the fact that a French employee has many more days off than an American worker. Americans work 14% more hours a year than the French, among other things, because they have much shorter vacations. Nevertheless, the hourly employee productivity is slightly higher in France than in the US within all the data. So, even though the French work less and are much less employed than Americans, the difference in GDP size is more negligible than it should be according to what other economic indicators suggest. (Krugman, 2009) This example shows that people in France have greater "life satisfaction" and confirm that

the free market, the economy, and entrepreneurial creativity do not have to suffer from progressive taxes for the wealthier and the extraordinary demands of the welfare state.

Reducing citizens to consumers and states to corporations especially brings to the fore the predicament of class in American society, which, by the way, has a long history of struggle, often neglected in official representations of American identity. The same technological developments which have allowed multinational corporations and transnational financial institutions to increase their reach and mobility can be used by migrants, refugees, women, labor unions, people living with AIDs, and organizations representing marginalized communities to create transnational ties and organize for social change across borders. (Glenn, 2000) In the 1970s, a joint decline in union membership and middle-class income share in total wealth began to occur in the US, although labor productivity continued to rise, meaning that productivity growth income went exclusively to the richest. The most significant drop in workers' share of total income had occurred since the early 1980s when US President Ronald Reagan introduced neoliberal measures such as market deregulation, tax cuts, budget cuts, and attacks on unions, such as the famous attack on PACTO, a union of air traffic controllers. Tax incentives to investin practice were to subsidize the flight of capital from the unionized part of the country to the unorganized and poorly regulated part of the country, destroying the union organization in general and putting the fruits of labor productivity in the hands of capital. The US stands out from many other countries without universal health insurance coverage. Healthcare delivery (andfinancing) is fragmented across many health systems and payers and government (e.g., Medicare and Medicaid) and the private sector, creating inefficiencies and coordination problems that may be less prevalent in countries with more centralized national health systems. Healthcare inequality in the US is so high that it is the only developed country that relies on private health insurance. (Vladeck, 2003) As a result, those with corporate-sponsored plans have better accessto healthcare than those who did not. Before the Affordable Care Act, around 20% of Americans had little or no health insurance, and a significant number of people died each year because they could not afford the high cost of healthcare (The Commonwealth Fund, 2019).

People are discriminated against on more than one basis; this is called "multiple discrimination," a phenomenon that has little attention to date, particularly in healthcare. The inequalities contribute to gaps in health insurance coverage, uneven access to services, and poorer health outcomes among specific populations. The unequal coverage distribution

contributes to health disparities as medical care costs lead individuals to delay or forgo needed care (doctor visits, dental care, and medication), and debt is common among insured and uninsured individuals. (Pryor and Gurewich, 2004) A report "Austerity: The New Normal. A Renewed Washington Consensus 2010-24" reveals how some of the most commonly considered measures have been pension and social security reforms, flexibilization of labor rights, and cutting of the wage bill, reduction or elimination of subsidies, strengthening of the public-private partnership, and healthcare reforms. (Ortiz and Cummmins, 2019) These measures reduce the amount of money spent on the public sector and expand private actors' involvement in the public domain. In capitalism, private investments in public services can only make sense if a profit accumulates. The capitalism matrix is that freedom always comes from an individual's responsibility, capacity, and hard work. Inequalities are seen as a necessary part of any society, and competitiveness is encouraged at every point. However, in neoliberalism, the wealthiest 1% worldwide control twice as much as 6.9 billion people.

Differences in earnings between ethnic groups in the US are both a cause and a consequence of their more inferior position. Housing, health, and education are also linked in other ways. The African-American population often lives in areas with high levels of air pollution, where they can buy less healthy food and often eat frozen fast food. It is the main reason why they are more susceptible to chronic diseases. Across the US, people of color are exposed to more air pollution than whites from industry, vehicles, construction, and many other sources, a recent study has found. (Costley, 2021) Moreover, adult African-Americans have diabetes almost twice as often as whites. The acquired form of type 2 - present in about 95% of diabetes - usually occurs due to improper diet and occurs more often in the uneducated and poor classes. On average, poorer health is reflected in lower life expectancy: According to official data from the National Center for Health Statistics, the health of whites is better than that of African-Americans, and the average life expectancy of whites is four years longer. (National Center for Health Statistics, 2018) In the COVID-19 pandemic, disproportionately more African-Americans than whites have died due to poor health, more inadequate healthcare in their neighborhoods, or because they cannot afford not to go to work. While COVID-19 has affected everyone, the magnitude and nature of the impact have been anything but universal. Evidence to date suggests that black and Hispanic workers face much more economical and health insecurity from COVID-19 than white workers. Although the current strain of the pandemic is one that

humans have never experienced before, the disparate racial impact of the virus is deeply rooted in historic and ongoing social and economic injustices. Persistent racial disparities in health status, access to health care, wealth, employment, wages, housing, income, and poverty all contribute to greater susceptibility to the virus—both economically and physically. (Gould and Wilson, 200) As an economic ideology of capitalism, neoliberalism has depleted public services, turned education and healthcare into profit-driven businesses, acquired profits at the expense of undervalued and underpaid workers, favored profitability of a militarized world over human security and well-being, and aggravated inequalities between people and countries.

The COVID-19 pandemic has revealed a subtle unbreakable bond, between race and capitalism paradigm, particularly in the US, where the racially colored nature of its spread and influence has made the routine brutality of American racism suddenly unbearable. Nevertheless, responses to the mass inequalities exposed by the current crisis all too often focus on a narrow issue - neoliberalism - rather than looking for their deeper roots. Noam Chomsky or Naomi Klein, or countless progressive international NGOs, blamed neoliberalism in academia, hoping that the pandemic would end the neoliberal order and neoliberalism. However, the focus on neoliberal reality is mislocated, as the current system is simply the latest repetition of the 500- year-old matrix of forces that continues to shape the modern world today. However, neoliberalism and racism as the associated phenomena must be treated at the root, not only current- pandemic circumstances. Achille Mbembe was the first to describe the role of extreme violence in the functioning of major biopolitical orders as "necropolitics" - not only the "right" ofthe state to kill and organize people to be killed (instead of living) but also to expose them to extreme violence and death, and reduces entire segments of the population to the most straightforward and most dangerous existence. (Mbembe, 2019) Of course, all this is to preserve the capitalist system's established economic and political hierarchies. Moreover, the inherently criminal dynamics of modern governance in the capitalist system rests on a relationship of dependence between rulers and subjects. Those in power both (protect) and at the same time exploit their clients. (Horkheimer and Adorno, 2002)

3.2. Racism and cognate inequities

It should be noted that, although racism is rooted in common attitudes, values , and beliefs, it can occur regardless of the intentions of the individual performing the activities of the institution.

Institutional racism has two primary forms: direct and indirect institutional discrimination. The first form involves the open actions of the dominant group concerning oppressed racial groups, and the exclusion of the oppressed group from well-paid jobs can be cited as an example. Another form of institutional discrimination is more latent, such as when local tax bases in publicschools are lower for the dominant class when students of different colors or members of different national minorities receive a disproportionately more modest education. (Feagin and Feagin, 2003) Continued discrimination against African-Americans is the main reason for the mass protests in the US that followed the assassination of George Floyd. There is the perception of the African-American population as a threat, criminals. It conditions racial attacks, blaming the victim for the violence happening to her. Furthermore, such lives taken are not regrettable, and they belong to a growing number of those whose lives are not valuable enough to be preserved. Nevertheless, centuries of discrimination have not been overcome. Persistent racial inequality in employment, housing, and a wide range of other social domains has renewed interest in the possible role of discrimination. Nevertheless, unlike in the pre-civil rights era, when racial prejudice and discrimination were overt and widespread, today, discrimination is lessreadily identifiable, posing problems for social scientific conceptualization and measurement. (Pager and Shepherd, 2008) Since the Civil Rights Act in 1964, African-Americans have been equated with whites, and "racial segregation" has become illegal. The protests are not just a reaction to his murder but centuries of systematic racial discrimination and state violence. African-Americans are not only the primary targets of law enforcement violence, from Rodney King to Breonne Taylor, but they are also targets of draconian laws. As Michelle Alexander explained in the book, "The New Jim Crow," the function of today's mass penal system, which holds more than two million Americans behind bars, is similar to that of segregation laws (Alexander, 2012).

Scholars who study critical race theory in education look at how policies and practices in K-12 education contribute to persistent racial inequalities in education and advocate for ways to change them. Among the topics they have studied: are racially segregated schools, the underfunding of majority-Black and Latino school districts, disproportionate disciplining of Black students, barriers to gifted programs and selective-admission high schools, and curricula that reinforce racist ideas. Critical race theory is not a synonym for culturally relevant teaching, which emerged in the 1990s. This teaching approach affirms students' ethnic and racial

backgrounds and is intellectually rigorous. Nevertheless, it is related in that one of its aims is to help students identify and critique the causes of social inequality in their own lives. To one degree or another, many educators support culturally relevant teaching and other strategies to make schools feel safe and supportive for Black students and other underserved populations. (Students of color make up the majority of school-aged children.) However, they do not necessarily identify these activities as critical race theory-related. An emerging subtext among some critics is that curricular excellence cannot coexist alongside culturally responsive teaching or antiracist work. Their argument goes that efforts to change grading practices or make the curriculum less Eurocentric will ultimately harm Black students or hold them to a less high standard. As with the critical race theory in general, its popular representation in schools has been far less nuanced. A recent poll by the advocacy group Parents Defending Education claimed some schools were teaching that "white people are inherently privileged, while Black and other people of color are inherently oppressed and victimized"; that "achieving racial justice and equality between racial groups requires discriminating against people based on their whiteness"; and that "the US was founded on racism." Thus, much of the current debate appears to spring not from academic texts but from fear among critics that predominantly white students will be exposed to supposedly damaging or self-demoralizing ideas (Sawchuk, 2021).

Rosa Parks and Martin Luther King Jr. repealed segregation laws; US politicians activated alternative segregation mechanisms. Law enforcement violence is part of a phenomenon that social scientists define as the US penal exceptionalism or that the US has the strictest penal system of all liberal democracies. It can serve as a key to understanding systemic racism and the production of racial inequality. One example is drug possession. While there are no significant differences between white and African-Americans regarding drug use, there are many more of the latter due to the crimes related to their use in prisons. In other words, it is expected that for the same crime for which a white man in the US will almost certainly not end up in prison, an African-American will almost certainly want to. Draconian prison sentences and racial inequalities in their application are only part of the punishment. Additional punishment comes in the form of literally thousands of so-called collateral consequences for people who have been in prison, from permanent deprivation of voting rights to restrictions on the type of jobs they are entitled to perform, such as truck drivers. At the same time, this system of perpetuated punishment, both inside and outside the prison, has criminogenic effects. If someone

is deprived of legal work possibility, they will be forced to work outside or on the edge of the law. Most former prisoners come from poverty and can often only be employed doing manual jobs to which they are suddenly no longer entitled. However, it is essential to provide information to the public that challenges racial stereotypes. Social workers need to continue to bring awareness to the devastating consequences of stereotypes and their impact on laws and policies that perpetuate race disparities in education and employment outcomes and arrests and sentencing in the judicial system (Taylor et al., 2019).

The "stop and frisk" practice has been declared unconstitutional, although law enforcement continues to behave similarly due to the power provided by law enforcement unions and the considerable share in city budgets. About $11 billion from the City's budget is allocated to law enforcement in New York City alone. (City Budget Commission, 2020) By comparison, these amounts are significantly higher than those for public health and housing. Wadsworth's publicly reported budget has shrunk by 40%, from $129 million in 2011 to $78 million in 2021. The tax-funded staffing has plunged 67%, from 620 to 205 full-time equivalents. Simultaneously, the Center for Community Health, whose responsibility includes monitoring infectious diseases, saw its publicly reported budget increase just 5%, about one-third, and its state-funded staffing drop 19%, from 617 to 499 full-time equivalents. Furthermore, the Office for Primary Care and Health Systems Management, whose purposes incorporate inspecting nursing homes, provided a 35% reduction in its publicly reported budget and 43% loss of state-supported organizations. (Hammond, 2021). At the same time, as the crime rate has been falling for years, law enforcement budgets continue to rise.

Many programs of the initiative called "Affirmative Action" should compensate for the shortcomings of the African-American population, such as reserving places for study. However, to date, the white majority population in the US is more affluent, more educated, and healthier. Over the past ten years, the "median" earnings (a median that more accurately reflects the actual situation than the average) of the African-American population in the US have been 20 to 25% lower than whites, not because there are super-wealthy like multi-billionaire Bill Gates or Jeff Bezos. The so-called median income shows how many households are above or below the average income level. (Hinrichs, 2020) Fifty % fewer African-Americans, whose parents are at the bottom fifth of the scale in earnings, manage to move into a higher-income group than white children.

When the government introduced social security in 1935, it exempted agricultural workers, servants, and occasional employees. These were all low-income occupations in which African-Americans were disproportionately represented. "Up to two-thirds of personal bankruptcies in the US are due to healthcare costs, and African-Americans are affected more than whites." (Ndugga and Artiga, 2021) The situation is similar in the educational system. A preferred theory is that much of the poverty in the US is due to insufficient education. It is argued that with more and better education, individuals would earn more money and be less likely to end up in poverty. Have educational programs removed the differences in the education of poor children and those from middle-class families? As usual, the attempt to answer that question is hampered by the fact that the choice for these programs is not accidental. These programs seek to achieve the idea that the state should create opportunities to develop the knowledge and skills required in the labor market. The bottom line is that the quality of schooling in African-American neighborhoods is significantly worse than that of whites. Therefore, the chances of African-Americans in the labor market are lower. The fact is that with the growth of income inequality, the number of the poor can also increase. It was officially determined that in 1979, 24 million Americans lived in poverty. That number had risen to 32 million by 1988, to reach 43.6 million people in 2010 (Engdahl, 2011).

Racial positional inferiority and differences in wages between African-Americans and whites in the US are both a cause and a consequence of housing, health, and education issues. For example, the African-American population often lives in zones with increased pollution levels, less nutritious food, consuming frozen fast food. It is the principal cause of chronic diseases. The most recent study reveals that the disproportionate numbers of non-white people were exposed to potentially hazardous fine particle pollution from nearly all primary US emission sources, regardless of where they live or how much money they make. Researchers found that Black, Hispanic and Asian people were exposed to higher than average levels of fine particle pollution, while white people were subjected to lower than average levels. "It does not matter how poor, it does not matter how wealthy, the racial disparities exist for all African-Americans and other people of color, " stated Paul Mohai, a professor of environmental justice atthe University of Michigan. He researched racial disparities in the distribution of hazardous waste dumps, industrial facilities, and air pollution at schools — and why and how these disparities exist (Costley, 2021).

3.3. Human rights, human security, and freedom from indignity

The inherent dignity and equality of human beings are fundamental principles of the Universal Declaration of Human Rights, the American Declaration of the Rights and Duties of Man, the American Convention on Human Rights, and the International Convention on the Elimination of All Forms Racial Discrimination. The International Convention on the Elimination of All Forms of Racial Discrimination was adopted in the 1965 and entered into force in 1969. It remains the principal international human rights instrument defining and prohibiting racial discrimination in all sectors of private and public life. However, emphasizing that modern human rights treaties are not formal multilateral treaties and are subject to a different legal order that features regimes of collective enforcement highlights the possibility of new pathways for human rights enforcement. Additionally, the inter-State complaint mechanism authorized under articles 11 to 13 of the Convention will focus on future efforts to address previously intractable failures of States to fulfill their obligations under the Convention. (McDougall, 2021) Contemporary racism has severely emptied society and privatized human rights and human security. The paths to the human security paradigm of freedom from indignity, commencing social justice and equity, are positively determined. However, there are many extended adverse determinations. Even today, as a rule, the world exercises senselessly, guided by the will of others, lacks social justice, and within the crowd identity. These forces are so strong that they are often subject to people who have even managed to reach the correct issues and, once, know how to live with dignity. It is enough to pay attention to racism and nationalism in order for that to become evident. Thomas Franck (1999) argued that "nationalism is in retreat" and that, in its place, "individualism" had emerged. (Franck, 1999) However, twenty years later, we can raise the vital question about the strength of nationalism and self-determination to individuality in a global world. Fortunately, the nation and race become an invincible stronghold of the disputed individual. It is the one to provide the endangered individual with a more or less calming framework of existence. Above it, of course, is the value and meaning of individual life, which is to say: justice. When this, the highest possibility of confirmation is disabled, individuals, in bad times, begin to remember that they belong to certain ethnoreligious, national groups and racial groups. If we thoughtlessly accept the expression "all lives matter," we can overlook that the African-American population is not

included in the idea of all lives. Therefore the truth is that all lives are meaningful. However, to achieve that all lives are significant, we must put in the forefront whose life is not worth it today; we must mark that exclusion and fight it.

Achieving that all lives are meaningful is a long process. The divisive othering and attribution of responsibility that stem from a crisis can increase the likelihood of intrastate political conflict but not necessarily lead towards interstate violence. Splitting populations into "us" and "them" categories is central to nationalism. As Fredrik Barth (1969) points out concerning ethnic identity, it is through contact with "others" that we construct a sense of "our" group. Unfortunately, this othering tends also to entail a moralizing process that glorifies "us" and vilifies "them." Therein lies the rub: at times of crisis, this tendency can propel ethnic and national conflict because it creates a logic that rationalizes violent or discriminatory practices against perceived malign or corrupted "others." It is because nationalism provides a cultural roadmap for attributing responsibility for a crisis, in the sense that it is typically the vilified "others" that shoulder the blame. (Woods et al., 2020)

A critical race theory within the legal history and doctrinal development of race and racism in international law must identify law's historical preference for framing legal protections around the concept of racial discrimination. Ana Bradley advances a long-overdue claim: racism should be affirmatively and explicitly recognized as a human rights violation under international law. She argues that addressing racism in the world today requires understanding how racial ideologies violate human rights in addition to discriminatory acts. Insights from neuroscience about racial bias deepen these understandings. By naming "human rights racism" as the central challenge, she calls upon the international community to affirmatively recognize racism's extensive harm and to take it more seriously its eradication. (Bradley, 2019) Moreover, high rates of racial inequality, poverty, and social exclusion in the US are closely linked and negatively affect the right to work and adequate working conditions, a dignified life, housing andeducation, and participation in cultural life. Empowerment is also a social process because it does not exist in isolation and continually occurs with other social processes. Although empowerment is believed to be one of the main instruments for achieving equality and justice, discussions on the correctness of empowerment of people, groups, and communities are divided. On the one hand, some think how differences are rooted in society and how a subordinate position is natural and unquestionable and that empowering vulnerable groups endangers non- members of these groups,

while on the other hand, it is seen as a positive contributing process fair and democratic society (Bilinovic and Skoric, 2015).

Explaining what human security is and why one of these exercises is essential. The mortification of people within a critical security framework and the human rights paradigm is a specific form of aggression. Human security means protecting fundamental freedoms - the essence of life and protecting people from critical (severe) and pervasive (widespread) threats and situations. Because of the connections between poverty and insecurity, poverty is tackled to determine how peace can be maintained in conflict and fragile countries. The first sentence of the preamble to the UN Universal Declaration of Human Rights speaks of innate dignity, and Article 1 begins: "All human beings are born free and equal in dignity and rights." If this is true, then the very moment of birth is also the first moment of the beginning of the loss of dignity and rights. Biology explained why a newborn human being cries, as the first sound, to the environment in which he arrived. Nevertheless, this fact does not lack symbolic value either. The new man is male or female, white or colored, rich or poor, believer or atheist, conservative or radical. He was born at some point in history, under certain circumstances, in a particular family, nation, political system. All these circumstances determine his future and the hereditary traits he carries within himself. These same circumstances will, through the mechanisms of socialization, affect whether a man, born free, will be accessible when he grows up; whether at all his memory of that one moment of freedom will be strong enough, insufficiently destroyed by upbringing and education, that he may - now creating himself - become and remain consciously free and genuinely dignified.

Human security should be essential not as a tool for research and analysis but as a signifier of (standard) political and moral value. The US government ignored the acceptance that economic and social rights are human rights, perceiving American society as "resourceful, enterprising patriots, engines of economic success" and poor as "wasteful, loser" and welfare money as wasted. Freedom from indignity should promote improved quality of life and enhance human welfare, permitting people to make choices and seek opportunities that empower them. Over the centuries, individuals have sought to formulate human dignity and human rights. Few have even tried to live up to this knowledge, regularly paying a high price for their boldness and consistency. In some epochs, their voices were few and weak, while in others, they reached far, but never far enough to grow from solid words into the rules of life of any society. Their works simultaneously

challenge contemporaries and the link between the past and the future. They are aservice to humanity, no matter how valued. Prometheus is the best example of human dignity and defiance. He does not yield to force, even when it uses the authority of an almighty god. Thomas Aquinas developed the concept of human dignity by setting it as a moral constraint on political power. One could, further, enumerate a whole series of thinkers, up to Kant and later, who, seeking truth and universal values, necessarily reached the realm of human rights. Nevertheless, the history of such individual searches is still inconsistent with political history, i.e., with the accurate functioning of human communities in which people's real lives occur. Because humanistic ideas live in one dimension, while people are still forced to live in another,in which the right to power is superior to the principle of justice, and justice is an ideal which, although formulated in books and even present in-laws, does not easily reach a particularindividual specific circumstances.

The dignity of the free man is active, creative; it is the precondition and basis for the progress of human society. Such an attitude towards oneself, others, and life require effort, thinking, and acting. It implies the risks that accompany every crossing of some known border. Staying within the boundaries is more painless; it gives security and protection in the familiar world. Unused human energy can then be directed in very negative directions of aggression, delegating the African-American assumed violent behavior. It is essential to provide people with information that challenges stereotypes. Because the media's portrayal of African-Americans has been conducive to forming stereotypes, interventions in media space are required. Social workers must also advocate for changes at the state and federal level to mandate that cultural competency training is implemented in all state and federal agencies to increase individuals' awareness and knowledge of other cultures that enhance their effectiveness in working with culturally diverse populations. (Taylor et al., 2019) It is unfortunate but still necessary to repeat universal values such as dignity and justice – critical human security.

4. Conclusions and Recommendations

The unfortunate results have shown that the most developed nations have not reached the highest degree of equality. Similar inquiries might promptly open in other Western countries considering the colonial history repression framework. Race stationed socioeconomic circumstances must not affect the primary healthcare mechanisms. Socioeconomic inequalities at

the national and supranational levels are constantly growing. Therefore, critical perspectives regarding the redistribution of social wealth are needed. The right to health is a fundamental precondition for achieving freedom from indignity contributing to non-violent behavior, legalism, and community improvement. Health, socioeconomic, legal, and other inequalities of African-Americans constitute a significant challenge for US health policy because they represent social injustice and resolve health issues of underprivileged groups that may affect the population's health status as a whole. The discrimination and unequal access to healthcare, education, and employment construct a paradoxical paradigm - the affluent US society contains disputable human security, welfare, and general prosperity. Health inequality can be interpreted as a measure, an indicator of insecurity. Racial inequality in health and cognate inequities can not be transformed unless the power of neoliberalism is simultaneously contested. Maintaining the most suitable state of healthis one of the fundamental rights of every human being. The inability to achieve the same living conditions and equal opportunities constitutes inequality in health. It refers to the unavailability of all resources that enable us to achieve a lifestyle that enables realizing the full potential of health for the individual and freedom of indignity conceptual paradigm. It also refers to the unavailability of information through education and even the unavailability of an identification model. The consolidation of wealth and power in one society could be ground for racial and other exclusivist discourses, and the improper system of governance and, ultimately, society become. With an ideal approach to skepticism and confusion regarding critical race theory, the legal history, doctrinal race development, and the International Convention on Racial Discrimination, a contemporary racial foundation needs to be developed, reaffirmed, improved, and protected to incorporate the democratic content of the US's principles of legal equality. Ethnic sensitivity, empowerment, and cultural competence should constitute anti-racism tools of liberation policies to constitute a dignified culture of equality and equity. Nevertheless, unfortunately, institutional racism, whether implicit or explicit, is often unnoticed or disregarded.Besides government, professionals who work with ethnic or racial minorities can empower these groups to counteract the negative notions formed through a long history of discrimination.

The phenomenon's roots and current issues lie in the realization of neoliberalism and capitalism, the morphology of the nation-state, and the generative order of colonialism. Neoliberalism increases health, cognate inequalities, and neoliberalism policies reduce human

security and deteriorating living conditions. The moral criterion and compulsory economic logic of direct financial benefits associated with poverty policies require considerable determination. It will require hard effort to implement systemic reforms and correct the functioning of institutions. A rational approach to assessing the social welfare system examines its impact on poverty, racial discrimination, and rates. This impact is significant. The causes of good health far exceed the quality of healthcare. It includes several socioeconomic factors that are interrelated. The COVID-19 pandemic consequence opens up ground, a rationale, for a neoliberal reversal within the alternative hybrid order. COVID-19 has confirmed long-standing structural variations pointing out inadequate policies, budget discrepancies, jeopardizing human security conceptualization. COVID-19 has a disproportionate impact on racialized communities in the US.

Adaptation to conventionality is not how a human being can develop all potentials, advance society, and live with dignity. If a man agrees to the status quo, conceding that the opportunity still exists, he consumes himself; others have frequently marginalized those who do not comprehend. The human security concept requires a comprehensive approach to diverse factors, such as the racial paradigm. Our goal should be to change the unjust world, not adapt to it. One of the central paths that should finally be rejected is the xenophobic path of irrational intolerance and distrust. The anti-xenophobic path of rational dogmatism rejection should reside within the fence of critical aspects of human security. It is a course to converge considerably more attention on raising human awareness and promoting equality to prevent more significant social unrest and extinguish the people's racial segmentation. Global democracy is in crisis, and democratic principles are under question. While neoliberalism ruled, the ideological framework was accepted by many economists. After all, it is lost the expected freedom proponents of neoliberalism promised. Rationalization and poor governance exhibit inequalities and distribution coverage within the neoliberal health sector. The COVID-19 has exposed the adverse effects of a system that has dominated every aspect of US society. Recognition of the neoliberalism misplacement is apparent; the market system de facto more issues generated than resolute. Contemporary liberal forces must set the policy fundamentally differently within an economic system, with adequate crisis management, that will not consider merging on a small percentage of the population but everyone. The solution is the so-called Scandinavian system, where states let capitalism operate in free-market conditions. However, tax systems and better

citizens' awareness provide social protection to all individuals who cannot participate in the labor market for various reasons. Historical experience declares that all socialist systems are designed to overcome injustice.

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HEALTH AND SAFETY-RELATED ISSUES AT LAKE BOSOMETWE, GHANA

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Abstract

Health and safety matters in attraction sites are some of the crucial aspects of tourism keeping the industry alive. Considering this, the study has explored the health and safety concerns at Lake Bosometwe in Ghana, and ways to deal with them due to the shortage of evidence-based empirical studies in the field. The study made use of exploratory research design; primary data (qualitative) from 387 responses were analysed in percentages and frequencies on tables and charts. The qualitative data was analysed through open content analysis. From the results, major health and safety issues associated with the site were cholera, skin diseases and headache. They were attributed to low cleaning practices like inadequate sewage disposals. Others were robbery, theft (due to inadequate security systems) and road accidents (due to the poor road system and carelessness of some drivers). The study recommends that there should be a provision of good road and security systems, health/clinic facilities, health and security policy programmes and intensive education to all stakeholders to contribute to healthy and secured tourism at the site.

Keywords: Tourism, Health, Safety and security, Lake Bosomtwe, Ghana

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Introduction

The safety and wellbeing of tourists are critical features of tourism. According to the West Virginia Bureau for Public Health (WVBPH, 2012) health and safety help to create a safe and secure atmosphere for people. Thus, providing a safer condition for successful tourism development. Although, it is widely accepted that somehow, tourism promotes the health of people from their stressful everyday work and boredom and an opportunity for people to engage in health-related activities like sports, spas, health tourism among others. However, these aspects of tourism have turned out to be otherwise in some parts of the world, especially in developing countries like Ghana especially, Lake Bosomtwe (Joy, 2018). This happens as a result of the inadequate security at these tourist destinations. That is not to say that there are inadequate safety systems to fully protect tourists in the country. Even in the so-called developed world like Europe such cases exist. As rightly put by Bauer et al. (2001), the overall injury mortality of non-domestic tourists was found to range between 130 and 200 fatalities per 100.000 person-years of exposure, with a mid-point estimate of 170 in Europe. Therefore, inadequate safety in tourism is almost a global issue.

Security and health issues have a significant detrimental impact on tourism (Novelli et al., 2018). This notion and the devastating terrorist attack on September 11th, have increased the research on health, safety and security at tourist destinations (Koravi & Zimanyi, 2011). For example, current studies such as Ji et al. (2021), Islam et al. (2020), Tuclea et al. (2020) and Hindley & Marmion (2019). In Croatia, Gotova (2007) also studied what effective tourist destination management should be like by highlighting security as a critical aspect in developing safe tourism to assure people's wellbeing through a multifaceted structure such as security and health services. Moreover, studies like Dosoo et al. (2020) Hindley et al. (2019) and Boakye (2012) as well have discussed similar subject matter.

However, despite the increasing studies, none has focused on evidence-based research on health, safety and security problems related to a particular tourist destination as a guide for relevant tourism stakeholders and management to better understand the narrative of insecurity and danger in the tourism sector. Based on this, the study has conducted an in-depth study on some common health and safety problems at Lake Bosomtwe, a popular lake in the second biggest city in Ghana, Kumasi. The study aimed to produce knowledge on key elements including the level of health and safety and the measures to help reduce safety risks and insecurity at the site. In this regard, the study sought to find answers to questions like:

(i) What are the key health and safety issues at Lake Bosomtwe?

(ii) What are the existing health and safety measures at Lake Bosomtwe?

(iii) What methods should be employed at Lake Bosomtwe to reduce health and safety issues?

1. Background

1.1 *The relationship among health, safety and tourism*

Tourism and health and safety of tourists have a symbiotic relationship. This is due to the current goal of tourism, which is to meet the health and safety needs of visitors aside from the tourism services they have paid for (Wall & Mathieson, 2006). Based on this Renata (2007) stressed the need for a concentrated effort with a clear aim in mind to safeguard tourists while also advancing tourism goals for the benefit of both the guest and the host. The comprehensive account from the author makes it clear that if the safety of relevant stakeholders in the tourism industry especially, tourists and indigenes are not assured, the prime goal of the UNWTO which seeks to 'commit tourism to peace, understanding, wellbeing and prosperity throughout the world" will be a standstill (McIntosh et al., 1995). On this note, Brenner (2017) suggests the need to promote secure tourism that will make a community a destination rather than insecure residential areas. Khajuria & Khanna (2014) corroborates that the concern for tourist wellbeing and security are essential part of travel and tourism.

The significant interrelationship between travel, tourism and health is not underestimated because they work together to achieve the overall tourist experience (Hindley & Marmion, 2019). For instance, tourism supports the health and wellbeing of a country by tactically reinvesting into its health-related services United Nations World Tourism Organization (UNWTO, 2015). Good health also promotes and protects people and the communities where they live, learn, work and play as indicated by the American Public Health Association (APHA, 2021). Binns et al. (2015) added that good health' helps to fight diseases to improve man's healthiness. The authors argue that even just an idea of disease is life-threatening to the thinker, whether he/she has experienced it or not. In the same case, the assumption of insecurity at a tourist destination is a threat to tourists' health and wellbeing.

The lack of proper health and security guarantee has posed a challenge to the tourism business. This element has been identified as one of the five forces generating changes in the global tourism sector in the past to date (Breda & Cost, 2005). These forces including wrongdoing, fear-

based oppression, sustenance security, medical problems and disastrous events as mentioned by the authors are forcing reform in the travel industry, making tourism security a major worry for travellers. They make tourists view destinations with two eyes, thus, viewing the positive and negative sides of a destination before a final decision is established. Pizam & Mansfeld (2006) likewise recognized four kinds of security occurrences noted to have negatively impacted the travel industry and tourists' satisfaction. These are psychological warfare, crime, war and political disorder (Poku, 2016). The author argues that these occurrences limit the expectations that are formed by tourists before, during and after their visits. Hampering future travel decisions due to the break of the relation between the tourist and the industry.

1.2 *Health and safety hazards in tourism*

The health conditions at tourism destination centres on supportive amenities, health products and services, sanitation, food safety, customer services, weather condition, local behaviour and other activities that directly affect tourists. Goodrich (1987, p. 217) described health in tourism as "the attempt regarding a tourist facility to pull in visitors by deliberately developing its health care services and infrastructure. This means that health in tourism focuses on the totality of people's wellbeing, prosperity and guidance on behaviour, not only the corrective action of sicknesses or treatment of illness. The health and safety hazards of tourists include tourist encounters with robbery, food insecurity, medical problems, disease and catastrophic events and other perceived abnormalities during tourist visits. Nwokorie (2014) posits that the concern for safety and security has become of higher importance over the last two decades in the global tourism space because of the emerging hazards in the industry.

Security hazards of tourists result in the terrible reputation of the destination in question, creating a negative picture in the minds of the existing and potential guests (Goeldner & Ritchie, 2002). Some tourist sites are becoming more associated with security risks such as pickpockets and criminals, hunting foreigners. For instance, in places like Beijing, Shanghai, and the shopping locale of Shenzhen, foreigner attacks and burglary are common occurrences in popular bars and clubs (Breda & Costa, 2005). Similarly, Boakye (2012) added that despite the fact that Ghana is known as a safe tourist destination, crime is on the rise. Consequently, creating a high degree of negative effects in the country's tourism sector.

It is important to know that tagging a single tourist destination with insecurity may leave a poor remark for a nation. According to Ritchie et al. (2017), the tourism sector has suffered in recent years as a result of the creation of an unpleasant environment for visitors' well-being, both real and imagined. This is because, through modern technologies, potential tourists after a bad remark of a place assume the same for other destinations which may be doing well with respect to tourists' safety. These and other safety concerns have prompted a growing desire to promote health and safety as a discipline, societal commitment and a goal especially, in the global tourism space.

1.3 *Methods of ensuring health and safety at tourist destinations*

Mostly, a bad image is formed after a tourist's encounter with a destination's environment. This is because, a destination's environment provides room for criminal and bad behavior (Lu et al., 2018). Meanwhile, the UNWTO (2017) suggests that destinations should reasonably develop more conspicuous wellbeing and prosperity while strengthening general health services and reducing imbalances. Considering this, a destination's environment can be modified to assure security and safety when tourism stakeholders work together towards a change in both assumed and identified health and security issues of a destination (Turker et al., 2016; Amira, 2015).

The study Peng & Wu (2017) aimed to analyze the tourism security in Jiangxi Province established the theme "Prevention first, safety first". The authors further explained that integration is key therefore, all tourism practitioners such as tour operators, trainers, local tourism authorities and other stakeholders, should establish a high grade to regulate emergencies and occurrences of tourism insecurities to build a sturdy barrier that will safeguard visitors and host communities. This means that the method of ensuring responsible (sustainable) tourism will improve the lives of locals and tourists (Mathew & Sreejesh, 2017; Goodwin, 2011). However, Mihalic (2016) argues that responsible tourism is not a replacement for sustainable tourism. From the author, there should be a need (a set of fundamental needs for all tourism facilities, regardless of service type or destinations) to protect all facets of the tourism industry to make its development a success.

Generally, a destination can improve its health and safety through effective communication of regulations at the site. The United Nations World Tourism Organization (UNWTO, 2017) recommends actions for tourism health and safety to be initiated to designate appropriate health services for tourists. This entails providing tourists with information about services and how such

activities or services should be carried out. Providing information helps to promote awareness of risk prevention and local customs among tourists to improve tourist-locals relationships (Andrews, 2016).

1.4. Theoretical Background

The Health Belief Model (HBM) by Becker & Maiman (1975) is useful in predicting public perceptions, attitudes and behaviours related to health. It takes into account the socio-behavioural determinants of health and security compliance. According to the model, the chance of performing health-related preventive actions will be determined by perceived dangers, insecurity and disease and the anticipated advantages of such preventive actions. This means that people's attitudes about health and security issues and their perceptions of the benefits of taking action to avoid them are said to impact their willingness to act, according to the model.

The Securitization Theory (ST) sheds insight on the ideas established in the HBM. The Securitization theory adds that the evaluation of people especially tourists is determined by many variables including individual perception and beliefs as stated in the Health Belief Model. Specifically, when it comes to security, there are three key categories, according to ST. These include security challenges, the actions needed and their repercussions (Wæver, 1995). This means that there are insecurity situations in tourist destinations that step into the smooth operation of tourist activities. Consequently, this causes the development of a system of action following the identification of danger or threat. With danger involving man, the Commission of Human Security (CHS, 2003) argues that such actions should focus on man’s liberties, satisfaction and the protection of life, particularly from crime.

Considering this, safety and security at tourist destinations that are threatened by crimes are issues mostly discussed with two theoretical approaches: the economic theory of crime (ETC) and the routine activity theory (RAT). The economic theory of crime helps to understand how insecurity and criminal activities continue to occur in tourism destinations. The theory states that the act of crime will continue to happen when people believe that the gains, they will make from criminal activities are higher than that of investing their resources like money and time (Becker 1968). Boakye (2012) agrees with the theory and adds that criminals are reasonable ‘decision-makers’ by weighing the profits (material resources) and cost (punishment) of their activities before a final decision is made.

He continued that criminal activity increases when tourists (victims) numbers increase in tourist destinations. Similarly, the routine activity theory also states that the more and more victims become available with fewer preventive systems like regulation and security systems (police) criminals are motivated to commit crimes. From the theory, in such cases, criminal activities will continue to become a routine (Cohen & Felson, 1979).

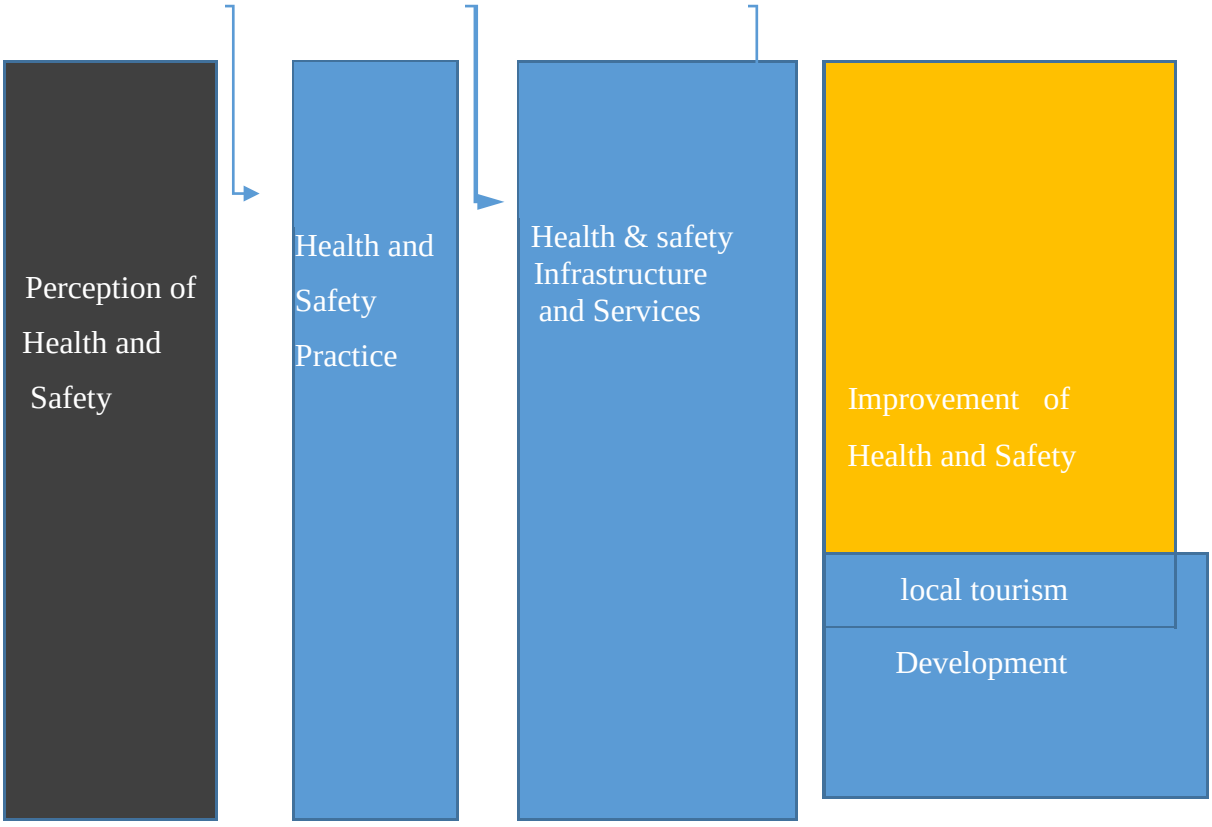
The ideas and arguments made in BHM give a clear view on tourist health, safety and security and the actions. that are likely to be taken when people perceive health and security issues. The other theories - ST, ETC and RAT have also provided a comprehensive account which is not far from the idea that when causal insecurity variables including crimes, rape, theft, robbery and perceived health problems are noticed by tourists will develop negative assumptions about a particular tourist destination. This is because a crime like assaults will put the health of tourists and host communities in danger (Akadiri et al., 2020). Consequently, tourism demand, motivation to travel, host community and repeat visits are at risk. This study on this note adds and concludes that an increased rate of insecurity like criminalities against tourists may cause a decrease in tourist visits, local investments and the overall tourism development of a tourist destination. Thus, if tourists continue to perceive or experience threats and health issues at a tourist destination, will not only affects their activities but also, repeat visit and the entire tourism industry.

Taken together, the comprehensive ideas mounted in BHM and other supportive theories like the ST, ETC and RAT have paved the way for this study to explore tourist health and safety issues that may hinder local tourism development and economic resilience at Lake Bosomtwe.

The conceptual framework adopted for the study was inspired by Partnership for African Social & Governance Research (PASGR, 2013) on its study 'Political economy of universal social protection policy uptake in Africa'. This framework provides an in-depth understanding of the application of developmental programmes. It emphasizes that with the availability of ideas, institutions and actors combined, an impact is achieved. From the framework, risk perception activates social policies to support security and growth.

Based on this, the study agrees that tourists' perception of health and safety risks involves many evaluations including subjective feelings, objective evaluation and awareness of potential negative outcomes. Specifically, the subjective feelings encompass the physical and psychological

elements of the risk. The objective factors focus on the economic, equipment, social, time and opportunities such risks may affect (Cui et al., 2016). Considering this, the framework states that an evaluation of risk develops health and safety consciousness and the right system to deal with them. As a result, tourists and locals' comfort and wellbeing will be ensured (Hamarneh & Jeřábek, 2018; Okan, 2010).



Source: Adapted from PASGR PEA framework, 2013

Figure 1: Conceptual Framework adapted from ''Political Economy Analysis Framework'' cited in De-Graft Aikins et al. (2016)

In summary, the framework of this study states that when security and health risks are identified by a tourist destination, it develops infrastructure and institutions to improve such destination's security and wellbeing status. In light of this, the study utilised the conceptual framework in three ways; (1) to identify the right health and safety measures to improve the health and safety of Lake Bosomtwe, (2) to guide and inform stakeholders to address dangers associated with the site to help promote tourism

at the site and (3) to usher relevant stakeholders to institutionalize a framework that will safeguard tourists' and locals' health and safety at the lake. Subsequently, this will help in the application of the 'Social Protection Floor' by the United Nations Development Group, which focuses on the need for industries to provide equal and universal access to essential services like health, education and sanitation (UNDG, 2010).

2. METHODOLOGY

2.1 *STUDY AREA*

The study was conducted at Abono, a town located inside the Bosomtwe district in the Ashanti region of Ghana, specifically, at Lake Bosomtwe. The study area was selected for the study mainly because of high tourist receipts to the site and its recognition as the only closed (endorheic) lake in Ghana and Africa, and the third-largest closed lake in the world (Amu-Mensah et al., 2019).

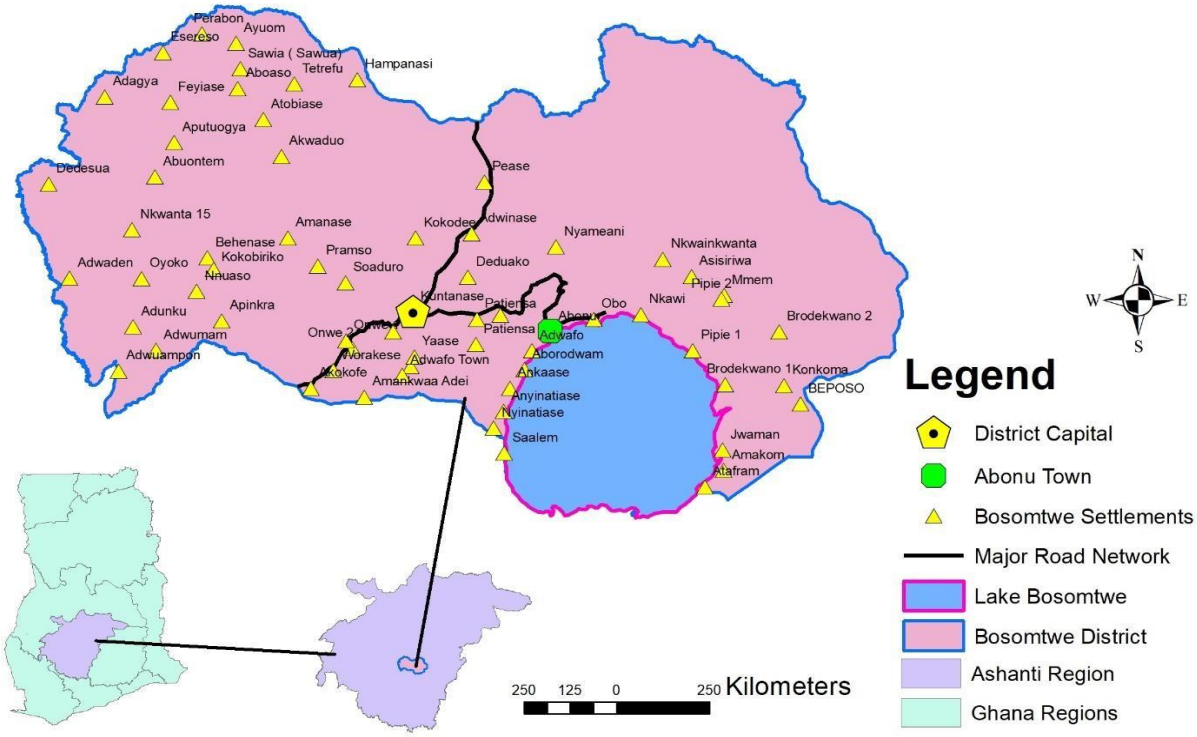


Figure 2. Map of Ghana showing the study area

2.2 *Research design and sampling procedure*

The study utilized an exploratory research design. This helped to acquire a representative sample of a total population in the study area (Sedgwick, 2013). To help establish a relationship between public health and safety (independent variables) and the promotion of local tourism (dependent variable), the study adopted accidental and convenience sampling techniques to select respondents. The accidental sampling technique was used to select (213) local respondents haphazardly in the Abono community. This technique was chosen to ensure that each member of the community can be selected randomly for the study (Battaglia, 2008). The convenience sampling technique was used to select (174) tourists. This was also employed to facilitate easy contact with tourists to participate in the study (Dornyei, 2007). Because most tourists visit the site during holidays, the researchers had little choice but to utilise convenience sampling to make responses more accessible (Lawrence et al., 2013).

2.3 *Data collection and instrumentation*

The study employed a mixed-method approach: quantitative and qualitative approaches. A quantitative research approach was adopted to quantify the presumed health and safety issues at the site and easily generate data for the study (Wyse, 2011). Questionnaires were administered to tourists and locals for their responses on experience on safety incidences at the site. The local tourism authorities at the site such as the Friends of Rivers and Water bodies and Bosomtwe District officials were also queried by the same instruments. Additionally, the study obtained qualitative data through semi-structured interviews and got access to extra evidence-based information (Williams, 2015). The interview was done to better understand the experiences and perceptions of respondents to get more information on health and safety issues at the site.

2.4 *Data analysis*

The quantitative data was analysed on a descriptive statistic; where Chi-square, frequency, and percentages were developed to group responses to common patterns in order to achieve the goal and objectives of the study. Before, the data were first examined to identify foreign responses that might not be needed from the study, but none was found. The quantitative data were presented in tables,

charts and graphs. The two levels of statistical analysis; univariate and bivariate were used. The univariate was used to understand the demographic features of the respondents (Babbie, 2007). The bivariate analysis was done to examine the relationships between the dependent and independent variables of the study (Sandilands, 2014). Furthermore, the study made use of qualitative data through interviews which were recorded, transcribed and critically analysed through content analysis. This technique was used to provide accurate meaning from the data gathered. After critical examination, responses were grouped into themes and evaluated accordingly based on the study's objective. Moreover, direct quotations from the interview and written observation were used to support the quantitative data.

3. RESULTS

Presentation of results and discussions from the study has been made in line with the background characteristics of the respondents and key targets of the study. Thus, identifying public health and safety issues/hazards at Lake Bosomtwe with methods to curb these issues to draw tourists, improve the lives of people and tourism development at the site.

3.1 *Demographic features of respondents*

Background characteristics of the 387 respondents include their gender, age, level of education, frequency of tourists visit, length of stay and tourist activities. From the study, there were 60.1% male and 39.9% female local respondents. Tourists constituted 51.1% females and 48.9% males see Table 1. From this, we conclude that more females visit Lake Bosomtwe than males. This was reaffirmed that female tourists are warmly welcomed by inhabitants of the site due to the fact that there are more female inhabitants. Additionally, the research inquired on the frequency of tourist visits to identify repeat visits to the site. From the study, majority (72.3%) of the tourists visited Abono very frequently while 20.2% of them rarely visited the site see Chart 1. Considering this, it is assumed that most tourists visited the Lake frequently.

3.3 *Key health issues of tourists at the lake*

The study identified some key health issues tourists are open to on the lake. From the results, most (35.6%) of the residents revealed that tourists who swim at the other side of the lake are exposed to cholera. Other tourists (23.4%) testified that skin infections are the most common hazards tourists

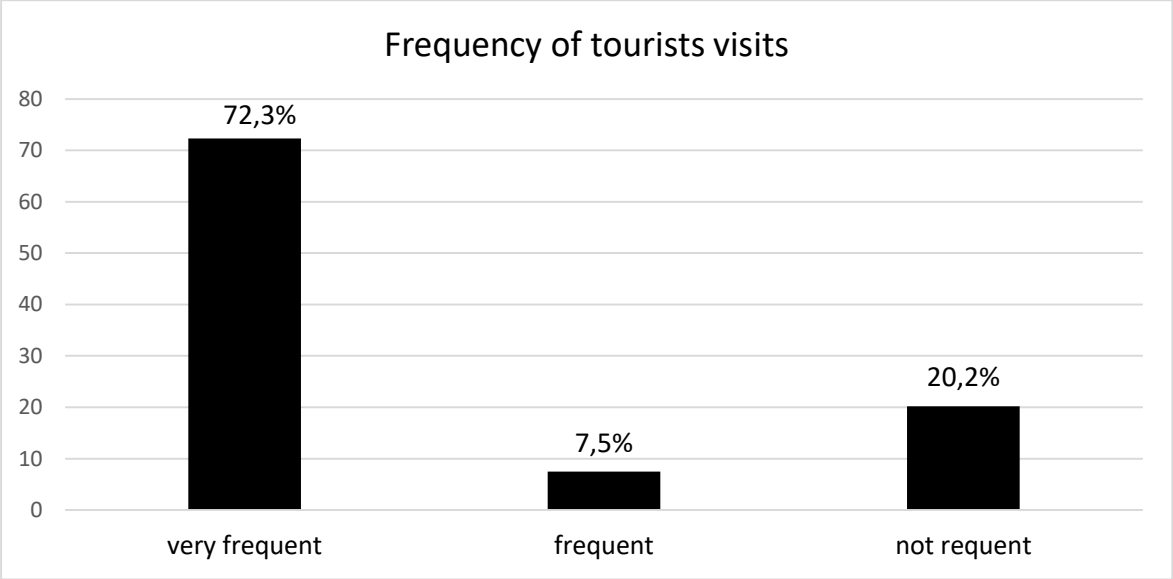
may be exposed to due to dumping by some locals. Agreeably, (25.5%) of locals and (10.4%) tourists believed headache was the next health issue some tourists face upon visiting the lake according to their interaction with some tourists who visit the site see Chart 2.

Table 1: Demographic factors of respondents.

Elements of respondents	Type of respondents	Frequency	Percentage (%)
Gender of respondents			
Female	Tourists	85	51.1
	Locals	128	39.9
Male	Tourists	89	48.9
	Locals	85	60.1
Educational level	**Tourist**		
	None	3	1.7
	Primary	22	12.6
	Lower secondary	0	0
	Upper secondary	62	35.6
	Tertiary	87	50
	Total	174	100
Educational level			
	Locals		
	None	40	18.8
	Primary	61	26.8
	Lower secondary	50	23.5
	Upper secondary	27	12.7
	Tertiary	33	15.5
	Total	213	100
Length of stay in Abono	**Locals**		
	Less than a year	11	5.2
	1-2 years	23	10.8
	3-5 years	21	9.9
	6-9 years	33	15.5
	Above 9 years	125	58.7
	Total	213	100

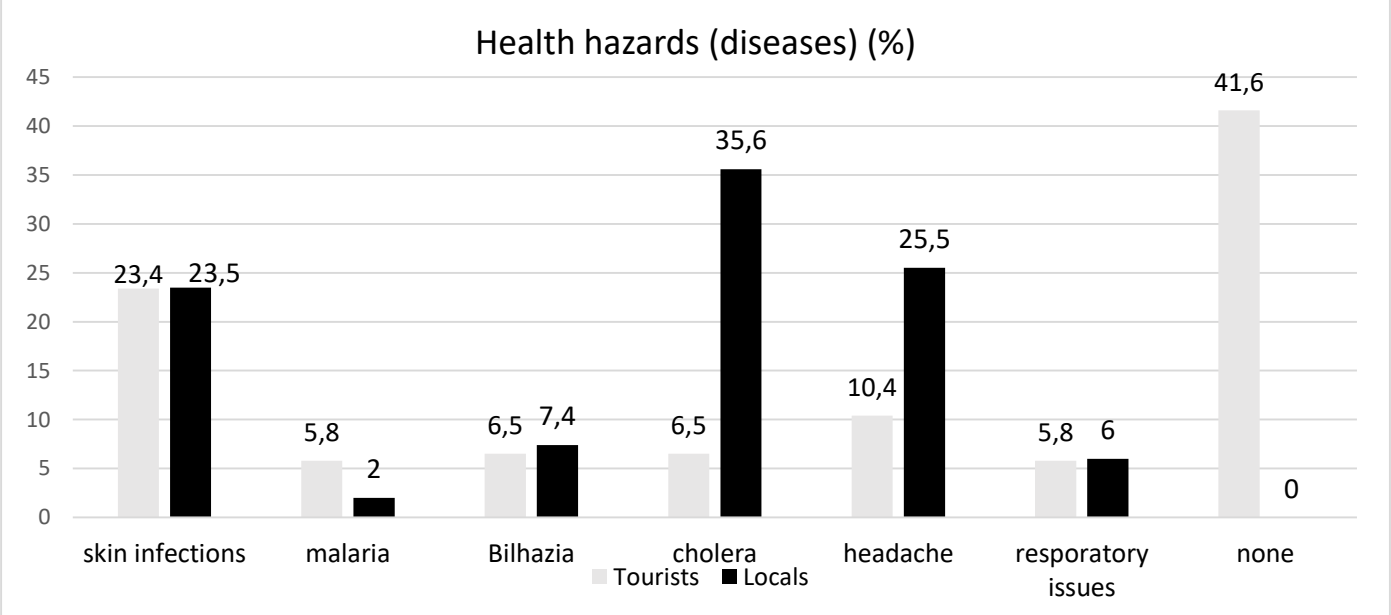
Source: Field Survey March 2018

Chart 1: Frequency of tourists visits to Lake Bosomtwe



Source: Field Survey March 2019

Chart 2: Key health hazards at lake Bosomtwe



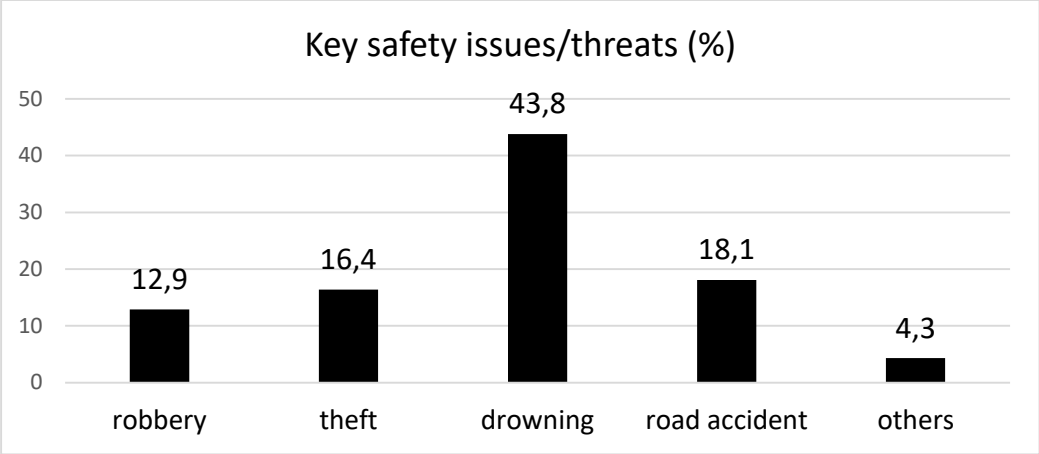
Source: Field Survey March 2019

From the results, some common health issues tourists face at the lake are cholera, headache and skin infections. According to a respondent (an officer) *"The washing away of weedicides and fertilizers from farm activities into the lake pollutes it and causes cholera".* This was further verified by an interviewee from the Bosomtwe District during an interview. Among the three major health issues, cholera was pointed to have occurred most. Locals indicated that this disease emanates from the dirt tourists make during their activities in the lake. Again, some tourists also believed that skin diseases may be caused by the urine and faeces from animals from the near forests. This was confirmed by a respondent who said, *"Due to the inadequate provision of KVIP (toilet facility) in some nearby small villages, most of the children from such villages defecate along the banks of the lake".*

3.4 *Key safety issues of tourists at lake Bosomtwe*

On respondents' perception of safety issues tourists may face at the lake, most (43.8%) stated that drowning was a safety challenge tourists face when participating in tourism activities at the lake see chart 3. They attributed this catastrophic incident to overexcitement, inadequate lifeguards and carelessness. A respondent from the community lamented, *"There is no official and permanent lifeguards at the lake to help tourists during swimming".* Another tourist also stated, *"There is lack of life jackets that tourists are supposed to wear when they want to cruise on the Lake. This prevented most of the tourists from cruising on the lake when they visit the site".* Similarly, A respondent from Friends of Water and River Bodies disclosed that *"There is no organized structure in protecting the tourists whilst they swim in the lake. We do not have life jackets for inexperienced swimmers neither do we have experienced guards who can rescue drowning tourists".*

Chart 3: Key safety issues that tourists face at Lake Bosomtwe



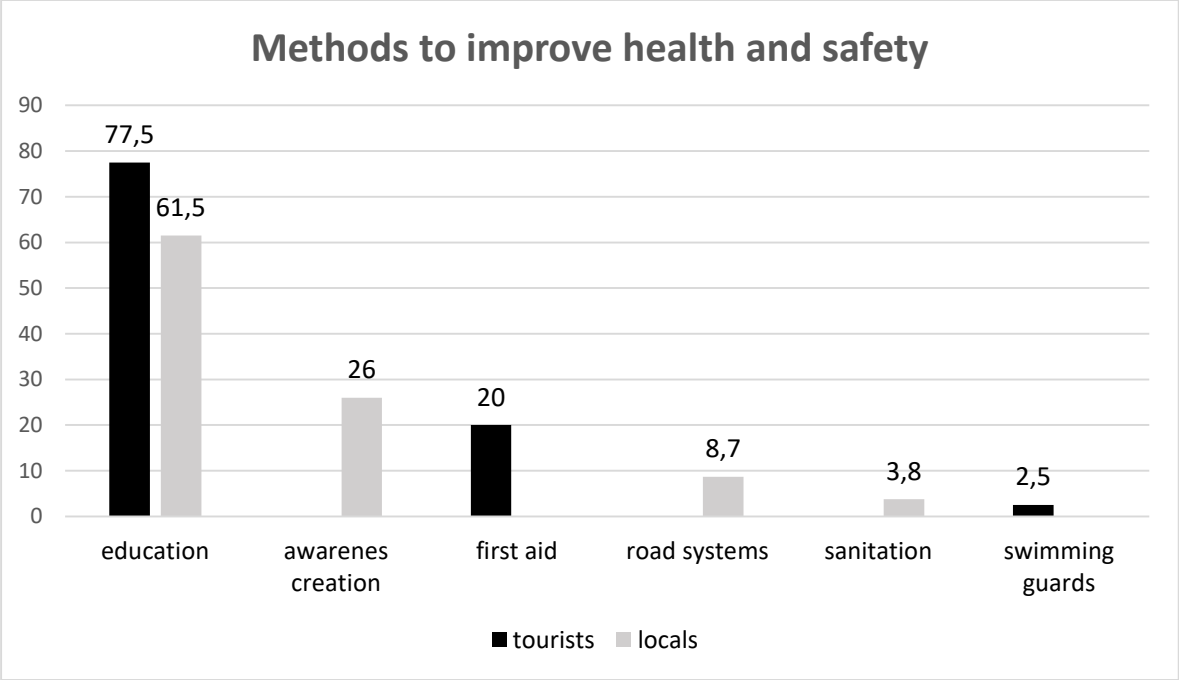
Source: Field Survey March 2019

Additionally, tourists' arrival at the site reaches its peak during festive seasons including Easter, Christmas and Valentine's Day. Consequently, accidents are mostly recorded during these periods (Joy, 2018). As a result, road accidents are recorded mainly because of the congestion and the bad road network within and around the destination. According to a respondent, *"the curvy nature and bad road network leading to the site causes frequent road accidents.'* Finally, robbery and theft have been noted as other security challenges at Lake Bosomtwe. It was discovered that tourists' belongings get missing as a result of insufficient security procedures. This happens especially when tourists over drunk and become careless or unknowingly misplaced their items due to over-joy.

3.5 *Suggested methods of improving health and safety issues at Lake Bosomtwe*

This section discussed the mechanisms that can be implemented to improve on health and safety of tourists and the local communities of the site. In identifying this, respondents were asked to express views on methods like education, awareness creation, first aid, good road systems, vaccination and swimming guards.

Chart 4: ways of improving safety at Lake Bosometwe



Source: Field Survey March 2018

On education, 61.5% of local respondents suggested that tourists should be educated about the safety hazards of the lake before and during their visits. Tourists constituting (77.5%) also suggested that they should be educated on safety precautions at the site to help reduce insecurity at the site see Chart 4. Moreover, to others, tourists should also be pre-informed on the ‘’dos and don’ts’’ to reduce their vulnerability to safety challenges like robbery, theft and accidents at the site. This was corroborated by an official at Bosomtwe District Assembly who said: *“The curvy nature and bad road of the site cause frequent road accidents. Hence, the district has instigated road ramps on the road to help improve the quality of the road and avoid accidents.’*

To help reduce drowning, a respondent said that “we have instigated training programmes for people to acquire swimming experiences to save drowning tourists, also there is signage in the lake which is used as a sign to warn tourists from swimming to dangerous zones, however, more should be provided”. Moreover, some respondents also registered their concern for the application of first aid and the implementation of rules and regulations - (soft measures) to manage risks at the site and (hard) measures like punishments if the rules are not obeyed.

Furthermore, majority of the respondents suggested that cleanliness can help reduce diseases and improve health systems at the site. One of them said, *“There are inadequate waste disposals/dustbins*

here which may result in cholera and other diseases". However, an officer added, "*There is an occasional clean up exercise done by community members as one of the tools to combat diseases, we are soliciting funds through individual investors and Non-Governmental Organisations (NGOs) to improve sanitation at the site".* The study identified that there was no official rule deterring locals from improper sanitation practices. On this note, a respondent suggested that *'rules and regulations should be implemented to help reduce health and safety hazards at the lake".*

4. CONCLUSIONS AND RECOMMENDATIONS

The results of the study have confirmed major security and health concerns in lake Bosomtwe. On this note, the study has discussed these challenges and have recommended adaptable measures to help reduce them to promote local tourism development and economic resilience at Lake Bosomtwe.

The research discovered that there are three major health challenges at Lake Bosomtwe. Among them are cholera, headache and skin infections. The study has proven that skin infection is a health hazard that is common at the site, and it is caused by open urination and defecation in and around some parts of the lake. This happens because indigenes of the communities believe that mere rubbish will not pollute the lake because of its size as the third-largest closed lake in the world (Amu-Mensah et al., 2019). Due to this, there is a belief that mere rubbish will not pollute the entire lake. Another health-related identified at the site is cholera. It is worth noting that the bacteria *Vibrio cholerae* can rapidly move from one person to another, making cholera contagious. At the lake, the spread may occur from drinking contaminated water while swimming or engaging in the same activity with infected people as noted in (UNWTO, 2010). If so, then the infection may even become more when tourists number increases at the site.

On security issues, theft, robbery, burglary and aggravated assaults are widely known as a danger to tourism growth (Matakovic & Mataković, 2019). Overwhelmingly, it was identified that some of these acts especially theft and robbery were big threats to security at Abono as corroborated by most of the locals. The study understood that they happened because of the inadequate security systems like a security guard who will provide a spy on potential and actual criminals at the site. Subsequently, some locals and tourists take advantage of vulnerable tourists and loot their items.

Furthermore, (43.8%) of the respondents were of the view that drowning was another safety issue they people exposed to at the site see Chart 3. Drowning is accidental but sometimes they occur

due to inadequate extensive care during swimming and other activities on the lake. Drowning appears to be one of the dangers faced by tourists who participate in water-based activities. For instance, due to water insecurity in Europe, the 'FTO Code' was established to provide detailed guidance for swimming pool managers to regulate the risk of drowning among European travellers (Wilks et al., 2003). This means that drowning at lake Bosomtwe is not a new thing. From the results, drowning mostly occur at the site during peak periods of the year. During such times, visitors number increases to a point that swimmable areas become over-populated. Consequently, people relocate to other sites of the lake which are deeper, leading to more drowning cases as notified by the respondents.

On suggested methods to help limit health and safety challenges at the site, respondents were of the view that tourists should be educated on the available health hazards at the Lake. Locals constituting (61.5%) they should be well-informed about the safety risks, thus, the infections and other threats they may be exposed to at the site. This is because the 'certainty about tourism risks' demands that at least tourists should have a certain amount of knowledge about the destination they visit (Cui et al., 2016). On this note, the local authorities should make available relevant information on how tourists should spend their holidays to lessen their vulnerability to diseases and properties lost at the site.

Additionally, respondents suggested that the key tourism management at the site should provide enabling environment to support the local communities to keep the place clean. Subsequently, wastes and other pollutants that cause bacteria such as *Vibrio cholerae* growth at the site will be minimized to reduce infestations. Other respondents also opted for the provision of health facilities like clinics and hospitals that will handle accidents and emergencies cases, to help reduce health-related incidence from becoming worst. This is because due to the absence of a clinic at the site, emergencies cases are transferred to other nearby places which sometimes delay the health treatment needed for immediate recovery.

Tourist health and safety are critical areas of concern in the tourism industry. For this reason, it was important to undertake an evidence-based study that deeply discusses the various health hazards and insecurity in the industry. By so doing, this study aimed to produce evidence-based knowledge on how to ensure good public health and safety at Lake Bosomtwe. Specifically, by revealing the level of safety, the available safety measures and methods of ensuring health and safety at lake Bosomtwe. From the findings, the study has come out with evidence-based facts on some health and security

hazards that threaten the lake. Among them, diseases like cholera, skin diseases, headaches have been recorded at the site for the dumping of materials like rubbers. Aside from this, the study also identified some common safety situations including the continuous increase in road accidents, theft and robbery cases at the site, which is a result of low-security systems in the site. In conclusion, the BHM upon which the study is formed has been confirmed with a clear understanding that public perceptions, attitudes, and behaviours related to health determine their compliance and decisions to travel. The adapted framework upon which the study was built has been confirmed that the perception of the health and safety challenges, will call for actions to ensure local tourism growth, economic development and repeat visits.

The main goal of the study was to identify public health and safety hazards at Lake Bosomtwe and offer some solutions and ideas for dealing with them. On key public health and safety issues, the study recommends that education must be given to the entire communities around the site on keeping the environment clean and hygienic. This will help reduce pollution in the lake to avoid diseases like cholera, skin infections, malaria among others. Specifically, all relevant stakeholders, especially, Ghana Tourism Authority should inculcate intensive education in the communities about the need to protect the lake and advise locals and tourists to refrain from dumping refuse and urine in and around the lake. Importantly, they should provide trash collectors, vans and bins at the bank of the lake, scenic sites around the lake, sporting areas at the lake and any other space close to the lake. According to the UNWTO (2010), unprocessed food carried by travellers may also contain diseases like cholera, therefore, a proper inspection must be carried out by the local tourism management at the site to reduce the carry of such infected food items to the site.

Moreover, the government should help in the construction of a good road network to and within the site. Road signs should be installed along the roads to reduce the occurrence of accidents. Also, road safety awareness should be initiated by the National Road Safety Commissions to educate both locals and tourists about reckless driving and the dangers associated with it. Though, accidents happen despite preventive measures; therefore, safety and health-associated institutions in the region should collaborate with the local authorities to provide medical treatment, hospitalization and emergency services to tourists. Such medical services can be given per normal national schemes such as free-of-charge, covered by health insurance or other arrangements. Importantly, visitors should be

informed about the existence and modalities of such services at the destination sooner rather than later, in order to improve the area's safety image to boost their visits.

Again, the study recommends that the site management, tourism practitioners, travel agencies and other service providers at Abono should be given the needed education with regards to their mode of operation to avoid any hazardous incidents at the site. This will be done when there is an organised compulsory health and safety training course for management. For instance, in Europe, Article 5 of the Package Travel Directive (1990/314/EEC) places a considerable burden on tour operators to ensure that their suppliers at each destination deliver safe products and services to the clients (EU, 1990). In the same way, there should be a provision of policies and programs that will oblige managements to concentrate on identifying and responding to tourist offences, securing the safety of everyone at the site and enforcing tough regulations against unlawful interference.

Lastly, emergency systems and health facilities like clinics/hospitals are encouraged to be built to help in case of cataclysmic incidence to relieve trauma patients. Again, tourists should be informed about the site's health, safety and security risks and these emergency facilities. Also, during an emergency, there should be a system that will guide tourists on how to get first-aid or emergency services. Moreover, tourists' safety may also be protected when a limit is set to certain locations in and around the lake.

Study limitations

A major limitation of the study was the unwillingness of some respondents. This happened because some locals did not see the relevance of conducting the study, Others also said, ''*Much research is done here but we have not received anything from the government up till now*". In that regard, the researchers explained the impact of the study and its benefit to them. Subsequently, the necessary information needed for the study was attained.

Recommendations for further studies

The study only used data from random tourists during the sites peak season due to the number of respondents required for the study. Considering this, future studies can consider the views of tourists visiting the site on any other day. Moreover, researchers who will study this topic or other related fields at the site or in other locations can use different methodologies and approaches like observation methods to verify responses of health and safety incidence/issues from victims. Thus, they can observe

it in a broader scope aside from the views and perceptions of tourists and locals that this study mainly made use of.

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THE IMPACT OF UNIONS ON JOB SATISFACTION: A REVIEW

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Abstract

In the last 40 years, the effect of unions on job satisfaction has attracted the attention of those working in the fields of economics, industrial relations, and industrial psychology. It is known that in most of the studies in the literature, this effect results in negative and 'out of the reasonable framework'. In studies published in recent years, it has been found that the direction of this effect has changed. This shows that the relationship between the union and job satisfaction is more complex than it seems. Thirty-five studies published in English included in the analysis section of this review by searching the Web of Science® database are included in the SSCI, SCI-Expanded, ESCI, CPCI-SSH indexes. Research articles, conference proceedings, and early access articles are included in the database search. In the literature, it is seen that the union membership status of the employee, the rate of unionization, the employee's being within the scope of the collective labor agreement and the existence of a union in the workplace are determined as the 'union variable'. In the 'exit-voice' hypotheses, the concurrent relationship between 'union variables' and job satisfaction is often not taken into account. In the 'reverse causality' hypotheses, it is seen that 'instrument variable' and 'fixed-effect' models have been developed to solve the endogeneity problem caused by the concurrent relationship. In the 'discussion and suggestions' section of this review; It is discussed how the effects of unions on job satisfaction can be tested in labor relations systems where the benefits obtained from the union gains do not depend on the membership status and the employees do not have the opportunity of collective labor agreement through the unions. In this framework, it is suggested that the employee's perception of union effectiveness scales, which are created in Likert type, should be determined as the

predictor variable and the effect on job satisfaction should be tested instead of the predictive variables measured at the dichotomous level.

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Keywords: Trade Union, Job Satisfaction, Quality of work-life, Job Dissatisfaction

Introduction

Union leaders claimed that the power of labor is being tried to be reduced because the 'new public management' model has started to take root in the public sector and the human resources management approach has been adopted in the private sector (Eren, 2017). Nonetheless, in the context of their organizational goals, unions are still able to maintain their existence in workplaces, different labor relations systems that vary at the national and international levels.

According to Budd (2004), who discusses the purposes of labor relations in a conceptual triad as ‘efficiency’, ‘equity’ and ‘voice’, positive externalities can be expected if a balance is established between these three elements. While economic ‘efficiency’ is the primary objective of the employer; ‘equity’ in procedural and distributional dimensions, and ‘voice’ with dimensions such as work-related autonomy and industrial democracy are among the objectives of the employee. The realization of this common goal between the actors of labor relations (employer, employee, and public authority) also depends on the balancing power of unions, which are important factors in the labor market, against employers.

The most important role and priority of the unions in the labor relations systems are to improve the working conditions of the employees and to increase their welfare. Therefore, it would not be a surprise if employees vote pro-union in their workplaces to find solutions to the factors that cause job dissatisfaction (Hammer and Avgar, 2005).

According to some studies in the literature, unions traditionally focus on improving the bread and butter conditions of their employees (Dawkins, 2016; Hipp and Givan, 2015). In collective bargaining with the employer, issues such as salary, job security, and fringe benefit are mainly discussed. Therefore, it is seen that union membership has a positive effect on the job satisfaction of the employees regarding the minimum living conditions. However, this effect can turn negative when other elements of job satisfaction such as the promotion opportunity of the employee, the scope of the job, and resource adequacy are concerned (Kochan and Helfman, 1981).

According to Pfeffer and Davis-Blake (1990), unions can have a positive effect on job satisfaction by eliminating work-related conflicts in the workplace. However, in terms of externalities, it is known that unions have different effects such as having a negative effect on job satisfaction of non-union employees (Haile et al., 2015) and improving occupational health conditions (Addison and Belfield, 2004).

As a result of the expected performance of the unions, how to analyze the effect of the employee on job satisfaction, especially in terms of 'equity' and 'voice', is discussed in the light of the findings of this review.

1. Background

The dominant evidence in the literature points to the paradox of the negative impact of unions on job satisfaction. This paradox was tried to be explained with the 'exit-voice' and 'reverse causality' hypotheses (Freeman and Medoff, 1984; Borjas, 1979).

The debates on the effect of unions on job satisfaction, which have passed their 40th year, gained a different momentum with the book called 'What Do Unions Do' (Freeman and Medoff, 1984), and Hirschman's (1970) typology of Exit, Voice, and Loyalty has become functional in shedding light on the solution of this problem.

The exit-voice hypotheses emphasize the '*actually insincere'* dissatisfaction of union members as they have the opportunity and ability to use the 'voice' instrument during negotiation with the workplace management, as an alternative to the 'exit' instrument. Although union members use the 'voice' instrument, which is a reflection of their dissatisfaction, the fact that they do not tend to 'exit' compared to non-union members is cited as evidence. However, the instrument of 'voice' depends on the presence of a union in the workplace as a means for employees to reflect their dissatisfaction, especially for workplaces (*closed-shop*) where the condition of employment in the workplace depends on the status of membership in the union (Freeman and Medoff, 1984).

The reverse causality hypotheses are based on the assumptions that unions exist in workplaces with poor working conditions or that employees with low job satisfaction levels may show a tendency to unionize (Borjas, 1979). Therefore, the concurrent relationship between union variables and job satisfaction variables points to the problem of endogeneity under these assumptions.

It is known that in a few studies in the literature, this problem has been tried to be solved with the ‘instrumental variable’ and the ‘fixed effect’ approach in panel data analysis (Laroche, 2016).

As seen in Table-1, most of the research studies in the literature were conducted in countries such as Great Britain and the USA. Especially in the states of the USA where there is no 'right-to-work law', it is known that unions achieve gains only for their members through collective bargaining. For the employee to benefit from these gains without being a member of the union, he/she must pay the union membership fee. At the same time, if employees in the states covered by the 'right-to-work law' in the USA work in a unionized workplace, they can benefit from the collective bargaining agreements made by the unions with the employer without paying any membership fee (Gius, 2012). Therefore, considering the unique characteristics of the countries' labor relations systems (such as the fact that the collective bargaining rights of civil servants in the public sector in the Turkish Republic of Northern Cyprus (TRNC) are limited by law), the predictive variables to be included in the research will need to be determined with a different approach.

In this review, it is aimed to discuss the suitability of the predictor variables used in the literature in terms of labor relations systems with different characteristics. The results obtained in the context of the two main hypotheses summarized above on the subject are classified in the 'analysis' section of this review.

In addition, it is argued that in labor relations systems where union gains are public goods, and employees do not have collective bargaining rights, union variables commonly used in the literature (such as union membership, unionization rate, presence of a union in the workplace, employee’s being within the scope of the collective labor agreement) may be insufficient to determine the effect on the job satisfaction of the employee. Predictive variables that could be alternatives are presented in the 'discussion and suggestions' section of this review, with reference to some sources in the literature.

2. Research Methodology

The literature search was conducted on November 26, 2021, using the Web of Science® database. Research articles, conference proceedings, and early access articles in the SSCI, SCI-Expanded, ESCI, and CPCI-SSH indexes published in English were included in the search.

The following keywords were used in the database search: (trade union (All Fields) OR labor union (All Fields) OR labour union (All Fields) OR unions (All Fields)). To improve the search results, the following keywords were searched in all areas of the full text: job satisfaction OR work satisfaction OR employee satisfaction OR quality of work-life OR job dissatisfaction.

By reading the abstracts and then the full texts of all 195 studies obtained as a result of the steps listed above, it was checked whether the conditions were met at the same time; (a) overall job satisfaction and/or certain aspects of job satisfaction (such as wage satisfaction) to be determined as the dependent variable (b) at least one of the union variables (such as membership status, the employee and/or workplace within the scope of collective labor agreement) is included as the predictor variable.

Studies in which unions were considered as a mediator or moderator variables were not included in the review. In addition, no publication date restrictions were imposed at any stage of the scanning procedure. Thirty-five studies published between 1983-2021 and whose findings were shared in the analysis section are marked with an (*) in the references. The selection of publications according to the literature search strategy is summarized in Figure-1.

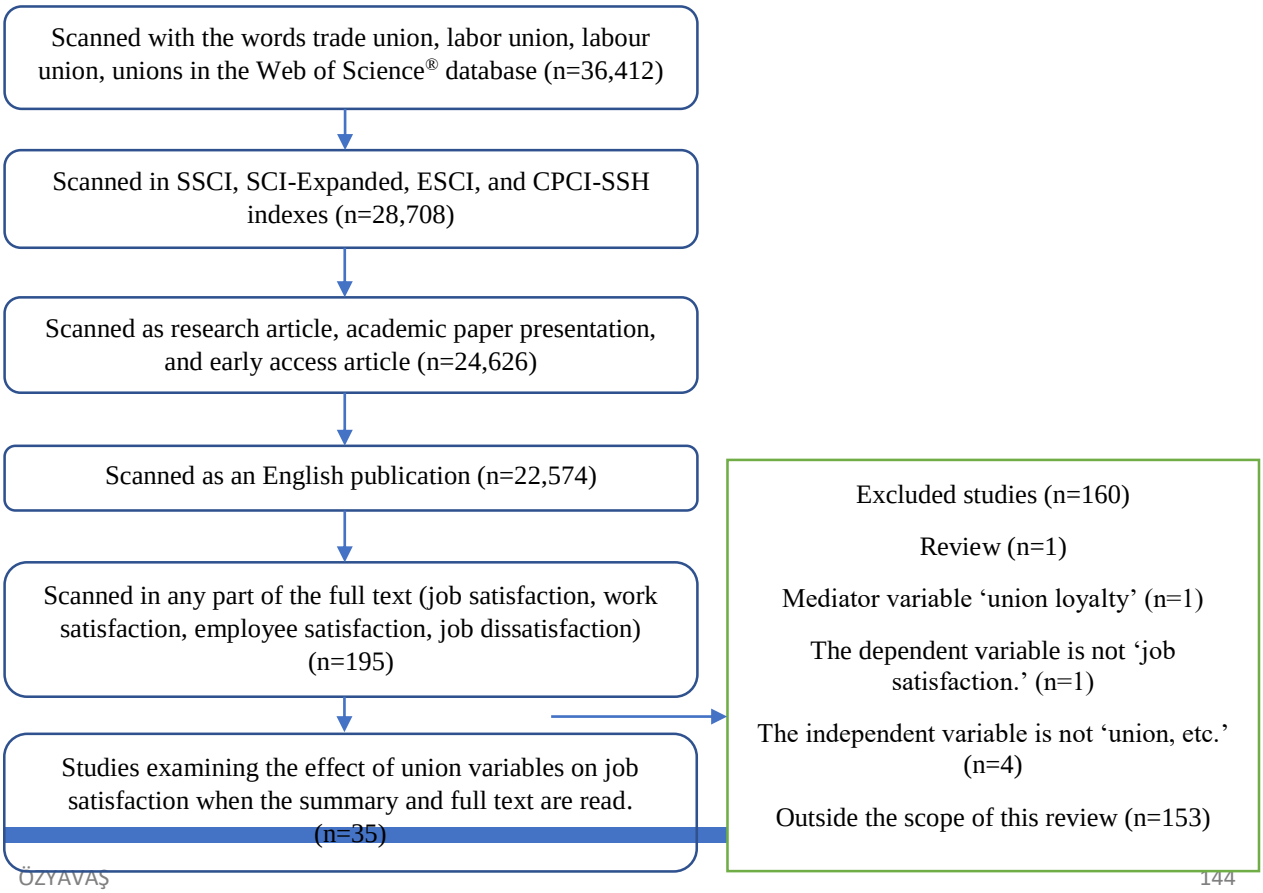

Figure-1: Literature search strategy diagram

3. FINDINGS

3.1. Findings specific to Turkey and TRNC

As seen in Table-1, there is no study specific to Turkey and the TRNC. Although OECD data are used in some studies, Turkey is not included (Clark, 2005; Hipp and Givan, 2015). Similarly, in some studies conducted in the EU region, data on Turkey are not included in the studies. (Bryson and White, 2016a; van der Meer, 2019; Humborstad, 2014). In the study of Blanchflower et al. (2021), Turkey is included in 38 European region countries, however, country-based results are not included in the study.

Although it is not clear whether it covers the data of the northern region of the island (TRNC), it seems that Cyprus is included in some studies (Blanchflower et al., 2021; Humborstad, 2014; Hipp and Givan, 2015). In two of these studies, results for Cyprus are not reported (Blanchflower et al., 2021; Humborstad, 2014). In another study, it is stated that there is a positive relationship between the density of unionization in Cyprus and the material aspects of job satisfaction (income, promotion opportunity, and job security). In the aforementioned study, although it was determined that the density of unionization had a positive effect on overall job satisfaction and also on the level of satisfaction with the context of the job, these findings were not statistically significant (Hipp and Givan, 2015).

3.2. Findings on other countries and regions

Table-1 provides summary information about thirty-five studies evaluated within the scope of this review. When the findings on the effects of unions on job satisfaction are summarized in terms of their statistical significance and the direction of the effect, it is seen that no significant effect/difference was detected in fourteen of the fifty results obtained. However, fourteen positive effects/differences and twenty-two negative effects/differences were detected.

Table-1: Characteristics of publications in the literature

Characteristics	N	Characteristics	N
Years		**Country / Region***	
1983-1992	4	EU	4
1993-2002	7	USA	12
2003-2012	9	Australia	1
2013-2021	15	Bangladesh	1
Background		Great Britain	10
Voice hypotheses	20	China	1
Reverse causality hypotheses	15	France	1
Conclusion		Japan	1
There is a positive effect/difference	14	Canada	4
There is a negative effect/difference	22	Korea	2
There is no significant effect/difference	14	OECD	2

** Studies that were compared at the international level were scored together.*

When we look at the studies that found a positive relationship/difference between union variables and overall job satisfaction and/or certain aspects of job satisfaction, it is seen that the following three predictive variables were determined; a) 'union membership', b) 'union density' and c) 'whether a collective labor agreement has been made' (Blanchflower et al., 2021; Hipp and Givan, 2015; Humborstad, 2014; Pohler et al., 2014; Krieg et al., 2004; Addison and Belfield, 2004; Meng, 1990; Evans and Ondrack, 1990; Berger et al., 1983).

In other studies based on reverse causality assumptions, it is seen that the analyzes are deepened by the use of 'instrumental variable' and the consideration of 'fixed effect' elements in the panel data. In van der Meer's (2019) study, a positive effect was detected in the UK and Ireland, while no significant effect was detected in Continental Europe. According to Bryson and White (2016a), membership has a positive effect on wage satisfaction if the employee moves to a job within the scope of a union. In his research, which classified the employees as non-members under union guarantee and as 'free-rider' employees, Powdthavee (2011) found that membership had a positive effect on job satisfaction in the first years of unionization. This situation was defined by Powdthavee (2011) as the 'anticipation effect'. However, if the employee's union experience

increases, the statistically significant effect disappears. This situation was defined as the 'adaptation effect' by the same researcher. When Artz (2010) distinguished employees with and without union experience from all non-union employees, he found that union membership has a positive effect on satisfaction. However, as union membership experience increases, this effect turns negative. Pfeffer and Davis-Blake (1990) used the industry factor as an instrument variable in their study and found that unionization had a positive effect on the satisfaction of those who were members of craft unions. Unionization does not have a significant effect on the job satisfaction of those who are members of industrial unions.

Considering the studies that found a negative relationship/difference between union variables and overall job satisfaction and/or certain aspects of job satisfaction, it is seen that the following four predictive variables were determined; a) 'union membership', b) 'union density', c) 'whether the union exists in the workplace' and d) 'whether a collective labor agreement has been made' (Blanchflower et al., 2021; Hipp and Givan, 2015; Haile et al., 2015; Krieg et al., 2013; Seago et al., 2011; Clark, 2005; Renaud, 2002; Kleiner and Lee, 1997; Hovekamp, 1995; Khaleque, 1993; Meng, 1990; Berger et al., 1983).

In other studies that found negative effects/differences under reverse causality assumptions, individual, profession, workplace, and country-specific characteristics (fixed effects) that are thought to have an impact on the decision to join a union were taken into account (Bryson and Davies, 2019; Laroche, 2017; Bryson and White, 2016b; Green and Heywood, 2015; Artz, 2012; Artz, 2010; Heywood et al., 2002). Among these studies, Bryson and White (2016b) found that leaving a job within the scope of a union has a negative relationship with satisfaction in terms of a wage increase. At the same time, researchers note that switching to a unionized job also lowers job security satisfaction because of the cost of re-employment.

Similarly, in some of the studies in which negative effect was detected, it is seen that the 'instrumental variable' was used. In the study of Gius (2012), it was found that the general level of job satisfaction in states subject to 'right-to-work law' in the USA is higher than in unionized regions. In another study in which the industrial relations climate, the attitude of the employee and the employer towards the union were determined as the instrumental variable, it was found that although union membership had a negative effect on job satisfaction, this effect disappeared when the perception of industrial relations climate was controlled (Bender and Sloane, 1998).

As indicated in Table-1, there are also studies indicating that union variables do not have any significant effect on general job satisfaction and/or certain aspects of job satisfaction (Nawakitphaitoon and Zhang, 2020; Holland et al., 2011; Kim and Kim, 2004; Renaud, 2002; Lincoln and Boothe, 1993; Evans and Ondrack, 1990; Brajcich et al., 2021; Bessa et al., 2021; van der Meer, 2019; Laroche, 2017; Green and Heywood, 2015; Powdthavee, 2011; Bender and Sloane, 1998; Pfeffer and Davis-Blake, 1990). Renaud (2002) was found that union membership has a positive effect on wage satisfaction. Renaud (2002) also highlighted that this significant effect is lost in Canada when working conditions at the workplace are taken into account. In their study in which the data of the USA and Japan were compared, Lincoln and Boothe (1993) found that union membership did not have a significant effect in the case of Japan. Evans and Ondrack (1990) determined that union membership had a positive effect on wage satisfaction. However, they stated that this effect disappeared statistically when the complexity of the job was controlled. In their study, Brajcich et al. (2021) determined the rate of unionization in the public sector as an instrumental variable and found that the presence of the union in the workplace had no effect on job satisfaction. Bessa et al. (2021) found that working conditions have an impact on job satisfaction rather than the intensified union campaign during the negotiation process. Laroche (2017) found that in labor relations systems where collective labor agreements are made at the national level, job satisfaction differences between union members and non-union members disappear. In their study, Green and Heywood (2015) found that the negative effect of the union disappeared when ‘free-rider’ employees and non-union employees under union guarantee (provided that they paid union dues) were excluded from the equation.

4. CONCLUSION AND DISCUSSION

The literature on the persistence of the paradox of the effects of unions on job satisfaction is in line with the findings of the study. In some analyses deepened by the ‘fixed effect’ and ‘instrumental variable’ approaches in the literature, it is seen that the negative effects of unions on job satisfaction are not statistically significant. In some studies, significant findings were found for both positive and negative effects. This makes it necessary to address the predictive variable with measurement tools that better comprehend the labor relations system to be observed.

So, how else can one test whether unions have an impact on job satisfaction in a structurally unique labor relations system?

Considering the organizational objectives of the unions, it is more reasonable to expect that they will have a positive effect on the job satisfaction of the employees (Bryson and Davies, 2019; Powdthavee, 2011; Hipp and Givan, 2015; Seago et al., 2011). However, according to the statements of Freeman and Medoff (1984), union members try to turn the process in their favor by expressing their *'actually insincere'* dissatisfaction with the employer during the negotiation process. and/or unions can strategically fuel these attitudes of the employees with the same motive. On the other hand, unions can strategically fuel these attitudes of employees with the same motivation. It is known that these statements of Freeman and Medoff are specific to 'closed-shops', where benefiting from union gains depends on membership status.

In a labor relations system in which the benefit from union gains is 'public goods' regardless of the employee's membership status, the membership status, or the density of unionization would not be expected to affect job satisfaction (Laroche, 2016). However, according to the statements of Bryson and Davies (2019), the unionization rate is an important factor that determines the bargaining power of unions, and the possibilities and abilities of unions in voicing employees' work-related concerns. As a matter of fact, can the unionization rate, which has been considered as a predictive variable in some studies in the literature, be a criterion that can be accepted alone as the determinant of the effectiveness-performance of the unions in the system in which they exist? To answer this question, it is necessary to consider other features of the labor relations system to be researched.

As an example, in TRNC, it is known that without compromising their rights (such as union representation and collective talks), there are limitations in the local legislation on the basic rights (such as collective bargaining and strikes) of civil servants in the public sector. At the same time, in the TRNC example, union gains are common benefits provided to all civil servants in the public sector, regardless of membership status. However, this situation may not be unique to the TRNC in some aspects. As Laroche (2016) stated, although France has the relatively lowest unionization rate (less than 8%) among industrialized countries since the 1970s, it is an extreme example with the rate of employees (more than 95%) covered by collective agreement.

As seen in the studies of Green and Heywood (2015) and also Powdthavee (2011) if the problem of the 'free-rider' employee benefiting as a public goods is taken into account, it is known that the effect can turn positive, even in a certain conjuncture, when the statistical significance of

the dominant empirical evidence is lost or vice versa. This evidence shows that membership status is not the main determinant. Gius (2012), on the other hand, emphasized this situation as a problem by referring to the fact that most studies in the literature have determined membership status as a predictive variable. According to Gius (2012), the 'right-to-work law' valid in some states of the USA has a significant positive effect on teachers' job satisfaction. Therefore, the fact that the 'state-level right-to-work law', which was determined as the 'instrumental variable' in the research in question, was considered rather than the membership status, is an emphasis on better understanding the nature of the labor relations system in determining the predictive variable. As a matter of fact, this evidence in the literature requires a more cautious approach to the issue.

On the other hand, it is known that in the studies of researchers such as Kochan and Helfman (1981) and Pfeffer and Davis-Blake (1990), the positive effects of these variables on job satisfaction have been proven by using measurement tools such as 'Union Performance' and 'Union Effectiveness in Increasing Employee's Control Over the Work'. However, this evidence is only the result of observations involving union members.

In their study, Kochan and Helfman (1981) found a strong and positive relationship between union performance and job satisfaction of union members and stated that these findings overlap with some of the results in the literature (*cited in Gordon et al. (1980) on p.44*). Kochan and Helfman (1981) emphasized that rather than discussing the causality aspect of this relationship, it would be more beneficial to evaluate it in terms of finding that the union, together with the workplace management, affects the job satisfaction of the employees. In conclusion, Kochan and Helfman (1981) have argued that assuming an 'average' union effect on job outcomes can be highly misleading and understanding these effects may indicate a more important phenomenon than anticipated.

According to Pfeffer and Davis-Blake (1990), unions affect job satisfaction positively by being effective in increasing the control of the employee over the work. In the same study, consistent with the literature, it was determined that membership status did not have a significant effect on job satisfaction. The researchers stated that this finding was inconsistent with the positive effect of unionization (in terms of its effectiveness in increasing the employee's control over the job) on job satisfaction. Therefore, by emphasizing the 'reverse causality' assumptions that suggest

that unionization is not a random event, they emphasized that unions may have characteristics that can change their job characteristics and work environment.

In their study, in which they examined the effects of 'union voice' and 'direct voice' channels on overall job satisfaction, Holland et al. (2011) hypothesized that employees' having the opportunity to give feedback to workplace management through unions might have a negative effect on job satisfaction. However, they did not determine a statistically significant relationship. Holland et al. (2011) attributed this to the fact that they evaluated this situation through the variable of 'union voice' (in the context of the existence of a union in the workplace) and emphasized that it is possible to solve this *'measurement problem'* with the measurement of union effectiveness perceived by the employees. According to Holland et al. (2011), union effectiveness is likely to directly predict job satisfaction.

When the components of the 'Labor Union Social Responsibility' variable in the study of Dawkins (2016) are examined, it is seen that the unions have a very similar structure with their effectiveness functions. In summary, 'Labor Union Social Responsibility' is framed with functions such as improving the living standards and job security of employees in the 'economy' dimension, finding positive solutions to work-related problems, and ensuring the continuity of occupational health standards in the 'workplace' dimension, reducing discrimination in the workplace and being the spokesperson for disadvantaged people in the 'social' dimension. In addition, it is an important factor in the commitment of the employees to the union and has an effect on improving the extrinsic aspects of job satisfaction.

In conclusion; rather than determining the variables, which are frequently used as predictive variables in the literature in investigating the effect of unions on job satisfaction, and summarized as 'union variables' in this study from a narrow framework (usually at a dichotomous level, for example, in determining membership status, the existence of a union in the workplace, or the existence of a collective bargaining mechanism in the workplace), the adaptation of union effectiveness-performance scales to the culture to be researched or the development of a new union effectiveness-performance scale specific to the work culture in question are suggested by emulating some studies in the literature (Kochan and Helfman, 1981; Pfeffer and Davis-Blake, 1990; Holland et al., 2011; Dawkins, 2016).

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