

# A Study on The Causes of Unrecorded Economy in Turkish Health Sector\*

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**Abstract:** This study was conducted to examine the reasons for the emergence of the unrecorded economy in the healthcare sector. As part of this qualitative research, interviews were conducted with managers, auditors, and sector representatives in the healthcare industry. These interviews were analyzed using Interpretive Phenomenological Analysis. The findings indicate that the unrecorded economy is not caused by a single factor. According to the participants' statements, insufficient income, lack of oversight, perceived lack of justice, legal uncertainty, and the unique characteristics of the healthcare sector are significant factors contributing to the unrecorded economy. Furthermore, cultural norms, social trust levels, erosion of ethical sensitivities, and the legitimization of informal relationships are cited as important factors fueling informality. The study contributes to the literature by addressing the multi-dimensional impact of economic, institutional, and cultural processes on unrecorded economic behavior. According to the findings, strengthening ethical principles, solidifying oversight mechanisms, and improving working conditions for employees are significant policy recommendations to support this process.

**Keywords:** Unrecorded Economy, Qualitative Research, Health

**Jel Codes:** I18, O17, I12

## *Türk Sağlık Sektöründe Kayıt Dışı Ekonominin Nedenleri Üzerine Bir Araştırma*

**Öz:** Bu çalışma sağlık sektöründe kayıtdışı ekonominin ortaya çıkış nedenini incelemek amacıyla gerçekleştirilmiştir. Nitel araştırma olarak yürütülen bu çalışma kapsamında, sağlık sektöründe yer alan yöneticiler, denetçiler ve sektör temsilcileriyle görüşmeler yapılmıştır. Yapılan görüşmeler Yorumlayıcı Fenomenolojik Analiz yöntemiyle analiz edilmiştir. Çalışma sonucunda elde edilen bulgulara göre kayıt dışı ekonomi yalnızca tek bir faktörün etkisi ile ortaya çıkmadığı görülmüştür. Katılımcı ifadelerinden elde edilen sonuçlara göre gelir yetersizliği, denetim eksikliği, algılanan adalet eksikliği, hukuki belirsizlik ve sağlık sektörünün kendine has özellikleri kayıt dışı ekonominin nedenleri arasında gösterilen önemli nedenlerdendir. Ayrıca kültürel normlar, sosyal güven düzeyi, etik hassasiyetlerin aşınması ve gayriresmî ilişkilerin meşruiyet kazanması kayıt dışılığı besleyen önemli faktörler olarak ifade edilmiştir. Çalışma; ekonomik, kurumsal ve kültürel süreçlerin kayıt dışı ekonomik davranışlara olan etkisini çok boyutlu bir şekilde ele alarak literature katkı sağlamaktadır. Bulgulara göre, etik ilkelerin güçlendirilmesi, denetim mekanizmalarının güçlendirilmesi ve çalışanların çalışma koşullarının iyileştirilmesi süreci destekleyecek önemli politika önerilerindedir.

**Anahtar Kelimeler:** Kayıt dışı Ekonomi, Nitel Araştırma, Sağlık

**Jel Kodları:** I18, O17, I12

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## 1. Introduction

The unrecorded economy has been defined in various ways in the literature, reflecting differences in scope and meaning across societies. Consequently, there is no single, universally accepted definition. The Turkish Language Association (TDK, 2019) defines “unrecorded” as the absence of official documentation. Tanzi (1980) conceptualizes the unrecorded economy as income that is not declared and therefore not measured. Feige (1989, 1994, 1997) emphasizes its hidden and illegal dimensions, highlighting activities that are deliberately concealed from public authorities. Differences among definitions stem from variations in terminology, research focus, and scientific approach. Overall, the literature indicates that the unrecorded economy extends beyond illegal activities to include transactions conducted outside formal regulatory frameworks.

Studies have assessed the unrecorded economy by examining a range of contributing factors. For example, researchers associate its emergence with tax burdens, inflation, economic instability, levels of trust, moral values, sociological structures, legal and political frameworks, and control mechanisms (Metin & Erdem, 2020). Each of these factors can directly or indirectly influence both the emergence and measurement of unrecorded economic activities. Accordingly, scholars have developed various methods to estimate the size of the unrecorded economy (Kirchgässner, 1983; Lemieux, 2007; Klovland, 2017; Schneider, 1986; Akça & Bal, 2018; Perry et al., 2007). The unrecorded economy poses a challenge to the state’s financial stability, prompting governments to attempt to manage and reduce its scale. Since governments rely on tax revenues to finance public services, these revenues depend on officially recorded economic activities. Unrecorded economic behavior disrupts the overall functioning of the system and negatively affects specific sectors.

Some researchers argue that, under certain conditions, unrecorded economic activities may contribute positively to social, economic, and political processes (Altuğ, 1998; Carter, 1984; Adam & Ginsburgh, 1985; Schneider et al., 1989; Portes et al., 1989). When government regulation is insufficient or systemic conditions deviate from expected norms, individuals may attempt to compensate for institutional shortcomings through unrecorded means. For instance, unrecorded employment may provide income opportunities when the state is unable to meet labor market demand. From this perspective, unrecorded economic activities can, in some cases, support social continuity, individual survival strategies, and poverty reduction. In the short term, individuals may engage in unrecorded activities to maximize income and sustain market dynamism.

In the current period, particularly during the COVID-19 pandemic, crisis conditions appear to have created gaps in the state’s regulatory capacity. The acceleration of digitalization during the pandemic led to significant transformations in labor markets. According to the literature, these transformations expanded both traditional and digital forms of unrecorded economic activity (ILO, 2021). In the health sector, which is structurally vulnerable to unrecorded practices, the growth of telemedicine, online pharmaceutical markets, remote diagnostics, and digital health services has intensified this vulnerability (OECD, 2021). These developments demonstrate that unrecorded activities in healthcare are not static but are continuously shaped by technological, economic, and institutional changes.

Health services contribute to individuals’ physical, mental, and social well-being and represent a core social service and a primary responsibility of the state. States are required to ensure universal access to healthcare and protect the right to a healthy and dignified life. The delivery of healthcare services depends on financial sustainability and public trust, both of which are essential for service continuity and societal well-being. Achieving these goals requires strong institutions and balanced resource allocation, indicating that healthcare systems cannot operate solely through market mechanisms. The sector is dynamic and must continuously adapt to evolving needs. Financial sustainability in healthcare necessitates balancing resources and demand through economic and political decision-making. Characteristics such as asymmetric information, multiple stakeholders,

fragmented markets, regulatory gaps, and profit-driven incentives increase the sector's vulnerability to unrecorded practices (Vian et al., 2006; Klitgaard et al., 2000; Tomini et al., 2012). In Turkey, the unrecorded economy in healthcare refers to covert transactions between suppliers, hospitals, healthcare professionals, patients, and insurers; tax evasion; fraudulent invoicing; concealed payments; and unreported labor (Savedoff & Hussmann, 2006; Metin & Erdem, 2020).

To analyze unrecorded economic behavior in healthcare, three theoretical frameworks are particularly relevant: institutional theory, agency theory, and moral economics. Institutional theory links weak regulatory enforcement and limited sanctions to the proliferation of unrecorded practices; when formal rules are inadequately enforced, informal arrangements tend to fill institutional gaps (North, 1990). Agency theory emphasizes information asymmetry among stakeholders, such as between physicians and patients or providers and public authorities. This asymmetry facilitates unrecorded payments, manipulation, and collusion, especially in complex healthcare systems where providers may shape demand or conceal information (Feldstein, 1970). Moral economics focuses on cultural norms, reciprocity expectations (such as "gratitude payments"), trust, and social values that may legitimize unrecorded practices in certain contexts (Kuti, 1984; Gaal & McKee, 2005, p. 1448). In some societies, such behaviors are socially normalized. Taken together, these perspectives illustrate that unrecorded practices in healthcare are not merely economic choices but multifaceted phenomena shaped by structural, institutional, cultural, and relational dynamics.

Although unrecorded economic behavior in healthcare has been widely examined in Eastern Europe, Central Asia, and OECD countries (Stepurko et al., 2015), research focusing on the Turkish healthcare system remains fragmented and limited. Existing studies primarily address specific components of unrecorded activity or focus on theoretical discussions (Tomini et al., 2012). Empirical research that integrates trust, ethics, governance, and institutional capacity is scarce. Moreover, few studies adopt a multi-stakeholder qualitative approach that captures the lived experiences of different actors within the healthcare system. To address these gaps, the present study aims to conduct an in-depth examination of the factors shaping unrecorded economic behavior in the Turkish healthcare sector by incorporating the perspectives of physicians, administrators, healthcare providers, inspectors, pharmacists, and other key stakeholders. By doing so, the study seeks to illuminate how structural conditions, institutional weaknesses, cultural values, ethical dilemmas, and governance challenges contribute to unrecorded practices in healthcare. Through stakeholder perspectives, this research aims to contribute to the international literature by explaining the drivers of the unrecorded economy in healthcare. Accordingly, the primary objective of the study is to identify and interpret the multidimensional factors associated with unrecorded economic behavior in the Turkish healthcare sector using the Interpretive Phenomenological Analysis (IPA) framework. The secondary objectives are:

- To investigate how healthcare workers, managers, supervisors, and other stakeholders perceive unrecorded practices and the meanings they attribute to these behaviors.
- To understand how individual, institutional, economic, and social factors sustaining the unrecorded economy are shaped and how they interact.
- To explain the underlying drivers of unrecorded economic behavior in the healthcare sector within a holistic framework derived from interview themes and to relate these findings to existing discussions in the literature.

Overall, understanding the drivers of unrecorded economic behavior is not only an analytical necessity but also a social and political priority, given the profound effects of unrecorded practices on equity, trust, quality of care, and the sustainability of healthcare systems.

## 2. Method

This research aimed to reveal the existence of a phenomenon and examine it in depth. For this purpose, the qualitative research method was chosen as the most appropriate approach. Qualitative research is defined as "an approach to exploring and understanding the meanings individuals or groups attribute to a social or humanitarian problem" (Creswell, 2016). It aims to examine social phenomena in their entirety. Therefore, it incorporates individual perspectives into the process and is considered a different way of approaching the empirical world (Yıldırım & Şimşek, 2016; Taylor et al., 2016). Within this framework, qualitative research offers the opportunity to address "why" and "how" questions, allowing the researcher to actively interact with the phenomenon and develop a holistic understanding that gradually emerges throughout the research process.

This study employed a phenomenological approach, a qualitative research design. Phenomenology is generally divided into two types in literature: empirical (psychological) phenomenology (Ihde, 2012) and interpretive phenomenology (Van Manen, 1990). This study aimed to examine how participants make sense of phenomena and construct meaning around their experiences. Interpretive Phenomenological Analysis (IPA), developed by Smith, Flowers, and Larkin (2009), was adopted to examine how these meanings can be interpreted by the researcher through a structured yet flexible analytical process. IPA is based on three fundamental principles: phenomenology, hermeneutics, and idiography. Accordingly, the researcher first seeks to understand how participants perceive and interpret their experiences. Then, a secondary interpretive action (double hermeneutics) is employed to understand the participants' meaning-making processes. According to the philosophy of IPA, each interview was examined in detail before proceeding to the inter-case correlation. Throughout the research process, the researcher was careful to reconsider biases and maintain awareness of how personal history, professional experiences, and assumptions could shape the interpretive process.

### 2.1. Participants

This study aimed to define and thoroughly examine the concept of the unrecorded economy. Therefore, the most appropriate method was selected. Qualitative research is classified as "an approach to exploring and understanding the daily journey individuals or society make toward a specific or humanitarian issue" (Creswell, 2016). Qualitative research incorporates individual perspectives to examine social phenomena holistically and is considered a different way of approaching the world (Yıldırım and Şimşek, 2016; Taylor et al., 2016).

A total of 25 participants were interviewed for the study. Table 1 shows the demographic and professional characteristics of the 25 participants. The table includes the participants' years of experience, professional roles, and interview duration. The study aimed to ensure transparency and to demonstrate sectoral diversity within the healthcare sector to provide a broader understanding of the situation. All participants had at least 10 years of professional experience, meeting the criterion of providing knowledgeable and experience-based perspectives on the concept.

**Table 1.** Participant Characteristics, Years of Experience and Interview Information

| Participant | Work Experience (Years) | Profession  | Duration |
|-------------|-------------------------|---|----------|
| Nermin      | 26                      | Academic/Nurse  | 1:10:50  |
| Mehmet      | 30                      | Health Technician/EMT                                 | 40:12    |
| Aysun       | 30                      | Family Physician                                      | 1:04:10  |
| Nazlı       | 24                      | Physician (Geriatrics)                                | 1:03:07  |
| İbrahim     | 19                      | Academic/Former Chief Physician Asst.                 | 55:33    |
| Varol       | 20                      | Admin (Revolving Fund)                                | 1:09:26  |
| Elif        | 19                      | Academic  | 1:25:21  |
| Doğan       | 30                      | Academic  | 30:02    |
| Melis       | 13                      | Pharmacist  | 43:00    |
| Kerim       | 11                      | SSI Inspector   | 48:00    |
| Emine       | 16                      | Medical Secretary                                     | 34:38    |
| Muzaffer    | 22                      | Medical Representative                                | 56:03    |
| Semih       | 16                      | Administrative and Financial Affairs Director         | 44:12    |
| Mehmet A.   | 18                      | Inspector   | 45:12    |
| Ayhan       | 18                      | Expert/Former Financial Affairs Department Head       | 1:10:00  |
| Ersin       | 14                      | Sectoral Services Department Head                     | 1:38:00  |
| Nuray       | 27                      | Nurse/Assistant Director                              | 38:00    |
| Ahsen       | 19                      | Tender Officer  | 1:30:00  |
| Erhan       | 13                      | Medical Representative                                | 1:24:00  |
| İsmail      | 22                      | Academician/Member of the Hospital Board of Directors | 36:17    |
| Savaş       | 18                      | Pharmacist  | 1:04:00  |
| Hüseyin     | 30                      | General Surgeon                                       | 56:58    |
| Mahmut      | 43                      | Academician/Former Hospital Director                  | 46:10    |
| Ahmet       | 13                      | Inspector   | 59:28    |
| Ali Murat   | 13                      | Family Physician                                      | 1:41:41  |

Although IPA studies generally use smaller samples, a larger sample was chosen for this study to better understand the process across different stakeholder groups, given the complex, multi-actor nature of the health sector. It is believed that the unrecorded economic behaviors under study occur not only within a single professional group in the health system, but also across relationships among many different stakeholders. Therefore, interviewees from each stakeholder were included in the study to ensure a holistic understanding of the phenomenon. Each participant represented a specific position within the health system. Detailed case-by-case analyses were conducted before the thematic analysis, thus preserving the unique focus of IPA and contributing to a more comprehensive understanding of the phenomenon. This approach, while increasing the sample size, enabled the maintenance of idiographic depth. Therefore, the sample of 25 individuals was designed to provide a wealth of information and is consistent with the interpretive nature of the method.

Of the 25 participants, 17 were male, and 8 were female. Interviews were conducted in participants' provinces of residence, without geographic restrictions, and with a focus on contextual diversity. The longest interview lasted 1 hour, 41 minutes, and 41 seconds, and the participant was interviewed twice upon request. The shortest interview lasted 30 minutes and 02 seconds (Table 1). Informed consent was obtained from all participants. Pseudonyms were used to protect confidentiality, and interviews were terminated when data saturation was reached. Ethical approval for the study was granted from the Social and Human Sciences Board of XXX University, after which data collection was initiated [Name deleted for anonymous review].

## 2.2. Semi-Structured Interviews

Semi-structured interviews were used to ensure researcher participation without influencing participants, as this format is considered the most appropriate for phenomenological studies (Seggie & Bayyurt, 2017). The researcher developed an interview protocol to guide the process and ensure flexibility (Kuş, 2012). Questions were prepared based on a literature review and tailored to the study's purpose.

At the beginning of the interviews, participants were asked to define the unrecorded economy. Participants generally defined it as "transactions prohibited by law or concealed

from official government institutions, or activities that are not prohibited but remain unregistered." Participants then reflected on unrecorded economic behavior in the healthcare sector, providing examples such as irregular practices by healthcare workers, hospitals, medical device companies, and pharmaceutical companies. Participants were then asked, "Why might an unrecorded economy emerge in healthcare?" to identify the underlying causes of these behaviors.

### 2.3. Process

In Interpretive Phenomenological Analysis (IPA), individuals are treated as subjective beings who give meaning to their experiences. The researcher attempts to uncover the essence of the phenomenon by interpreting participants' narratives regarding this meaning-making process. In line with this understanding, the study was conducted on a voluntary basis, with interviews conducted at times and locations convenient for the participants, and data saturation was achieved when recurring phrases were identified.

A total of 464 pages of interview transcripts were obtained from the study. The analysis process followed the six-stage structure suggested by IPA. In the first stage, the obtained transcripts were read several times to obtain a holistic understanding. In the second stage, a descriptive and conceptual analysis was conducted in the margins of the transcripts. Notes included initial comments on how participants expressed their experiences. In the third stage, "emerging themes" were developed separately for each interview, and recurring ideas, core concepts, and semantic units in the statements were identified. In the fourth stage, the relationships between the emerging themes were examined. The themes were grouped together, and higher-level themes were created by establishing semantic connections. In accordance with the IPA approach, these four stages were completed separately for each participant. In the final stage, the similarities and differences between the participants were compared, and the final thematic structure was created.

To enhance the reliability of the coding process, the interviews were independently read by two researchers, who derived preliminary codes. At this stage, a high degree of similarity was ensured between the codes, and any discrepancies were identified and revised. After the initial coding was completed, the researchers reviewed the codes a second time, allowing a one-week period to prevent overinterpretation or omissions.

A code tree was created with a hierarchical structure, containing codes and subcodes. A code tree is a thematic diagram that reflects the structural relationships among main codes, subcodes, and the meaning units associated with these codes. For example, under the theme "Reasons Related to Expectations," there was the subtheme "Economic Expectations." Under this subtheme, subcodes such as "economic dissatisfaction," "economic interest," "income ambition," "motivation to receive payment from SUT," and "quota anxiety" were structured based on participant expressions.

The final code tree was evaluated in several sessions by a committee of 15 academics with expertise in health policy, economics, and qualitative research. The academics did not conduct independent coding; instead, they examined the existing code-subcode-theme structure to assess the content overlap of the codes, the extent to which the themes represented the data, and the logical consistency of the code placement. Discussions were held on points of disagreement, and some codes were renamed or combined, thus enabling a consensus-based validation process.

In qualitative research, it is important for the researcher to be aware of how their own position might influence the study. Although the researcher is not professionally involved in the healthcare sector, they possess knowledge and perceptions of the healthcare system from both patient and healthcare user perspectives. The researcher is aware that personal experiences can shape certain perceptions. Therefore, during the analysis of the interviews, regular reflective notes were kept to ensure that personal expectations or observations did not guide the coding process, and the congruence of each theme with the participants' statements was re-evaluated. Comparative reading with a second researcher

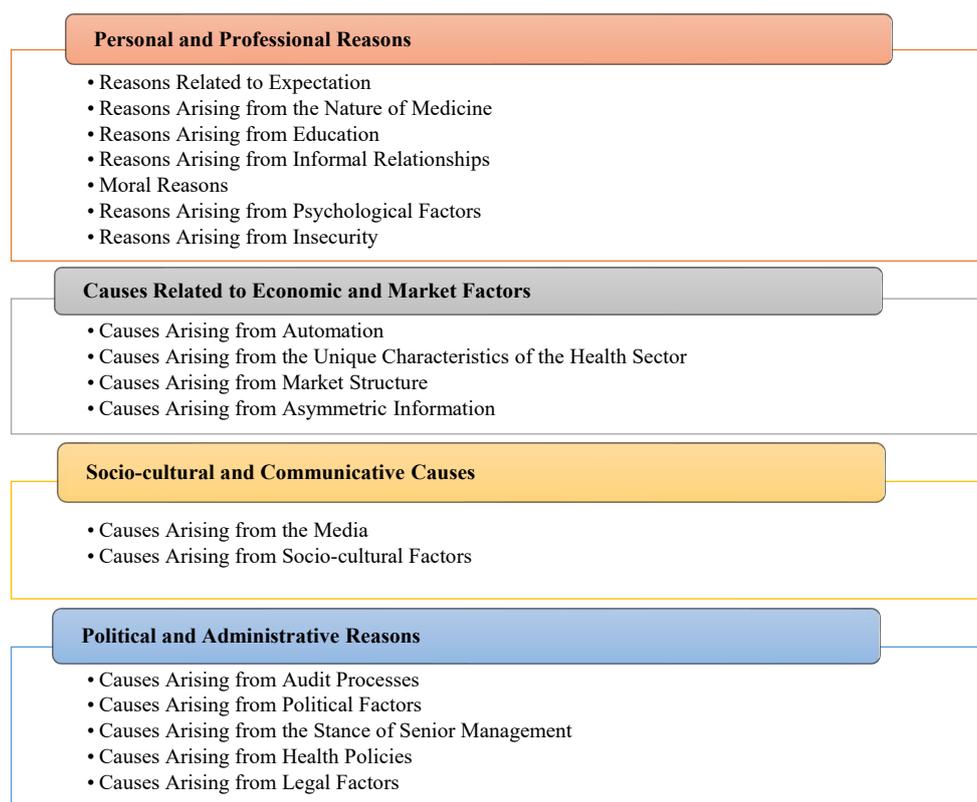
and review of the themes by an expert group during the coding phase aimed to reduce the risk of bias that might arise from the researcher's interpretation. Due to the nature of IPA, the researcher's interpretation cannot be completely excluded. However, the principle of double hermeneutics was followed to ensure that this interpretation process was based on the meanings expressed by the participants. At every stage of the process, the researcher aimed to remain as faithful as possible to the participants' experiences, while considering their own influence.

MAXQDA 18 Pro Analytics software was used to systematically organize the data, create a code tree, analyze code associations, and visualize the themes. The software simplified the management of large datasets and increased the traceability of analysis steps.

### 3. Results

The thematic structure generated through the analysis is briefly summarized to explain how the participant narratives are organized. The study identified 18 main themes, grouped under four overarching categories, that reveal the causes of unrecorded economic behavior in the healthcare sector and reflect its multilayered structure.

The first category, Personal and Professional Reasons, addresses psychological, ethical, and professional factors, including individual motivations and expectations, moral norms, professional autonomy, unrecorded relationships, distrust and the inherent characteristics of medical practice. The second category, Economic and Market-Related Factors, encompasses structural and financial mechanisms such as asymmetric information, market competition, sector-specific dynamics, and limitations on automation or recordkeeping. The third category, Sociocultural and Communication Factors, encompasses societal norms, cultural expectations, and the media's influence on public perceptions and behavior. The fourth category, Political and Administrative Reasons, concerns systemic governance issues, including regulatory deficiencies, political priorities, managerial attitudes, oversight and control mechanisms, and legal shortcomings. Taken together, these four categories demonstrate that unrecorded economic behavior in the health sector cannot be explained by a single determinant. Instead, it emerges through the interaction of individual incentives, professional norms, institutional weaknesses, sociocultural practices, and systemic governance structures. In the following sections, each theme is presented with illustrative quotes that illustrate how participants interpreted the drivers of unrecorded economic behavior.



**Figure 1.** Causes of the Unrecorded Economy

Figure 1 presents the conceptual map derived from the coding process. It demonstrates how participants' statements were clustered into sub-themes and then into broader thematic categories. The map also reflects the interconnections among personal, economic, sociocultural, and administrative factors contributing to unrecorded economic behavior.

### 3.1. Personal and Professional Reasons

This category includes themes related to individual motivations, professional dynamics, ethical perceptions, and interpersonal relationships within the health system. Participants frequently emphasized that unrecorded economic behavior is shaped by personal expectations, moral attitudes, occupational structures, and psychological pressures.

#### *Reasons Related to Expectation*

Expectation refers to the anticipated benefit individuals hope to obtain from a behavior. Participants consistently reported that unrecorded practices are often driven by economic gain, service-related demands, privacy concerns, and professional advancement.

Economic expectations—such as financial dissatisfaction, desire for additional earnings, and avoidance of financial obligations—were among the most prominent reasons:

*"Greed for money... because there are professors who want to earn more and more, unfortunately there are professors who are greedy, unfortunately there are professors who see everything as money (Emine, Medical Secretary)."*

*"Now human beings are always insatiable. He always wants two when he is one, he always wants more when he is two. He always wants more (Melis, Pharmacist)."*

*"...nobody wants to pay taxes, you know, taxed income is sacred and all that, that's a story, nobody wants to pay taxes. I mean, they don't want to (İsmail, Academician)."*

Privacy expectations, especially in sensitive medical areas—psychiatry, sexual health, or gynecology—also encouraged off-the-record transactions.

*“sexual things, especially sexual diseases. Why? He doesn’t want it to be known. It happens in psychiatric diseases. ... things that don’t need to be known are done, other than psychiatry, gynecology comes to my mind.... In such areas, they may turn to these areas not only in economic terms but also in order not to create records (Savaş, Pharmacist).”*

Participants further noted that service expectations, such as wanting faster or higher-quality care, could similarly motivate such behavior.

#### **Reasons Arising from the Nature of Medicine**

Participants emphasized that the autonomous, indispensable, and high-responsibility nature of medicine contributes to unrecorded practices. Physicians’ central role in health care and their unique professional power sometimes create environments prone to unrecorded behavior:

*“Since the main element of the system is the physician, the physician is also the administrator.” (Erhan, Medical Representative)*

*“Okay, friends, let’s not touch him anyway, we already have a child psychiatrist, if we miss him, we will have problems.” (Nazlı, Physician)*

#### **Reasons Arising from Education**

Participants noted gaps in medical training, especially in communication and ethics, as well as deficiencies in public health literacy, which create room for misuse.

*“... the more conscious you are about health, the more conscious health care you will receive. If the level of awareness is low, you will not use health consciously anyway. You don’t know from whom you will get what service. And you become vulnerable to abuse. That’s why such people can practice extreme abuse.” (Aysun, Physician)*

#### **Reasons Arising from Informal Relationships**

Unrecorded relationships in this context refer not to sincere bonds but to hidden, interest-based networks. Participants used expressions such as “secret partnerships” and “crony-sergeant relations”:

*“If you are close to management, your audits are more flexible.” (Aysun, Physician)*

*“Political reasons... unethical things.” (Ahmet, Inspector)*

#### **Moral Reasons**

Low moral standards, blurred ethical boundaries, and normalization of unrecorded earnings were highlighted as key contributors:

*It is innocent to go out illegally, that is a moral problem of human beings, and there is a lot of it in our country (Kerim, Inspector).*

#### **Reasons Arising from Psychological Factors**

Psychological factors include anxiety, a sense of obligation, helplessness, and survival concerns. The urgency and irreplaceability of health services intensify these pressures:

*“The price of health, that is, the amount that people will pay to relieve their pain, is incalculable, okay? So when a heart transplant or, let’s say, a liver transplant is done for a patient waiting for a heart transplant or a liver transplant, the man is ready to give you his fortune, so gratitude, that is the price of gratitude.” (İsmail, Academician)*

*“... worries should disappear. Why do they turn to the unrecorded sector? Because of their anxieties. As I mentioned before, there are psychiatric disorders, abortion, this and that. These create anxiety in people.” (Savaş, Pharmacist)*

#### **Reasons Arising from Insecurity**

Participants frequently pointed to distrust in the system, institutions, or others as a major driver:

*I mean, who trusts whom and how? I mean, trust is the biggest, I mean, in my opinion, the biggest problem in this country is that we don’t trust each other (Muzaffer, Medical Representative).*

### **3.2. Causes Related to Economic and Market Factors**

This category captures structural dynamics, including automation gaps, market competition, pricing structures, and information asymmetry.

#### ***Causes Arising from Automation***

Insufficient automation and weak record-keeping systems facilitate unrecorded practices.

*“... there is really no such thing in any hospital in the Ministry of Health hospitals. In other words, there is no way to keep a proper record of the material, to ensure proper consumption, everyone is focused on purchasing.” (Semih, Participant)*

#### ***Causes Arising from the Unique Characteristics of the Health Sector***

The non-deferrable, vital nature of healthcare makes the sector structurally prone to unrecorded practices:

*“But you have to take it. That surgery has to be done. That patient comes to you because he/she has to undergo surgery.” (Nuray, Health Services Manager Assist.)*

#### ***Causes Arising from Market Structure***

Participants emphasized issues such as uneven competition, multi-stakeholder conflicts, and private sector pressure:

*“... if there is no competition on equal terms, everyone wants to win, and if you are in a structure that is not taken care of and made more difficult than your competitors, you have to turn to more things in order to increase your earnings as much as they do.” (Aysun, Physician)*

#### ***Causes Arising from Asymmetric Information***

Asymmetric information—where one party has more knowledge—was considered one of the strongest drivers:

*“When it comes to supply and demand, demand creation is extremely important. Why is it extremely important? You create demand so that if you create a demand in the market when it doesn't need it, you can offer some products when it doesn't need them.” (Hüseyin, Physician)*

### **3.3. Sociocultural and Communicative Factors**

Socio-cultural and communicative causes refer to the ways in which shared values, cultural norms, collective expectations, and communication practices shape individuals' interpretations of the health system and their engagement in unrecorded economic behaviors. In this theme, participants emphasized how cultural traditions, societal attitudes, and media jointly normalize or reinforce unrecorded practices within the healthcare field.

#### ***Causes Arising from the Media***

Insufficient media regulation and misleading health content were frequently mentioned:

*“... he goes on TV, he does something, aromatherapies and so on. In other words, since it is a new field, there are many gaps. There is no regulation, there are not many regulations on the subject... Patients and citizens accept that all kinds of information can be accessed by asking Google or the internet and that this information is correct.” (Savaş, Pharmacist)*

#### ***Causes Arising from Socio-cultural Factor***

Participants emphasized traditions, cultural norms, and gift-giving practices:

*“We have gifts in our traditions. In Azerbaijan they call it gratitude. This is a little bit in our traditions and customs, they already get money from the state, they say why is it necessary. But in our country, such a gift is a circumcision, it is also part of our beliefs and beliefs. It needs to be measured and adjusted well.” (Doğan, Academician)*

### **3.4. Political and Administrative Reasons**

This final category includes oversight failures, political dynamics, managerial attitudes, policy gaps, and legal shortcomings.

#### ***Causes Arising from Audit Processes***

Lack of personnel, ineffective inspections, and inconsistent enforcement were repeatedly noted:

*“There are not many inspections except for complaints because there is not enough staff.” (Ersin, Head of Department)*

#### ***Causes Arising from Political Factors***

Participants stated that political interests and tolerance of unrecorded practices weaken control:

*"... Do those who govern the country not see it? In other words, there is some kind of turning a blind eye."* (İbrahim, Academician/ Former Chief Physician Assistant)

#### **Causes Arising from the Stance of Senior Management**

Managerial inaction and discretion amplify vulnerability:

*"When the will to control and monitor all areas is not strong from above, do these areas have the potential to be exposed?"* (İsmail, Academician)

#### **Causes Arising from Health Policies**

Performance systems, remuneration mechanisms, and procurement policies were criticized as drivers:

*"... just think of it like this, working and non-working people get the same money, it's state policy. That's why the man may be buying these things to bring additional income for himself."* (Emine, Medical Secretary)

#### **Causes Arising from Legal Factors**

Weak sanctions and legal gaps, especially in online sales, were emphasized:

*"The biggest reason is that criminal sanctions in our country are insufficient."* (Ersin, Head of Department)

## **4. Discussion**

Healthcare is a sector where purely economic decisions cannot be made, and market logic and profit-loss concepts often become dysfunctional (Arrow, 1963). This demonstrates that the underlying reasons for decisions and behaviors in healthcare are multifaceted rather than a single cause. This study, which aims to explore the reasons behind unrecorded economic behavior in healthcare, identified eighteen main themes through interviews. Each theme represents participants' perspectives on the reasons individuals or institutions engage in such behavior.

The majority of participants emphasized that material gain (specifically, income dissatisfaction, unequal distribution of earnings, and performance-based pressures) is the primary motivation behind these behaviors. Economic expectations for individuals and organizations were highlighted as the primary driver. Individuals or organizations seek to earn additional income or maintain their current position through these behaviors. Numerous factors, including income inequality and the perception of being unfairly compensated for one's labor, directly shape these expectations. Another important reason relates to moral boundaries and problems. Proponents' emphasis on low moral standards or the normalization of unrecorded earnings aligns with Tanzi's (1984) argument that moral decline is a major driver of unrecorded behavior. This suggests that when professional ethics weaken—especially in contexts where income dissatisfaction is high—unrecorded practices gain legitimacy and become socially tolerated. This supports moral economy perspectives that emphasize how cultural norms and perceptions of "deserved earnings" frame what individuals consider acceptable.

Consistent with institutional theory, participants repeatedly emphasized the weakness of oversight mechanisms. A lack of deterrent sanctions, unregulated oversight, and fragmented legal frameworks were identified as conditions that reduce the perceived risk of detection and thus facilitate unrecorded behavior. As Adam (1984) noted, the lack of oversight and accountability in the health sector is a key factor driving individuals and institutions to engage in unrecorded practices. When individuals are not afraid of being audited, they disregard control mechanisms and assume their unrecorded behavior will go undetected, thereby facilitating such activities. In addition to the lack of oversight, participants also highlighted the inadequacy of sanctions resulting from audits. This is seen as reflecting a poorly functioning penal system, where processes are not thoroughly examined and are instead resolved through ad hoc decisions or workarounds. Participants also emphasized that short-term and inconsistent legal regulations undermine efforts to combat the unrecorded economy. These conditions can create

economic insecurity for individuals and institutions while also fostering a sense of freedom of action (Çolak, 2012).

The findings strongly emphasize the political dimension of informality among participants. Neoliberal reforms, marketization pressures, and political tolerance of unrecorded practices directly contribute to the emergence of unrecorded spaces within the health sector by weakening formal structures. International studies demonstrate that when health systems have unstable governance or high political discretion, they consequently experience higher levels of unrecorded payments (Kuti, 1984; Bordas, 1993, cited in Gaal and McKee, 2005).

Trust has emerged as another important theme. As İşler (2020) and international research have shown, higher levels of institutional trust reduce unrecorded economic tendencies. Participants' repeated statements of distrust toward the system, institutions, and other individuals indicate that the trust problem is directly reflected in unrecorded behavior. Furthermore, information asymmetry, a fundamental mechanism in principal-agent theory, has been identified as one of the strongest drivers of unrecorded behavior. Participants indicated that patient dependence on physicians, combined with the complexity of medical information, provides opportunities for physicians to manipulate service requests, encourage unnecessary procedures, or legitimize informal practices. These findings align with those of Felstein (1970) and Izumida (1999), who argue that professional authority, combined with asymmetric information, expands the space for unrecorded practices. Socio-cultural factors also play a significant role. Traditional gift-giving (gift culture), gratitude payments, and the veneration of physicians normalize and reinforce unrecorded practices. These findings also take on meaning within the framework of the moral economy. The fact that some behaviors were described by participants as "normal," "harmless," and "thank-you" demonstrates that cultural norms and reciprocal relationships can legitimize unrecorded economic behaviors. This finding is similar to the unrecorded payment literature in Eastern Europe and Central Asia (Gaal & McKee, 2004).

The digital transformation and the emergence of new unrecorded spaces, emphasized in the post-pandemic literature (ILO, 2021; WHO, 2021), also align with the study findings. The participants' particular focus on gaps in online sales, e-prescription processes, and digital systems shows that informality is expanding not only through traditional mechanisms but also through technological changes.

## 5. Conclusion and Recommendations

According to the research findings, the emergence of the unrecorded economy in the healthcare sector cannot be attributed to a single factor. Rather, the unrecorded economy is perceived by participants as arising from a multidimensional structure encompassing economic, social, cultural, institutional, and political dimensions. Healthcare services, by their nature, extend beyond biological processes and constitute a complex field shaped by economic expectations, societal values, political approaches, institutional capacities, and ongoing technological transformation. Accordingly, based on participants' statements and interpretations, the unrecorded economy is understood not merely as a product of individual interests, but also as a phenomenon associated with institutional functioning, societal norms, and the broader structural context of the healthcare system.

From the participants' perspectives, these interrelated factors suggest that unrecorded economic practices in healthcare emerge through the interaction of structural, cultural, and administrative processes alongside individual preferences. Participants described economic expectations—particularly insufficient income, perceptions of injustice, and performance-related pressures—as prominent factors associated with unrecorded behavior. In addition, weaknesses in control mechanisms and the perceived lack of deterrent sanctions were frequently mentioned as conditions that facilitate the avoidance of accountability by both individuals and institutions. Participants also emphasized that political preferences, neoliberal policy orientations, the increasing

commercialization of healthcare services, and frequent changes in legal regulations generate uncertainty within the sector, which is experienced as contributing to unrecorded economic practices. Furthermore, the findings indicate that cultural and ethical factors—such as low levels of social trust, concerns regarding confidentiality, the erosion of ethical sensitivities, and the prevalence of informal relationships—are perceived as significant influences on the unrecorded economy.

These findings suggest that efforts to address the unrecorded economy cannot be confined solely to administrative or financial regulations. From the participants' viewpoints, strengthening ethical principles, enhancing transparency in the patient–physician relationship, safeguarding confidentiality, and fostering social trust should be considered integral components of a holistic approach. Participants also highlighted the importance of expanding ethics education for healthcare professionals, reinforcing institutional mechanisms to prevent conflicts of interest, and improving citizens' health literacy as part of this process.

With regard to policy implications, participants perceived the strengthening of control mechanisms through digital infrastructure—such as real-time record-keeping systems, digital billing processes, automated alert systems, and online monitoring tools—as a potentially effective means of reducing unrecorded economic practices. However, consistent enforcement of sanctions, the limitation of amnesty practices, and greater legal predictability were also emphasized as essential for enhancing institutional trust. To address economic pressures, participants underscored the need to re-evaluate the income levels, working conditions, and performance expectations of healthcare professionals and to move toward a fair and sustainable remuneration structure.

For the effective governance of the healthcare sector's multi-stakeholder environment, participants stressed the importance of regular consultation between policymakers and key actors, including physicians, administrators, regulatory authorities, and representatives of the pharmaceutical and medical device industries, as well as the systematic assessment of sectoral needs. Moreover, participants noted that digital health policies should be updated to reflect emerging drivers of a new generation of unrecorded economic practices, such as increasing digitalization, online access to health-related products, and the risks associated with counterfeit pharmaceuticals and medical devices.

In conclusion, from the perspectives of the participants, unrecorded economic practices in healthcare represent not only a financial concern but also a challenge to social equity, ethical integrity, and the long-term sustainability of the healthcare system. Developing effective responses to the unrecorded economy therefore requires the simultaneous strengthening of oversight, implementation, transparency, ethical responsibility, and trust-building mechanisms. By adopting a multi-stakeholder IPA approach, this study contributes to the literature by offering a multidimensional exploration of how the unrecorded economy in the Turkish healthcare sector is experienced and interpreted. Future research focusing on digital health applications, cross-national comparisons, and more in-depth analyses of patient experiences may further enhance understanding of unrecorded economic practices in healthcare.

## 6. Limitations

While this study offers a significant qualitative contribution to understanding the causes of unrecorded economic behavior in the healthcare sector, it also has some limitations. First, because the research employed a qualitative design and an IPA approach, the findings are not generalizable. Participants' experiences and interpretations are context-specific, and the institutional and cultural characteristics of the Turkish healthcare system shaped the scope of the results.

Secondly, while the study sample encompassed a wide range of stakeholders, the limited representation of 25 participants and some professional groups makes it difficult for the findings to reflect all actors in the sector equally. Furthermore, while data

saturation was achieved, greater socio-demographic diversity could have contributed to the emergence of diverse perspectives.

Thirdly, the researcher's lack of professional experience in the healthcare sector, but personal experience with informal practices as a patient, is both an advantage and a potential limitation for reflexivity. While the researcher developed an awareness of suspending bias throughout the process, the possibility that interpretations were influenced by the researcher's sensitivities and past observations cannot be completely ruled out. Fourth, the study was conducted solely within the Turkish context. Therefore, the results cannot be generalized to countries with different health system structures, cultural characteristics, or economic models. A comparative analysis, particularly with OECD or developing countries, is a future research opportunity that would strengthen international validity.

Finally, the data collection process relied solely on semi-structured interviews. While qualitative interviews provided an in-depth understanding of the phenomenon, the use of additional methods such as record reviews, focus groups, or observation could have increased data diversity and further strengthened the reliability of the findings through triangulation.

Despite these limitations, the study provides a holistic understanding of the structural, cultural, economic, and political dimensions of informality in the health sector and provides an important foundation for future research.

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