APPLICATION OF MARKETING CONCEPTS AND PRACTICES TO THE OPERATIONS OF PRIVATE HOSPITALS IN ISTANBUL

(Ph.D. Thesis)

Selime D.(Özden) Sezgin

May, 1982

ACKNOWLEDGMENTS

I have to express my thanks to all the administrators of private hospitals, and physicians who graciously granted permission to use their material. I am also indepted to Prof.Dr.Ahmet N.Koç for his invaluable advice and assistance in shaping this thesis. I want to thank my father and mother for their support and understanding. If it were not for their encouragement this thesis would have never been realized. I also want to thank Yıldız and Simin Celasun, and Gülay Dörter for their help in the tabulation of results and printing of the thesis. Last, but not least, I have to thank my son and husband for their patience.

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PART I

I. INTRODUCTION

Throughout the last decade, marketing has achieved a new recognition and stature in business, particularly in enterprises in which consumer response dictates the success or failure of the products or services offerred. Because of the widespread adoption of marketing principles by industry and industry's resultant success in using them, marketing techniques have spread today into almost every area, and even into areas providing services rather than products.

Modern Marketing has two different meanings in the minds of the people who use the term. One meaning of marketing conjures up the term selling, influencing, persuading. Marketing is seen as a huge and increasingly dangerous technology, making it possible to sell persons, things, propositions and causes they either do not want or which are bad for them. The other meaning of marketing unfortunately is weaker in the public mind; it is the concept of sensitively serving and satisfying human needs. By the recognition that effective marketing requires a consumer orientation instead of a product orientation, marketing has taken a new role in life and tied its economic activity to a higher social purpose. It is this second connotation of marketing that provides a useful concept for all organizations as all organizations try to serve a group of consumers (clients, donors whatever you call them) as efficiently as its limited competence or resources allow. We can define marketing as that function of the organization that can keep in touch with the organization's consumers, read their needs, develop products and services to meet these needs and keep the organization in harmony with its publics(1). Theodore Levitt, states "Marketing is concerned with all the exhilarating big things and all the troublesome little things that must be done in every nook and cranny of the entire organization in order to achieve the corporate purpose of attracting and holding customers"(2). So, every organization which has customers must employ "marketing effort and practice" to keep intact its future

(1) P.Kotler and S.J.Levy, "Broadening the Concept of Marketing", Journal of Marketing, XXXIII (January, 1969), 10.

(2) N.N.Wexfer, "What is Marketing?", Journal of American Hospital Association, II, (June, 1977), 51.

survival and success. The merchantalistic image of marketing is the main reason why certain professional groups have rejected the idea of marketing to be applied to their operations. One such group is the medical profession, whether administrators of private hospitals which are established on the basis of profit motive or private physicians who work to gain a livelihood. They regard their profession beyond the merchantilistic concept of marketing, see their work as fulfilling certain responsibilities to society at large. But, with the use of the "marketing concept" not 'the selling concept', they will be better able to fulfill their duties as their profession dictates, as "social marketing concept" is defined as a management orientation aimed at generating customer satisfaction and long-run cunsomer and public welfare as the key to satisfying organizational or professional goals and responsibilities"(3).

With the advanced definition of marketing, certain social issues can be examined from a new focus. An important social problem in Tufkey, is the inefficiency of medical care service; patients are complaining about the services offerred, doctors are complaining about the whole system, so there is consensus that the medical care sector, while ever costing more, is not performing any of its functions well for all those who could benefit by them. The multiplicity of proposals for the cure in terms of delivery, organization, financing and control is evidence that dissatisfaction with the performance of the medical care sector has reached the status of a politicized social problem. As in other complex diseases, while there is agreement that something is drastically wrong, there is no consensus on either the diagnosis or the therapy.

The medical care industry, defined to include the services of physicians and other health professionals plus the capital, labour and intermediate goods used at their direction, is one of the largest and fastest growing in the entire economy. The analysis of the entire sector from a marketing perspective would be too broad an issue and unfruitful because of the diversity of practices and organizations. So, in this thesis; private institutions (hospitals, clinics) are taken as the units of analysis. We

(3) P.Kotler and G.Zaltman, "Social Marketing: An Approach to

will try to analyze private hospitals as any unit of business with specific products and a group of consumers who purchase the products to satisfy certain needs and wants. In this analysis, we will try to bring the two sides of the exchange process -(the production of medical services by hospitals and the consumption of these services by a group of customers)- together, and the tool by which a whole will be formed, is the marketing tools and techniques. We will try to offer a therapy to the malfunctioning of private institutions in the form of "application of the marketing concept" to the operations of the institutions, to show that by the use of marketing tools and techniques, the efficiency can be increased (efficiency in the form of consumer satisfaction with organizations' products and practises). We think that hospitals would do well to explore the techniques and strategies of marketing as they search for new, more effective ways to attract patients, qualified personnel, and other resources and deliver services that are needed and wanted and that will be used, in order to ensure their future development and survival. Marketing, will keep the hospitals on target for efficient use of resources which are scarce within the economy.

2. MARKETING OF SERVICES

Before starting an analysis of medical care marketing, it is important to note how marketing tools are used in service industries (as medical care involves services plus goods and capital) and how they differ from those employed in product areas

In a survey of the literature; it became apparent that marketing discipline has a strong "goods" orientation. In academi courses in marketing, tangible goods are considered but rarely services to any extent(4). It is apparent that services have unique characteristies which differentiate them from products, so new concept are necessary if service marketing is to succeed. Merely adopting product marketing's labels does not resolve the question. The importance of the issue arises from the fact that services have become an increasingly important part of the consumers' life styles. TABLE 1 indicates that services are now the largest single component of per capita spending in U.S.A.

TABLE 1- Personal Consumption Expenditures

Year	Durables	Nondurables	Service
1960	280	1.124	1.022
1961	270	1.131	1.038
1962	298	1.152	1.067
1963	321	1.164	1.102
1964	347	1.206	1.143
1965	387	1.248	1.192
1966	412	1.291	1.231
1967	414	1.300	1.275
1968	457	1.334	1.319
1969	476	1.348	1.365
1970	458	1.372	1.384
1971	502	1.385	1.409
1972	556	1.434	1.463

a) Per Capita Real Spending (All per capita figures in 1972 dollars).

b) R.M. Bessom and D.W.Jackson, "Service Retailing: A Strategic Marketing Approach", Journal of Retailing, LI, (Summer, 1975), 79.

(4) I.M.Rathmell, "What is Meant by Services?", Journal of Market-

TABLE 2- Personal Consumption Expenditures in the Fourth Development Plan, 1979-1983

	1978		1983		Percentage Increase	
	Amount	Percentage	Amount	Percentage	Five Years	Yearly
Agriculture	201.2	25.5	254.4	24.5	26.4	4.8
Mining	2.2	0.3	3.0	0.3	36.4	6.4
Food items	107.7	13.7	143.3	13.8	33.1	5.9
	59.4	7.5	79.8	7.7	34.3	6.1
Other manufactsector	127.7	16.2	180.7	17.4	41.5	7.2
Electricity, water and gas	8.4	1.1	14.3	1.4	70.2	11.2
Transportation	73.1	9.3	96.1	9.2	31.4	5.6
Communication	4.1	0.5	5.4	0.5	31.7	5.7
Services Sector	194.8	24.7	248.3	23.9	27.5	5.0
Import	9.6	1.2	14.3	1.3	48.9	8.3
Total	788.2	100.0	1.039.6	100.0	31.9	5.7

a) 1978 prices, in billion TL.

b) T.C. Başbakanlık Devlet Planlama Teşkilatı, Dördüncü Beş Yıllık Kalkınma Planı, 1979-1983, Başbakanlık Devlet Matbaası, Ankara, 1978, p.146.

From Table 2, it can be seen that the service sector has the highest amount of personal consumption expenditures, after agriculture in Turkey. Also, personal consumption expenditures in service sector shows a high yearly percentage increase (second after electricity, water and gas). This shows the increasing importance of the service sector within the Turkish economy. Also, the amount of employment in the service sector has doubled in the last decade, nearly 68 % of employment in U.S.A., is in the service sector. This impressive increase in services sector has been associated with:

(1) Increased affluence, (2) Rising tide of education, (3) changing attitudes toward work and leisure, (4) a more sensate way of life, (5) greater personal fulfillment and (6) a more complex society(5). So in order to keep pace with the economy's expansion, companies accustomed to selling products alone for profitable growth have diversified more and more into services.

(5) T.C. Taylor, "Changing Markets -Selling the Services' Society" Sales Management- The Marketing Magazine, (March, 1972), 23.

What are services? There are probably as many definitions of services as there are writings on the subject. The committee on definitions of the American Marketing Association defines services as "activities, benefits, or satisfactions which are offerred for sale or are provided in connection with the sale of goods. Examples are amusements, hotel service, electric service, transportation, the services of barber shops and beauty shops, repair and maintenance service, the work of credit rating bureaus. This list is merely illustrative and no attempt has been made to make it complete"(6).

So, not only the definitional committee of the American Marketing Association made "no attempt" to make it complete but no one else either. To find, a clear definition of "service" in literature is difficult; there exists no authoritative consensus on either the boundaries or the classification of the service industries. So, the discussion proceeds to analyze the characteristics of "service units" without giving a clear definition of the entity called "service".

2.1. CHARACTERISTICS OF SERVICES

From the survey of literature it becomes apparent that services have many qualities which differentiate them from physical products. These characteristics can be grouped as follows:

1- intangibility
2- human intensive
3- heterogeneity
4- attractiveness of consuming without ownership
5- inseperability
6- perishability

Each of these characteristics will be examined in turn, and how these characteristics influence marketing strategies will be noted.

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(6) R.C.Judd, "The Case for Redefining Services". Journal of

2.1.1. Intangibility

Michael R.Reagosa, Philadelphia regional sales manager of Honeywell Information Systems Inc., points out that "when you sell a service, there's no pretty black box to show the customer, and the results aren't demonstrable"(7). This statatement shows that intangibility refers to the lack of tangible features that appeal to a buyers' senses of hearing, sight, taste, smell and touch; in short to the absence of a tangible product. But, there is a difficulty in application of intangibility criterion to all service areas. A dentist who makes a false tooth and places it in the patient's mouth is certainly delivering a tangible product, but dentistry is invariably classified as a service. It is difficult to make a sharp distinction between the activities of an auto assembly plant and those of an automobile repair shop, but the former is invariably classified in industry and the latter is usually regarded as a service. A haircut, a shoeshine, the giving of a medicine or therapy by a doctor is something tangible. So intangibility also includes some tangible aspects in a service. Alfred Marshall sharply pointed up this dilemma by noting that in one sense all industries provide services. "Man cannot create material things"(8).

2.1.2. Human Intensive

It refers to the fact that service marketing involves the interaction of people. Service is presumed to be performed by individuals for other individuals generally on a one-to-one basis. It is recognized that the person, personality and perceived behaviour of the seller is an integral part of the purchase decision(9). The delivery of most services results from the activities of people not products, and a consumer chooses a supplier of a service because of his image or impression of the people who will produce and supply the service.

(7) T.C.Taylor, "Changing Markets-Selling the Services Society", Sales Management-The Marketing Magazine, (March, 1972), 26.

(8) Alfred Marshall, Principles of Economics, (8th ed.; London, MacMillan and Co., 1929), 63.

(9) R.M.Bessom and D.W.Jackson, "Service Retailing-A Strategic Marketing Approach", Journal of Retailing, LI (Summer, 1975), 76.

2.1.3. Heterogeneity

The intangibility and human intensiveness of the services, makes it impossible to standardize services, so evaluation of quality differences even between the services of the same producer becomes difficult (no evaluative criteria by which services can be compared). For example, no two haircuts from the same barber are identical, neither are all repair jobs a mechanic does on cars. So buyers of services cannot make quality evaluations or comparisons in advance of buying a service.

2.1.4. Attractiveness of Consuming Without Ownership

Refers to rentals and public transportation and utilities whose ownership may often be burdensome. So, without ownership, the user is free from risks of product style change and absolescence. Non-ownership implies "shared use" of the same product among various consumers. Communal use of certain property like transportation, equipment, and housing may reduce unnecessary production, economizing on scarce resources.

2.1.5. Inseperability

Another distinctive feature of service marketing is the fact that the product cannot easily be seperated from the producer. It is therefore usually impossible to distinguish between the creation of a service and the marketing of it, as these are created and consumed simultaneously. Since, there may be no transfer of ownership in the sale of a service, buyers are more dependent on the seller during the consumption and use of the purchased service.

2.1.6. Perishability and Fluctuating Demand

Within the intangible character of the services, perishability of the service output is an important characteristic. It refers to the fact that services cannot be stored for periods of peak demand as these cannot be mass produced. The utility of most services is short lived. This perishability factor of services is illustrated by a common expression in the hotel field. "A hotel room is the most perishable commodity imaginable. If it is not booked tonight, that revenue is lost forever"(10). Unsold theatre

(10) R.M.Bessom and D.W.Jackson, "Service Retailing-A Strategic

tickets and empty seats on airline flights also illustrate the risk inherent in service perishability. Furthermore, the market for services fluctuates considerably, by seasons, by days of the week and even by hours of the day.

To evaluate the marketing mix decisions for services, one has to delve into a complex job of scanning the vast literature on the subject, as analysis on the subject has not evalued into a complete theory. So we have, proceeded to analyze differences of service marketing from product marketing and how these differences arise from the characteristics of services. To answer this question, product and service retailing can be examined from four aspects.

- product and service development and planning
- pricing
- promotional strategies
- channels of distribution of services

2.2. PRODUCT AND SERVICE DEVELOPMENT AND PLANNING

The more human centered the service, like professional and personal services, the more it seems to depart from the conventional treatment of the product. The most obvious reason for this change is that with a tangible good you have the actual product to evaluate, to try and determine if the product meets your expectations. On the other hand, as Wittreich has stated "there is a mystique involved in evaluating a service that does not apply in buying a typical product". In negotiating the purchase of a service the buyer often feels as though he is putting his fate in the seller's hands. The image and the reputation of the service seller and its personnel are perceived to be part of the product. Thus, personnel and company image become the physical representation of the offering. This is important from marketing point of view, because companies in planning their services, must take into consideration characteristics of its personnel and company's public image, because the consumer can be expected to choose a service supplier whose place of business and sales personnel

(11) W.J.Wittreich, "How to buy and sell Professional Services", Harvard Business Review, (March-April, 1966), 127.

clearly suggest the quality of service desired for the satisfaction of his needs. As outward appearances will play an important part in a consumer's evaluation of the quality and nature of the service he is to purchase, the service business must be good and it must look good. Some service businesses may be able to neglect this important aspect of marketing strategy for a time because effective competition does not exist. Eventually, however, some competitor seeking new opportunities may enter the market and offer a more satisfying mix of services for consumers. The threat of competition of this kind challenges all service businesses, even medical, dental and other professional services.

An important difference between product and service marketing is that when marketing a product, the primary task is to create a desire or a need for the product in the minds of the consumers. Services are best marketed by meeting already established needs, due to the absence of a physical product. The primary difference between two marketing strategies is that product manually determines the marketing strategy; while in services the strategy often develops out of the motivational influences surrounding the service(12). An important implication of the above statement is that service or the content of the service changes according to the needs and preferences of a single, unique customer, so there exists a particular service for each particular customer. This heterogeneity aspect of the services enables the marketer to recognize and satisfy the individualized needs of the consumer, increasing customer satisfaction.

Intangibility makes the quality judgements difficult. Buyers are usually not able to set standards by which to make quality comparisons before making a purchase decision. Due to intangibility, branding, brand development and acceptance, and packaging are usually not prominent in the marketing of services. Also, patent rights cannot be kept in service industries; competitors are more likely to gain access to major innovations in the service industry compared to product sector.

Due to the inseperability of the service and the service

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(12) T.C.Taylor, "Changing Markets-Selling the Services Society", Sales Management-The Marketing Magazine, (March, 1972), 27.

giver, consumption and use is not possible without the participation of the seller. Once, the service has been consumed and used, then the buyer is independent of the seller. Because of the simultaneous production and sale of most services, marketers of services are mainly concerned with time and place utility. Convenience is a factor that weights heavily in most consumers' choice of a service supplier. If a consumer with rather specific needs perceives no appreciable difference in the quality or price of competitive services, he can be expected to select the supplie whose location is most convenient and available to him. Thus, location becomes an integral part of service component.

Perishability and high fluctuating demand of most services makes production planning and capacity planning especially important in service industries. As services cannot be mass produced ahead of time and stored for periods of peak demand, the utility of services is short-lived. When seasonal and load variations in sales of service industries arise, service firms must have the facilities available to meet peak periods even though these facilities remain idle during other times of the year or day. An example, is hospital capacity planning. Where demand is uncertain and uneven, resulting in long waiting lists and multitudes of unattended patients, which shows the amount of unsatisfied consumers, decreasing over all efficiency of the organization.

2.3. PRICING OF SERVICES

Although the price of a service can be determined by several factors, it must be high enough to cover the costs to produce the service and the related amenties as well as to contribute something to profit. So, as in product industries, cost-plus-pricing is common in service industries. The consumer both sectors must feel that the value he receives is greater tha or equal to the price he pays for the service.

Since, so many of the values derived from services are intangible in nature, price is often difficult to equate with value. Aware of this factor, some service firms use prestige pricing, or differential pricing to imply that price of the service implies the quality of the output, that is they make customers feel that they are getting higher values as they don't

have any standard except price to make comparisons and that they feel that they are getting what they have paid for.

It must be remembered that while product sector is relatively unregulated, service sector is highly regulated leading to set prices. A common argument in the literature is that this regulation leads to decrease in quality of services and to lower overall satisfaction on the assumption that market mechanism is a better allocative tool. In certain sectors of the service industry market mechanism cannot regulate or determine price due to lack of competition. The code of ethics of most professional services feel disdainful towards competitive pressures; this is especially true in the medical and legal professions. Also human centeredness of services implies that such services are not price sensitive, leading to inflexible pricing schemes.

Intangibility and heterogeneity of services contribute to the difficulty of making meaningful price comparisons. Perishability and fluctuating demand aspect of services necessitates a "flexible pricing" schedule. Peak load pricing is not uncommon related to capacity planning.

2.4. PROMOTION STRATEGIES

When consumers purchase a service, due to the intangible aspect of the service, visible tangible reinforcement is missing. This uncertainty concerning the satisfaction or benefits to be derived is increased by the fact that, if not satisfied, the consumer is unable to return a service as he usually can an unsatisfactory product. This aspect increases cognitive dissonance felt by the service purchaser so promotional activities take the form of adaptive, courteous and empathic behaviour when dealing with customers(13). In addition to reducing cognitive dissonance, such human and personal dimensions of the service should add materially to the perceived value of the service. Such behaviour can establish close contact between the seller of the service and the consumer. As Holloway and Hancock(14) have stated, "services

(13) R.M.Bessom and D.W.Jackson, "Service Retailing-A Strategic Marketing Approach", Journal of Retailing, LI (Summer, 1975), 66.

(14) R.J.Halloway and R.S.Hancock, Marketing in a Changing Environment, (New York, John Wiley and Sons. Inc., 1973), pp.55-56.

have a considerable personal element in their relationships with the public, more so than do other marketing establishments. This human-intensiveness of the service, leads to the consumer choosing a supplier of a service because of his image or impression of the people who will produce and supply the service-the appearance of their place of business, their location, their relationships with customers and their reputation. As a consequence of these realities, public relations is much more important for attracting customers to service establishments than are the types of promotion and advertising so common in product marketing.

Promoting the undesired services such as medical care, funeral services and legal advice is less common and prohibited in most countries. Indirect forms of promotion is used in order to remind people of the availability of the service and its crisis prevention aspects.

2.5. CHANNELS OF DISTRIBUTION FOR SERVICES

The intangibility, inseperability, perishability and heterogeneity of services imply that services are created and consumed simultaneously. Hence, direct distribution is necessary for most services. Also, cost savings which result from the fact that there are no goods to be stored and handled is an advantage for the service industry. There are no inventories for resale and therefore the costs and problems of storage are eliminated. Performance of transportation function is also less important since there are no tangible products to be handled.

Direct distribution often limits the geographical markets that service sellers can reach leading to localization of various service institutions. However, the trend has been to broaden the channels for services considerably. One way to achieve intensive distribution is to increase the number of locations where the service can be performed.

Another way by which service marketers are seeking to increase their market coverage is by the use of intermediares. They are not the traditional middlemen, they perform more of an information-giving and coordinating function; for example in health care sector in Britain, Health Maintenance Organization (HMO) performs an intermediary role between practitioner and the patie

Regan suggested over a decade ago that the service revolution would be based on a mass production approach to develop service technologies(15). These service systems routinize service operations so that services can be provided faster, more frequently, and at lower costs for mass markets. The most relevant examples of the industralization of services are supermarkets and mass-merchandizing stores which provide wide selection and fast, efficient self-service in contrast to the narrow selection and incompetent sales clerk service of the past. They represent the industrialization of an ancient retail service such as the assembly line represents the industralization of ancient craftsmanship. Other examples include automatic teller machines, credit cards, mutual funds, group health plans, prepackaged vacation tours. These standardization of distribution of services is not in accord with human intensiveness of most services; so, for most customers standardization of service distribution results in loss of some of the ego-satisfying properties, and intrinsic values are lost when extrinsic qualities are enhanced.

2.6. MARKETING MIX STRATEGIES FOR SERVICES

So, the above analysis shows that marketing mix strategies for services, although they exhibit certain similarities, are different from those used in product marketing. The similarities and differences can be summarized as follows:

	Similarities	Differences
1- Product (Service) Development		
a) product or service development incentives	1- Utilization of capacity problem	-
b) product or service development, sources of ideas	1- The market place as a source	-
c) product or service stages	1- Marketing program	1- Patent unavailability for service
d) branding	1- Trade and service marks	-
e) packaging and labeling	-	1- Services lack use for packaging

(15) W.R.George, "The Retailing of Services-A Challenging Future", Journal of Retailing, LIII (Fall, 1977), 94.

	Similarities	Differences
f) warranty and service	-	Law of warranty appears inapplicable
2- Sales Effort		
a) advertising	1- Objectives	-
	2- Institutions and media used	-
b) sales promotion	1- Use of printed promotion material	Lack of physical display in services
	2- Use of coupons	No samples possible services
	3- Use of contests and prizes	No demonstration possible in services
c) sales management and selling	1- Selling techniques	
d) product differentiation	1- Service differentiation urged to parallel product differentiation	-
3- Pricing		
a) price basis	1- Value	
	2- Cost	
b) price management	1- Price variation principles	Services do not use discount structure generally

Another interesting issue is to show how each characteristic of the services affect marketing mix decisions such as product planning, pricing, promotion and channels of destribution for services. These results are summarized in TABLE 3, to give a clearer idea about service marketing.

ABLE 3- SERVICE MARKETING

Service characteristics	Planning and developing the services.	Pricing of services.	Promoting the services.	Distribution channels for services.
luman-intensive	Company and personnel are perceived to be the product.	Price insensitive	Promoting the results of performance	No deliveries.
ntangibility	Branding and packaging not prominent.	Price comparisons are difficult.	Reputation and image of the company.	- direct distribution - non-traditional intermediaries
Inseperability	Buyers are dependent on the seller for the consumption and use.			- direct distribution - non-traditional intermediaries.
Perishability and fluctuating demand.	Requires "service-line extentions; altering the existing sources.	Flexible pricing - special rate schedules - Peak load.	Flexibility of prices used as a promotional tool	- direct distribution - non-traditional intermediaries.
Heterogeneity	Service offerer can be better equiped to meet the individualized needs.	Price comparisons are difficult	Non-standardized quality makes promotional task difficult.	- direct distribution - non-traditional intermediaries.
Attractiveness of consuming without ownership.	- Increased emphasis on product quality - More attention to maintenance and service requirements in product design - Lease rental packages	- Flexible pricing to better reflect the conditions of the product at the time of the rental.	Publicity; emphasizing the need for a better balance between ecology and economy.	- use of traditional intermediaries. - new inventory concepts.

a) Muzaffer Bodur, Unpublished paper.

3. ANALYSIS OF MEDICAL CARE SERVICE

The analysis of the characteristics of services and unique marketing strategies are important in the study of medical care service. The medical care sector is functioning to restore and ameliorate health of consumers. It can be defined as giving sickness care. Good health is one of man's most precious assets. The desire to live, to be well, to maintain full command over one's faculties and to see one's loved ones free from disease, disability or premature death are among the most strongly rooted of all human desires(16). The product to meet this complex need, is indeed very complex in character, as the commodity called "medical care" consist of services provided by different people, surgeons, physicians, nurses and in different institutions, clinics, hospitals, physician's offices, in ambulatory service etc. There can be no doubt that medical care is not the same thing as other economic goods. So the thesis will proceed to analyze the medical care service and to show its differences from other commodities and services in the economy.

3.1. EXPENDITURES ON MEDICAL CARE SERVICES

The medical care industry defined to include the services of physicians, and other health professionals plus the capital, labour and intermediate goods used at their direction is one of the largest and fastest growing within the entire economy as can be seen from rising expenditures in both developing and developed countries.

As can be seen from Table 4, for the sample of countries, current public expenditure on health stood at some 4 1/2 per cent gr of GNP in the mid. 1970's. This 4 1/2 per cent ratio represents, however, somewhat less than 80 per cent of total expenditure on health, reflecting the countinuing significance of private spendin in at least some countries. The GNP shares of private and public expenditure together vary between peaks of 7 1/2 per cent in the United States to lows of 3 1/2 per cent in Greece. Capital expenditure varies from 3 % to 12 % of total health expenditure. In patient services are a large and fast growing part of all

(16) V.R.Fuchs, "The Output of the Health Industry", Milbank Memorial Fund Quarterly, XLIV, (1966), 65.

TABLE 4- TOTAL AND PUBLIC EXPENDITURE ON HEALTH
1974 or near date.

Country	Total health expenditure	Public health expenditure
Australia (FY 1975/76)	6.5	5.0
Austria	5.7	3.7
Belgium	5.0	4.2
Canada (1973)	6.8	5.1
Denmark	...	6.5
Finland (1975)	5.8	5.5
France	6.9	5.3
Germany	6.7	5.2
Greece (1975)	3.5	2.3
Iceland (1973)	5.6	4.8
Ireland (1975)	6.2	5.4
Italy	6.0	5.2
Japan (1975)	4.0	3.5
Luxembourg	4.0	...
Netherlands (1972)	7.3	5.1
New Zealand (FY 1973/74)	5.5	4.2
Norway (1973)	5.6	5.3
Portugal	...	3.2
Spain	4.8	3.0
Sweden	7.3	6.7
Switzerland (1973)	5.0	3.5
Turkey	...	1.4
United Kingdom (1975)	5.2	4.6
United States	7.4	3.0
Dispersion	1.1	1.1
Average	5.7	4.4

a) OECD Studies in Resource Allocation, Public Expenditure on Health, No: 4, July, 1977, p.10.

b) Percent of "trend" GDP at current price.

medical service expenditures, hospital costs tend to be nearly half the total current expenditure; staff costs - which alone account for about half the cost of all personal health care - together with drug costs take up the largest share of all health service expenditures. Even in some of the richer countries the proportion of national income devoted to health is still increasing and if present trends continue, several may be spending some of 10 % of their national income on health before the year 2000(17).

Health care involves more than the cure of ailments; indeed considering the importance of psychosomatic factors in the genesis of disease and of socio-economic factors in the genesis of psychological disturbance, most household consumption can be treated as preventive medicine(18). So health care services can be segmented into two groups. a) preventive health services. b) curative health services. Preventive health services decrease community health risks, e.g. by providing enviromental sanitation or communicable disease control. Curative health services reduce personal health impairments or problems, where possible and provide personal care in the sense of increasing the patients' comfort and alleviating pain and suffering. The latter group has been the predominant vocation of the health personnel for many centuries while the importance of preventive health has been newly recognized.

In medical care sector, it is apparent that expenditures have been rising steadily since 1950's, more than the rise in expenditures on food items. In other words, in developed nations, demand for food is slowing down, while demand for medical care is steadily increasing. The slowing down of expenditures of food items may confirm. Engels' Law, but the fact that medical care expenditures has gained importance within the family budget compared to food expenditures, is apparent. It can also be assume that this is due to the slow rise in prices of medical care while

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(17) World Health Organization, Health Economics, Public Health Papers, No: 64, Geneva 1975; p.15.

(18) M.W.Reder, "Some Problems in the Measurement of Productivity in the Medical Care Industry," Production and Productivity i the Service Industries, ed. V.R.Fuchs (National Bureau of Economic Research, 34 Vol; Colambia University Press, 1969), p.97.

prices for food items have shown a larger increase(19). The same situation applies in socialist countries, for example, in Soviet Union, in 1960, the percentage of medical care expenditures within a worker's family budget was 10 %; in 1972, this increased to 14 %. In the same period, the percentage of food expenditures decreased from 38 % to 35 %.

Another study conducted in France, states that between 1965-80, the total expenditures in durables decreased from 32 % to 17 % of total expenditures whereas the percentage of medical care expenditures, increased from 12 % to 20 %. This great increase in medical care expenditures shows the importance of the sector within the economy.

TABLE 5- MEDICAL CARE EXPENDITURES

	1961 (Abel Smith)	1968 (OHE)	1969 (S.S.A)	1972 (Maynard)	Average Annual growth rate of health expenditures at constant prices (S.S.A)	
U.K	4.2	4.69	4.8	5.1	1962-69	5.6
France	4.4	4.90	5.7	5.5	1963-69	10.9
West Germany	4.5	-	5.7	5.8	1961-69	6.8
Netherlands	4.8	-	5.9	6.7	1963-69	10.1
Canada	6.0	7.25	7.3	-	1961-69	10.1
U.S.A.	5.8	6.71	6.8	-	1962-69	6.9
Sweden	5.4	6.26	6.7	-	1962-69	9.2

a) A.J.Culyer, The Political Economy of Social Policy (Oxford, Martin Robertson, 1980), p.218.

3.2. OUTPUT OF MEDICAL CARE SERVICES

What is the output of medical care services? This question is important for those who believe that medical care sector is in a crisis because expenditures are continually rising; that is, costs are exceeding benefits derived from medical care. Medical services, of course, appear in response to disease, disability and death. Hence, the health services must handle these in such a

(19) Cahiers De L'Association Française De Science Economique,

way as to prevent, cure, manage or rehabilitate, or at least palliate. So, the output of medical care services can be shortly stated as "increasing the health level within the society". But, another question that has to be answered is "what is health?" Definitions of health abound. Agreement is hard to find. The definition of WHO can be stated as a guiding principle "A state of complete physical and mental and social well being"(20).

A few points must be made clear. First, health has many dimensions - anatomical, physiological, mental and so on- Second, the relative importance of different disabilities varies considerably, depending upon the particular culture and the role of the particular individuals in that culture. Third, most attempts at measurement take the negative approach. That is, they make inferences about health by measuring the degree of ill health, as indicated by mortality, morbidity, disability, etc. We can summarize the indices of health as follows:

1- Mortality(21):

a) Crude mortality rate: The number of deaths in a pop/ 1000 pop./yr.

b) Age specific mortality: number of deaths in a specific age group/1000 pop. in that group/yr.

c) Cause-specific mortality: number of deaths due to a given diagnosis/1000 pop. in a year.

d) Age-specific-cause specific mortality: death related to age at death and diagnosis simultaneously.

e) Survivors at given ages out of each 100.000 born alive.

f) Curve of expectation of life; years of life remaining.

g) Average life expectancy. Other variables can be introduced such as sex or race depending on the problem to be

(20) R.Llewelyn-Davis and H.M.C.Macaulay; Hospital Planning and Administration, World Health Organization, Geneva, 1966, p.2

examined.

h) Infant mortality: Number of deaths under one year per 1000 live births in a year.

It has been argued that mortality rates do not accurately reflect the effect of health services; although medical care expenditures have increased, small change has been seen in the mortality rates. An explanation is that changes in enviromental factors in these years have had on balance, a negative effect on health, thus offsetting the favourable effects of increases in services and medical knowledge. So, new health indices have been used in combining mortality and morbidity information;one such index is the one suggested by Culyer(22) which consists of calculating years of "effective" life expectancy, based on mortality and morbidity rates. Such an index would measure the number of years that a person could expect to live and be well enough to fulfill the role appropriate to his sex and age. This approach could be modified to take account of the fact that illne or disability is a matter of degree. The years deducted from li expectancy because of disability should be adjusted by some percentage factor that represents the degree of disability; to give more reliable data. Another set of indices is the increase life expectency, a set of data given in Table 6 shows that expectation of life for age groups 30 and above in selected OECD countries. These results indicate that while some increase has taken place since early this century, the increase appears to have stopped during the 1960's. So, it is apparent that the effect of using expenditures on medical care has been offset changes in environmental factors in this case, due to rising standards of living including motor and factory accidents. Withi OECD countries, the major cause of death for the age group up to 44 is accidents. Economists label the utilization of goods by individual persons and households as "consumption" in contrast t "investment" which is the instrumental use of goods to produce other goods. Health services-with the exception of some environmen medical services-do not produce any economic commodities directl

(22) A.J.Culyer; "The Quality of Life and the Limits of Cost. Benefit Analysis", York Studies in Economics, Institute of Social and Economic Research, Department of Economics and Related Studies, University of York, No: 246 (Martin Robertson Co.Ltd, 1977) p.143.

TABLE 6- MALE LIFE EXPECTANCY AT AGE 30 AND INFANT MORTALITY IN SELECTED OECD COUNTRIES.

COUNTRY	Years of expected like at age 30 for a male in the vicinity of				Infant mortality rate.	
	1910 or nearest year	1950	1960	1970 or Patest year	1960	1975
Australia	36.5	....	41.0	(41.2)	2.02	1.61
Belgium	....	39.3	40.9	40.9	3.12	1.46
Canada	....	41.6	42.2	42.5	2.73	1.55
Denmark	36.8	43.7	43.3	43.2	2.15	1.04
Finland	32.5	38.0	38.5	39.3	2.10	1.02
France	....	39.4	40.7	41.4	2.74	1.36
Germany	34.6	41.3	41.1	41.0	3.38	1.97
Greece	36.3	42.9	43.4	(45.7)	4.01	2.40
Ireland	....	44.8	46.4	46.3	2.93	1.84
Italy	36.7	41.1	42.3	42.6	4.39	2.07
Japan	34.3	38.1	40.0	41.4	3.07	1.00
Netherlands	32.2	44.3	43.8	43.4	1.65	1.03
New Zealand	38.8	41.9	42.1	41.8	2.26	1.60
Norway	38.8	44.2	44.6	43.6	1.89	1.11
Spain	33.9	39.1	42.0	42.9	4.21	1.21
Switzerland	33.8	40.8	42.2	43.0	2.11	1.07
United Kingdom	34.5	40.2	40.9	41.7	2.24	1.60
United States	-	-	-	-	2.60	1.67
White	27.4	31.2	31.7	32.6	2.29	1.48
Non-White	....	27.3	28.7	29.3	4.32	2.49

a) OECD Studies in Resource Allocation, Public Expenditure on Health, No: 4, July, 1977, p.49.

It is therefore legitimate to consider most of them as consumption rather than investment.

On the other hand, better health is one of the objectives of socioeconomic development, but only one along with, for example, improved material standards of living, improved work and educational opportunities and more equal access to the benefits of modern science and technology. In a narrow sense, economic development requires among other things, a better quality of labour achieved through better health, education and other social endeavours. This is the basis of a newer theory of human

capital(23), in which health contributes to economic development as one of its components. In this context, health services can be regarded as instrumental, i.e. as in the nature of investment in a wider sense. Although it may be agreed that medical services in general can have both consumption and investment characteristics, it is not clear whether particular health services such as personal preventive health services are to be regarded primarily as consumption or rather as investment. Also Fuchs(24) states that health services can be defined as services rendered by.

1- Labour: Personnel engaged in medical occupations, such as doctors, dentists and nurses, plus other personnel working directly under their supervision, such as practical nurse, orderlies and receptionists.

2- Physical Capital: The plant and equipment used by this personnel e.g. hospitals, x-ray machines.

3- Intermediate goods and services: i.e. drugs, bandages purchased laundry services.

This argument shows that health care services are complex in character, ranging from consumption to investment good characteristics, creating certain problems in their identification.

The above argument shows that analysis of the health care sector presents many difficulties, one of which is, whether the commodity "health care" defined generically as the kinds of service provided by surgeons, physicians, hospitals are different from other commodities in particular and crucial ways. As is well known, this question has been the subject of frequent controversy over the last twenty years, a controversy that is today as lively as when it began. Certain descriptive characteristics of health care service has been studied by Arrow, Clark 1957; Feldstein 1963 Klarman 1965, pp.47,56, Mushkin 1958, Titmuss, 1968, Weisbrod 1961, Liees 1960,1962,1964, Jewkes 1961,1963, Fuchs 1966, Lindsay 1969, Lindsay and Buchanan 1970 and Culyer 1971. In this

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(23) World Health Organization, Health Economics, Public Health Papers, No: 64, Geneva, 1975, p.20.

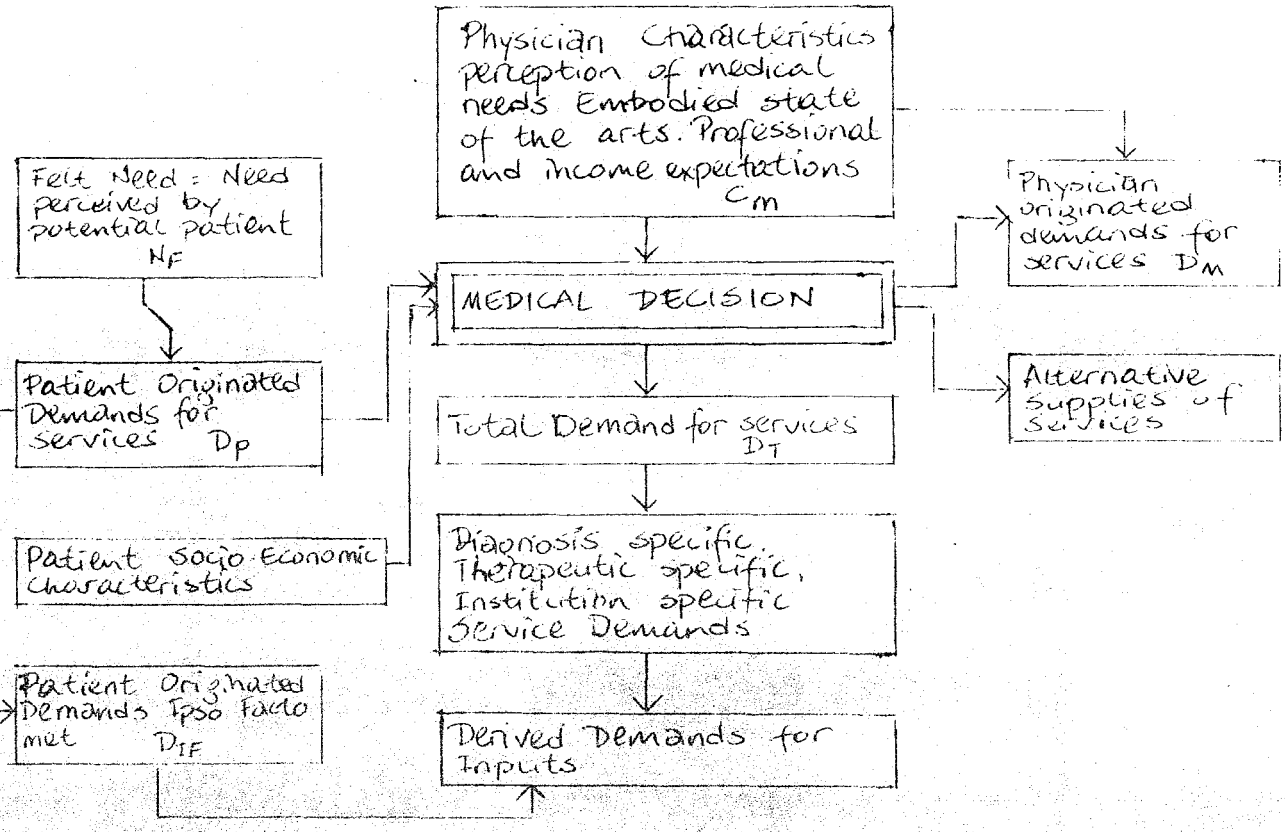
(24) V.R.Fuchs, "The Output of the Health Industry", Milbank

part of the thesis, we have tried to summarize these arguments to come to a clear definition of the health care service, as there can be no doubt that health care is not the same thing as other economic goods.

3.3. THE MEDICAL DECISION PROCESS

Before starting an analysis of the choice of the consumption pattern of health care services, we have to state that through this analysis, certain important characteristics of health care service can be seen. The medical decision process can be summarized as in Figure 1.

FIGURE I- FIVE SETS OF FACTORS DETERMINING INITIAL MEDICAL DECISION PROCESS(25)



(25) Sylvester E.Berki, Hospital Economics, (Lexington Books, Studies in Social and Economic Process, 1972), p.3.

To summarize Figure 1, first we have to consider that ther exists some level of perceived need which influences the potentia patient's decision to seek care. Once that decision is made, contact with a provider is made. At this point, the patient enter the formal medical care system, and the medical care process begins. The concept of "illness behaviour" has been suggested by Mechanic and Volkart to refer to "the way in which symptoms are received, evaluated, and acted upon by a person who recognizes some pain, discomfort, or other signs of organic malfunction"(26) Suchman analyzes this behaviour in terms of social patterns accompanying the seeking, finding and carrying out of medical care(27). He divides the sequence of medical events into five stages representing major transition points. These stages are:

3.3.1. The Symptom Experience Stage
3.3.2. The Assumption of the Sick Role Stage
3.3.3. The Medical Care Contact Stage and The Dependent-Patient Role
3.3.4. The Recovery or Rehabilitation Stage

All these stages do not have to be present in every case o illness, but they will usually be found, even if in a condensed form. Kadushin(28) found the following five stages to be present in the decision to undertake psychotherapy.

1- recognition of an emotional problem,
2- exposure to the existence of a problem within the circl of friends and relatives
3- decision to seek professional help
4- selection of a professional area of help and
5- selection of a specific practioner.

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(26) D.Mechanic and E.H.Volkart, "Stress and Behaviour and the Sick Role", American Sociological Review, (February, 1961), p.27.

(27) Edward A.Suchman, "Stages of Illness and Medical Care", Patients, Physicians and Illness-A Source book in Behavioral Science and Health, ed. E.Gaitly Jaco, (New York, Macmillan Limited Co. 1972), II, p.11.

(28) C.Kadushin, "Individual Decisions to Undertake Psychotherapy Administrative Science Quarterly, (December, 1958), 3, pp.3 411.

These correspond roughly to the first three stages of our formulation of the process.

We will briefly describe each of the stages in turn indicating certain characteristics of the medical care service.

3.3.1. The Symptom Experience Stage

(The decision that something is wrong). There are three analytically distinguishable aspects of the symptom experience.

a) The physical experience by which we mean the pain, discomfort, change of appearance, or disability actually felt.

b) The cognitive aspect, by which we refer to the interpretation and derived meaning for the individual experiencing the symptoms

c) The emotional response of fear or anxiety that accompanies both the physical experience and the cognitive interpretation. Basic to the initiation of the medical care process is the perception and interpretation of symptoms of discomfort, pain or abnormality - "the meaning of symptoms for the individual(29). These symptoms, for the most part, will be recognized and defined not in medically diagnostic categories but in terms of their interference with normal social functioning. Two aspects of the illness decision-making process during this stage with particular relevance for medical care are the denial of illness or "flight to health" and "delay in seeking and securi treatment"(30). In some cases a real dilemma is created for the individual who may wish to avoid "bothering his family, friends, and doctor too early in the symptom experience stage, but who fears the harmful consequences of waiting too long.

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(29) A great deal of social research has been devoted to the varying meanings of symptoms and illness for different cultural groups, for example.
P.M.Moody and R.M.Gray, "Social Class, Social Integration an the Use of Preventive Health Services", Patients, Physicians and Illness-A Sourcebook in Behavioral Science and Health, ed. E.Gartly Jaco, (New York, Macmillan Limited, 1972), II, pp.250-261.

(30) B.Kutner and G.Gordon, "Seeking Care for Cancer", Journal of

3.3.2. Assumption of the Sick Role Stage

(The decision that one is sick and needs professional care During this stage, the potential patient begins to seek symptom alleviation, information and advice and temporary acceptance of his condition by his family and friends. The "lay referral structure"(31) of the individual gains greatest importance at thi time. How this lay referral consultants react to his symptoms and accept these as important or trivial will influence the individual' ability to enter the sick role. The ill person will seek confirmation, advice, reassurance and finally, a form of provisional validation which temporarily excuses him from his normal obligation of activities.

3.3.3. The Medical Care Contact Stage

(The decision to seek professional medical care) and The Dependent-Patient Role Stage (the decision to transfer control to the physician and to accept and follow prescribed treatment).

At this stage of illness, the sick individual seeks a medical diagnosis and a prescribed course of treatment from a "scientist" rather than "lay" sources. Thus, an individual may translate his perceived need into effective demand simply by walking into an emergency room or an outpatient department. In consulting a physician, he seeks authoritative sanctioning to become "legitimately" ill, but a potential patient cannot have effective demands beyond the initial contact. He can only request but not express an effective demand for say, serum cholesterol tests or chest x-ray examinations. The resource intensive service of the medical care sector are legitimated by or independently generated by the physician.

Thus, the most important element in medical care services is an overwhelming proportion of demands become effective demands or utilization, if, and only, if legitimized by professional decision makers. These stages are of fundamental importance to an understanding of the utilization of medical care facilities and

(31) Edward A.Suchman, "Stages of Illness and Medical Care, "Patients, Physicians and Illness-A Source Book in Behaviora Science and Health, ed. E.Gaitly Jaco, (New York, Macmillan

services. The medical decision maker is the sole and unique participant in this process who has command of the stage of knowledge. It brings the physician's central role in generating demand. Very few industries could be named where the consumer is so dependent upon the producer for information concerning the quality of the product. In this service sector, he is even subject to the producer's recommendation concerning the quantity to be purchased. A recent report by the American Medical Association says flatly "the quantity of hospital services consumed in 1962 was determined by physicians"(32). It is clear from everyday observation that the behaviour expected of sellers of medical care is different from that of businessmen in general. The ethics of business (e.g. Hippocratic oath) demands treatment independent of the patient's ability to pay. The physician's behaviour is supposed to be governed by a concern for the customer's welfare which would not be expected of a salesman. In Parson's terms, there is a collectivity orientation(33), which distinguishes medicine and other professions from business, where denial of self-interest on the part of participants is the accepted norm. Also, the physician claims that his skills are so esoteric that the client is in no position to evaluate them. One reason for consumer ignorance is the inherent uncertainty of the effect of the servic on any individual. How can the lay person be expected to know the value of a particular procedure or treatment when in many cas the medical profession itself is far from agreed? Also many medical services are infrequently purchased. The average consumer will buy many more automobiles during a lifetime than he will major operations. Therefore, he cannot develop the necessary expertise. Furthermore, the consumer is often not in a good position to make a cool, rational judgement at the time of purcha because he is ill, or because a close member of his family is ill Finally, the profession does little to inform the consumer; in fa it frequently takes positive action to keep him uninformed. So, from this stems the physician's privilege to be somewhat removed from the market place and to accept the evaluation of his colleagues rather than of his clients. This is one of the most important characteristic of the medical care service, the

(32) K.J.Arrow, "The Welfare Economics of Medical Care", American Economic Review, LIII, p.942.

(33) T.Parsons, "The Professions and the Social Structure", Essays in Sociological Theory, (New York: Fresspress, 1949),

insignificance of the client against the knowledge and expertise of the service giver. The nature of medical practice is seen as determined largely by the practitioner's relation to his colleagues; the medical practitioner is typically a colleague in a structure of institutions and organizations, the patient being an essentially minor contingency. This is the picture presented in the general discussions of Carr. Saunders and Wilson, Parsons, Merson and Goode, as well as in Studies of medical practice by Hall and Peterson(34).

The preceeding discussion shows the central role of the physician in using medical care service. Thus, demand for medical care is largely physician originated, with patient focused outcomes. To continue with the medical care decision process, we can assume that physician, although bounded by ethical considerations, is not indifferent to the financial rewards, peer recognition, professional status rewards, community recognition and so on, associated with alternative patient focused outcomes, it is reasonable to expect that his preferences in these respects, or his valuations of them, are relevant in understanding his medical decisions. Especially, where alternative diagnostic and treatment processes are available and considered probabilistically medically appropriate. (Probabilistic due to uncertainty associated with the outcome of the treatment), the chosen course of action is likely to be the one which the physician expects to maximize his preference function(35). Thus, the physician is likely to shoose from among the available alternatives that hourse of action which

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(34) See:
A.M.Carr, Saunders and P.A.Wilson, The Professionals, (Oxford Clarendon Press, 1933).
T.Parsons, "The Professionals and Social Structure", Essays in Sociological Theory, Pure and Applied, (New York: Free-press, 1949), pp.185-199.
R.K.Merton, "Some Preliminaries to a Sociology of Medical Education", The Student-Physician, ed.R.K.Merton, G.G.Reader and P.L.Kendal (Cambridge, Mass.Harvard University Press, 1957), pp.73-79.
W.J.Goode, "Community Within a Community; The Professionals" American Sociological Review, XXII, (April, 1957), pp.194-20
O.Hall, "The Informal Organization of the Medical Profession Canadian Journal of Economics and Political Science, XII, (February, 1946), pp.30-41.
O.L.Peterson, "An Analytical Study of North Caroline General Practise", Journal of Medical Education, XXXI, (December, 1950), pp.1-165.

(35) Sylvester E.Berki, Hospital Economics (Lexington Books. Studies in Social and Economic Process, 1972), pp.4-6.

he associates with the highest reward state to himself. Service demands may be originated by the physician for purposes of resear for teaching, for demonstrating high esoteric skill achievement, for status and for increasing his income or decreasing his work-load or both simultaneously. So, although patient welfare is the primary determinant, it is apparent that it is not the sole determinant in physician decision making.

The medical decision is subject to three types of contraints

1- Patient's socioeconomic characteristics and
2- The availability of alternative supplies of services,
3- Ethical, legal and institutional factors that both help shape, the physician's preferences and constrain his choice set.

It is apparent that the patient's age, family status, education and social status are variables relevant in the physician's choice of care pattern. Moody and Gray have shown how social class, social integration and other socio-economic characteristics influence the consumption of preventive health services(This (Will be examined within the analysis of demand for health care) It is found that a higher rate for hospitalization exists for conditions manageable on an ambulatory basis for children in smal families, or for children in lower income than in higher income families, as the physician feels that the appropriate care pattern is less likely to be followed in a household full of children with multiple demands on the parents than in one with fewer competing chores.

The financial constraints facing a medical decision will change by the patient's willingness and ability to pay himself or to have paid on behalf of insurance or use of free services offered by the public institutions. These financial constraints will be examined in more detail in demand analysis.

The second constraint on the medical decision is the

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(36) P.M.Moody and R.M.Gray, "Social Class, Social Integration a the Use of Preventive Health Services", Patients, Physician and Illness-A Sourcebook in Behavioral Science and Health, ed. E.Gartly Jaco, (New York: Macmillan Limited, 1972), II, pp. 250-261

availability of alternative supplies of services. The extent to which complex diagnostic facilities are available, as well as their costs to both the patient and the physician is not indepenc of their use. It is not unwise to think that physicians who own diagnostic facilities are more likely to be extensive users of them. The availability of alternative supplies of services is determined not only by economic, institutional and physical factc One important aspect of availability is accessibility. Thus, certain social and psychological characteristics of both, patients and physicians, as well as economic factors, help determine which among the physically available alternative supplies are infact accessible, and available.

The last set of constraints consist of ethical, legal, and institutional factors which help shape the physician's preference and contraint his choice set. Legal prohibition of fee splitting, or the inability of one physician to charge another physician for referring patients, legal prohibition against the delegation of certain medical functions to persons who are not licenced to perform them are examples of legal constraints. The practise setting, or institutional matrix of the physician, partly determined by his preferences, also act to shape them. Even if we assume that technical medical knowledge is uniformly distributed, the physician's professional and physical location will influence the outcome of the medical decision. The physician in private fee - fo service practice with an established referral practice in a suburban setting is likely to make choices that will differ from those of the equally technically competent internist in the emergency room of a city hospital on a hurried week day. So in th Medical Care Contact stage of the medical decision process and that of the Dependent. Patient Role Stage, the central role is that of the physician, most specific diagnostic and therapeutic ambulatory services are physician originated. This physician centerness of medical decision process is the most important element in medical care service, and which makes the relation of consumer and producer somewhat hazy. So in the analysis of marketing services of hospitals; this centeredness of physician i the process of medical care decision brings certain dimensions which differentiates the study from the classical approach to marketing mix decisions.

3.3.4. If we continue with the study of illness behaviour, the fifth stage will be The Recovery or Rehabilitation Stage. (the decision to relinguish the patient role). The course of medical treatment comes to a close when the patient is dismissed or withdraws from active medical care and is expected either to resume his old role of a healthy individual again, or to adopt a new role of chronic invalid or long-term rehabilitation. During the stage of convalescence or rehabilitation, the ex-patient must learn to be once more in the world of the healthy. In the case of acute illness the return may present no particular difficulties, but for many chronic illnesses, and physical impairments, this process is a slow and demanding one and may involve recurring episodes of illness. This stage contains some highly significant problems for medical care, especially in view of the increasing ascendence of the chronic diseases with little hope of definitive cures. The provision of home care for the aged, of rehabilitation for the handicapped, of long term care for the chronically ill are the type of cares that will be needed at this stage.

These five stages, then represent the content and sequence of medical care decision process. From this analysis, certain unique characteristics of medical care in relation to the physician service can be pointed out.

3.4. CHARACTERISTICS OF MEDICAL CARE SERVICE

3.4.1. Consumer Ignorance and Professional Power

A prerequisite for the effective operation of any market is that the consumer have a great deal of knowledge concerning th quality of the product so that he can make a rational choice in the process of attempting to maximize his satisfaction. A fundamental characteristic of the medical services market however, a characteristic that makes it significantly different from the market for most other products, is the relative lack of knowledge on the part of the consumer considering the nature of the product being purchased. Medical knowledge is extraordinarily complex, so complex that the knowledge possessed by the physician concerning the necessity for or consequences of treatment is tremendously greater than that possessed by the consumer. We have to note that the crucial difference in knowledge between the patient and the physician is not in concerning production methods, the producer

invariably knows more than the consumer about production methods. What is of significance is the difference in knowledge as to the satisfaction that will be gained from the purchase of a particular product. For most products, the consumer knows as much about the utility of the product as the producer. In considering the purchase of a loaf of bread, a television set or a washing machine consumers have a reasonable knowledge of the satisfaction these commodities will yield and can make reasonably intelligent choices. Suppose that the consumer has persistent abdominal pain. It is the physician who makes the decision as to what kind of treatment is needed and by his recommendations he can create a demand for his own product. It is the physician who decides whether or not drugs are required, whether or not hospitalization is desirable whether or not surgery is necessary. The consumer has no way of knowing which alternative is best for him, he must rely upon his faith in the integnity and competence of the physician. Moreover, the consequences of a wrong choice on the part of the consumer can be disastrous. If a consumer finds that a particular loaf of bread purchased is tasteless, he can try a different kind the next time and the cost of error is small. Let him make a mistake in his choice of medical care, however, and the error could produce acute pain and discomfort and in the extreme, death. So the risk associated with the consumption of medical care, forces the consumer to use professional referral system.

3.4.2. Irrationality of Consumers

In welfare economics; it is assumed that welfare of consumers is acquired through a rational choice of alternatives, and that these choices reveal preferences. Three arguments have been put forward which undermined the rationality assumption of optimization of welfare in medical care consumption. These are:

1- Many consumers, though sick, do not desire treatment and may even be ignorant of their sickness.
2- The mentally sick fit oddly into a "consumers" sovereignity model.
3- Patients requiring emergency treatment are frequently not in a position to reveal their preferences.

1- The first of these impediments have been well analysed. Spectacular evidence for the truth of this proposition was discovered in the famous "Peckham experiment" of 1935-9., where 64 percent of the persons examined had identifiable disorders but were unaware of them(37). This was supported by Israel and Teeling Smith's findings in 1967, where it was proved that there were 150.000 unknown diabetics in Britain(38). It also appears that the problem has similar dimensions in other countries. But there are two dimensions to this problem. On one hand, ignorance of consumers violates the rationality rule of market mechanism. On the other hand, this inference ignores the possibility that the degree of ignorance measured in experiments such as at Peckham, may, in fact be optimal. If information about one's health is cost to collect, it may be irrational to dispel all ignorance. So, the question about the amount of ignorance that can be tolerated is a question of tradeoffs between costs and benefits associated with the search for information.

2- A similar conclusion must hold with regard to patients, who, though knowing that they are sick, fail to demand treatment. This is true due to the fact that illness behaviour is underlined by irrational fears, resulting from the fear of the unknown. As most patients feel that there is something wrong with themselves, anticipate fear of pain, of discomfort, risk of total or in - complete or delayed recovery, in short, prolonged deprivation of normal function, try to delay the acceptance of the fact that ther is something wrong with themselves. It is not a myth that a great number of doctors, who have cancer, delay the start of their treatment. This escape from reality is especially important in analysis of consumption of medical care service.

3- Similar conclusions hold with respect to the emotionall disturbed, children and emergency cases. It is apparent that these individuals are in no position to choose, then some people must decide for them. Thus, it is apparent that there exists external demand for the care of these people. This brings the question of externalities which is an important problem in health

(37) A.J.Culyer, "Is Medical Care Different?", extract from "The Nature of The Commodity Health Care" and its Efficient Allocation", by the author, Oxford Economics Papers, XXIII, pp.189-211.

economics. Externalities will be discussed later.

The above discussion shows that in the consumption of medical care, rationality aspect is somewhat not applicable. This differentiates medical care service from most of the other products in the market.

3.4.3. Expected Behaviour of the Physician

It is clear from everyday observation that there are certain societal, as well as ethical standards which govern the behaviour of physicians. This is due to the fact that the consumer cannot test the product before consuming it, and therefore there is an element of trust in the relationship. The patient wants to have some guarantee that at least the physician is using his knowledge to the best advantage. There is no way to evaluate this, so it leads to the setting up of a relationship of trust and confidence, one which the physician has a social obligation to live up to. As the patient cannot enforce standards of care (as he does not know as much as the physician), he replaces direct observation by generalized belief in the ability of the physician. To put it another way, the social obligation for best practice is part of the commodity the physician sells; even though it is a part that is not subject to thorough inspection by the buyer.

In this process, the product and the activity of production are identical, the exchange process is between the physician and the patient. In this context of exchange, the transaction involves the physician in the traditional role of the small servicemen or businessmen. He charges a fee for services rendered, accepts money sends bills and reminders. And yet, it is only necessary to point to certain commercial practices which the medical profession rejects to realize that the medical relationship is qualitatively different from the commercial relationship. The ideology of the profession, for example, places great stress on the obligations of the physician toward the patient's welfare and the exclusion of the profit-motive in professional decisions. Nor, the physician is expected to advertise, to give bargain fees, to guarantee a cure, to refuse a patient because he is a poor credit risk, to split fees with referring colleagues, or to refrain to send his bill if the patient dies. The assumption is that the physician does his

There is, thus in theory and practice, a complete segregation between the exchange aspect on the one hand and the performance of services on the other(39). The same principle applies to hospitals, where relative unimportance is given to making of profit, as it is thought that the very word, "profit" is a signal that denies the trust relationships.

The above fact, as Parsons has pointed out should not be misjudged, as meaning that the physician is altruistic and the business men egoistic. This dichotomy is not only too simple, it is basically inaccurate. We can assume that both physicians and businessmen are concerned with occupational success in their respective field of endeavor. Success in the business world is measured by profits and failure by losses, all expressed in moneta terms, it is therefore expected of a businessman that he will strive to maximize profits. To do otherwise, would be contrary to the accepted definition of the businessman's role. Occupational success in the professional, and particularly the medical role is only indirectly measured by monetary criteria. The criteria used to determine success in this field is different; training, knowledge, professional performance, intelligence, publications, contributions to science and medicine, new clinical procedures, respect on the part of the professional colleagues and of the lay community (to believe otherwise, would be, according to my persona belief to undermine one of the ideals of the society which can be summarized briefly as; "there can be no value placed on the profession of the physician nor on the life of any patient"). These conditions, furthermore are the functional prerequisites for the establishment of physician-patient relationship based on confidence, this confidence, which is of undeniable therapeutic value, could hardly exist in a typical buyer-seller relationship governed by the rules of the market.

Control over the professional actions of the physician appear to be vested primarily in an internalized and self-enforce code of professional behaviour of the type mentioned above and in the lay community (what Freidson calls the "lay referral system)(

(39) T.Parsons, "The Professions and the Social Structure", Essays in Sociological Theory, (New York: Freepress, 1949), pp.185-199.

(40) E.Freidson, "Client Control and Medical Practise", Patients, Physicians and Illness-A Sourcebook in Behavioral Science an Health, ed. E.Gartly Jaco (New York: Macmillan Limited 1972)

In such a system the physician is under some pressure to please his patients in order to acquire clientele. Word-of mouth recommendations, become an important element in building a practice, and inability to please the clientele will be reflected (in a competitive situation, at least) in mediocre success and a correspondingly poor income. In a non-competitive situation, ther is of course less of a pressure to please patients (not from the medical point of view but from other services that result in time loss due to waiting in queues).

3.4.4. Product Uncertainty

Uncertainty as to the quality of the product is perhaps more intense here than in any other important commodity. Recovery from disease is as unpredictable as its incidence. In most commodities, the possibility of learning from one's experience that of others is strong because there is an adequate number of trials. In the case of severe illnesses the uncertainty due to inexperience is added to the intrinsic difficulty of prediction the outcome. Although automobile and houses are also expenditure sufficiently infrequent so as giving way to uncertainty, amount of uncertainty of consumption of medical care is certainly much greater in the case of severe illnesses.

Furthermore, there is a special quality to uncertainty, a medical knowledge is complicated, the information possessed by t physician as to the consequences and possibilities of treatment necessarily very much greater than that of the patient. Both parties are aware of this informational inequality, so that the consumer (as he cannot feel cognitive dissonance after the purchase of the service, because it will be too late, his conditi of health has changed for good or for worse) will try to dissolv the risk by high knowledge on the side of the physician. As most people are risk-averters when it comes to the use of medical services, they will try to decrease the risk by complete trust i the knowledge of the physician. Control on the quality of care given by the physician will depend on the outcome of the treatme Reder(41) proposes an interesting alternative where the size of

(41) M.W.Reder, "Some Problems in the Measurement of Productivit in the Medical Care Industry", Production and Productivity the Medical Care Industry, ed. Victor R.Fuchs, (National Bureau of Economic Research, Columbia University Press; 1969), XXXIV, p.103.

the doctor's fee is related to the success of the treatment by which the patient can decrease some uncertainty as to the outcome of the consumption act. This practise is uncommon (as in the possibly apocryphal story of the Chinese who allegedly paid their physicians only when they were well) and not likely to gain favour in the near future. Thus, quality cannot be judged due to:

1- Consumer ignorance of quality, fostered by professional "ethics" against advertising and public criticism of other doctors (mal-practise suits are very seldom and where they appear they create a social uproar-Mındıkoğlu event),
2- Restrictive practices that impede entry into the profession (this will be analysed in detail in part on supply of medical service).

3.4.5. Externalities

Another set of characteristics of health care that may have implications for the analysis of market behaviour can be grouped together as problems of external relationships. An externality occurs if the consumption of a good by someone else affects the level of satisfaction attained by any given consumer(42) In medical care services, externalities can be grouped as:

1- a) Cases of communicable diseases where the benefit from an individual's immunization accrues to others in society beside himself (or alternatively, the external costs of not being immunized). b) The problem of ensuring that sufficient capacity is available for those who do not currently require, say, hospital beds but who value the existence of sufficient capacity to ensure them a place should they require it at some later date. c) finally and possibly most important in health care, is the problem alluded to previously concerning individuals who, though possibly behaving perfectly rationally, may not consume sufficient health care in the opinion of other individuals in society. This may arise either

(42) Richard M.Leftwidth, Health System and Resource Allocation, (New York, Macmillan, 1953), 6th ed. p.34.

because of a low income level or because of uninsurability due to chronic and costly illness, or for other reasons such as myopia, social milieu, or any of the many factors that shape a person's preferences and circumstance.

2- The problems involved in the case of communicable disease and other enviromentally harmful effects fall into the category of physical externality. There is the risk to society of increasing probability of contracting the disease if an individua is not immunized. There is agreement among economists that these activities, called preventive services, is most appropriately subsidized under government auspices and financed out of general taxation. This solves the "free rider(43) problem; so that each individual contributes to the cost while enjoying the benefit.

3- The problem of ensuring optimal option capacity has been identified recently in the literature. Individuals cannot be sure when they will require medical treatment and new capacity can be created in finite time. So there must be some mechanism to help the creation of more capacity. This takes the form of increased taxes, going into increasing capacity in hospitals or a form of voluntary charitable activity to assist hospitals in prov iding more capacity.

4- The problem of those who are not sufficiently concerne with their health and those who are too poor to be able to implement any concern they may have by actual consumption, is an issue that gains attention by many economists. The most common approach to these problems has been to regard health care as a "merit" good(44). With imposed choice being implemented in some way. It has been stated that replacement of voluntary with impose choice must, in general cause an uncompensated welfare loss. But more recently, however, it has been realized that all cases of apparent merit wants need not involve uncompensated changes in individuals' positions, for to enable consumption by one set of

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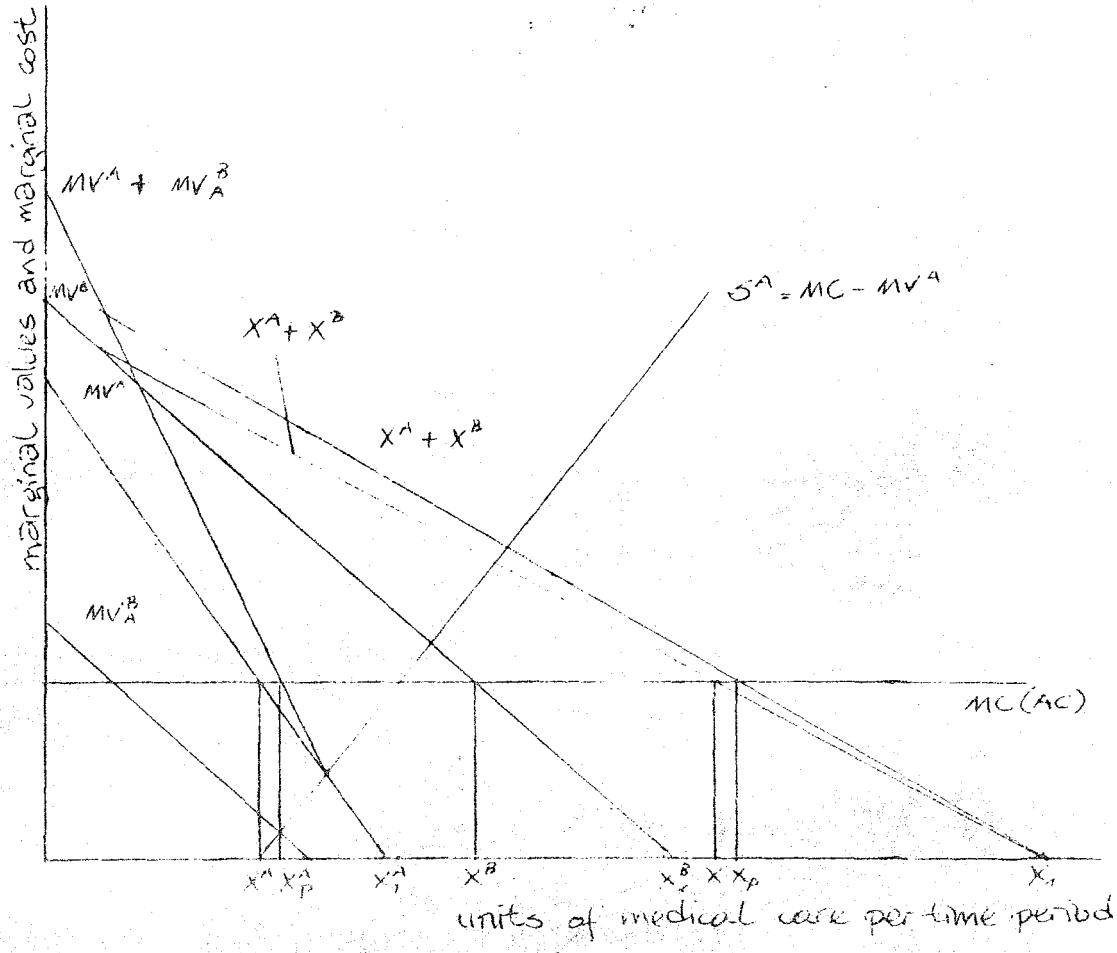
(43) The "free rider" problem called prisoner's dilemma refers to a situation in which each individual would reach a privately optimal situation if others provide the public good or servi while he enjoys a free ride, i.e. fails to contribute to the cost while enjoying the benefit.

(44) M.S.Feldstein, "An Aggregate Planning Model of the Health Care Sector", Medical Care, V, 1967, pp.369-381.

individuals to take place may, under certain circumstances, constitute a social good for which other individuals may be prepared to pay. So, if the society consisted of two groups, one rich and the other poor, the rich would be warned of the low quantity and quality of the medical care service that the poor are getting, this creates external disutilities for the rich. In this approach it requires the dropping of the assumption of selfishness in human behaviour, with alternative institutions analyzed in terms of altruism or interdependent utility functions. A two-person Marshallian model can assist in setting out the essence of the problem(45).



(45) A.J.Culyer, "Is Medical Care Different?", extract from, "the Nature of the Commodity 'Health Care' and its Efficient Allocation", by the author, Oxford Economics Papers, XXIII, pp.189-211.

In the above figure, MV^A and MV^B are the Marshallian demand curves of A (poor) and B (rich) for units of medical care. If both individuals are selfish, the open market produces a result where A consumes O_X^A and B consumes O_X^B with total demand (= supply) of X. B thinks that it is unjust that A receives so little care,(A places an externality on B). Denote B's demand for more care for A by MV_A^B. X (medical care) now takes on public good characteristics in that a unit of X consumed by A is also 'consumed' indirectly by B, and society's marginal valuation curve for A's care is now given by the vertical summation of $MV^A+MV_A^B$. The optimal amount of A's care is now X_P^A, and the total optimal amount for society is X^P where optimum allocation for B remains at X^B.

From the above figure, it can be seen that externalities can be internalized so as charitably inclined persons can assist those less well off themselves. The problem of externalities is an important characteristic of medical care, which forms a bond between the private and public good concepts. In medical care; we have to consider both the characteristics of public and private goods.

3.5. DEMAND FOR MEDICAL CARE

Unlike the demand for the usual consumption goods, the demand for medical care is not for specific goods but for good health, or more specifically, for the remission of disease state. Furthermore, a large segment of the demands for health services, particularly those for hospital impatient services, are physician legitimated or physician originated. The main characteristic of demand for medical care is the centeredness of the physician in generating demand with demand for drugs, for services of hospital and other medical personnel, and for services of x-ray departments and labaratory-being derived demands. Berki(46) formulates a demand model, such that the medical care process can be initiated by (1) the potential patient voluntarily (2) the potential patient involuntarily (3) a social mechanism directly (4) the potential provider of services (the physician). Cases (2) and (3) are not

(46) Sylvester E.Berki, Hospital Economics, (Lexington Books. Studies in Social and Economic Process, 1972), pp.123-136.

important, both are not stated demands by the individual as in a cerebral accident (the patient is unable to indicate his preferences) and when social preferences override them (as in involuntary confinement).

Demand for medical care arises when the individual perceiv his actual health status to be less than his expected health status. The perceived disequilibrium between the actual and the expected health level, leads to a perception of felt need and initiates a sequential decision process.

An individual's desired health status is some function of a multitude of factors as economic and family status, education, role expectations, geographic location, degree of socialization, work experience, age, past health experience and societal norms.

The expected health status can be defined as:

$$H_t^* = f(A,E,R,S,N,H_{t-1})$$

where A = age, E = education, R = role expectation, S = societal and family status, N = cultural norms, H_{t-1} = individual's previous health status experience. Then it can be stated that demand for medical care arises when

$H_t^* < H_t$ where H_t = actual health status.

At this stage of the decision process the potential patien is faced by four options: (1) Do nothing, but wait for the disequilibrium to correct itself. (2) undertake self-medication (lots of orange juice), (3) Seek information and advice from informal, non-scientific, non-medical sources, such as family members or friends; or (4) initiate contact with a medical care provider. At the fourth option, the patient has translated his felt need into effective demand. The preference of the potential patient is restricted by his budget constraint, the availability of alternatives and their prices, and the severity of his conditi The severity of the case can be summarized as follows:

$$D_{IF_1} = f(H_p^d)$$

Where in severe cases, the disequilibrium $H_e^d = H_t^* - H_t$ is directly translated into effective demand, with the prices of medical services P_m and the patient's income, Y, playing no role in the decision. Whereas in minor cases, demand for medical care, is determined by the potential patient's income and the prices of medical services.

$$D_{IF_2} = f\ (H_p^d\ ,\ P_m\ ,\ Y.)$$

After the initial contact with the physician is made, the physician may or may not agree with the patient's estimate of his own state. In emergency cases, the physician originated demand for services is determined by the estimation of medical appropriatenes and the physical availability of resources or service capabilities The demand of the physician in this case is

$D_{M_1} = f(H_{em}^d)$ where H_{em}^d is the degree of disequilibrium between expected and actual health status of the patient.

If the physician's estimation of the disequilibrium is not emergent, the physician originated demands for services D_{M_2} are determined by his characteristics, C_M, (professional and personal objectives), the prices of services, and the patient's income Y.

Then $D_{M_1} = f(H_m^d\ ,\ C_M\ ,\ P_M\ ,\ Y)$ in cases of mild conditions.

The observed demand D_O, or total utilization, is the equivalent of total demand D_T which consists of four elements.

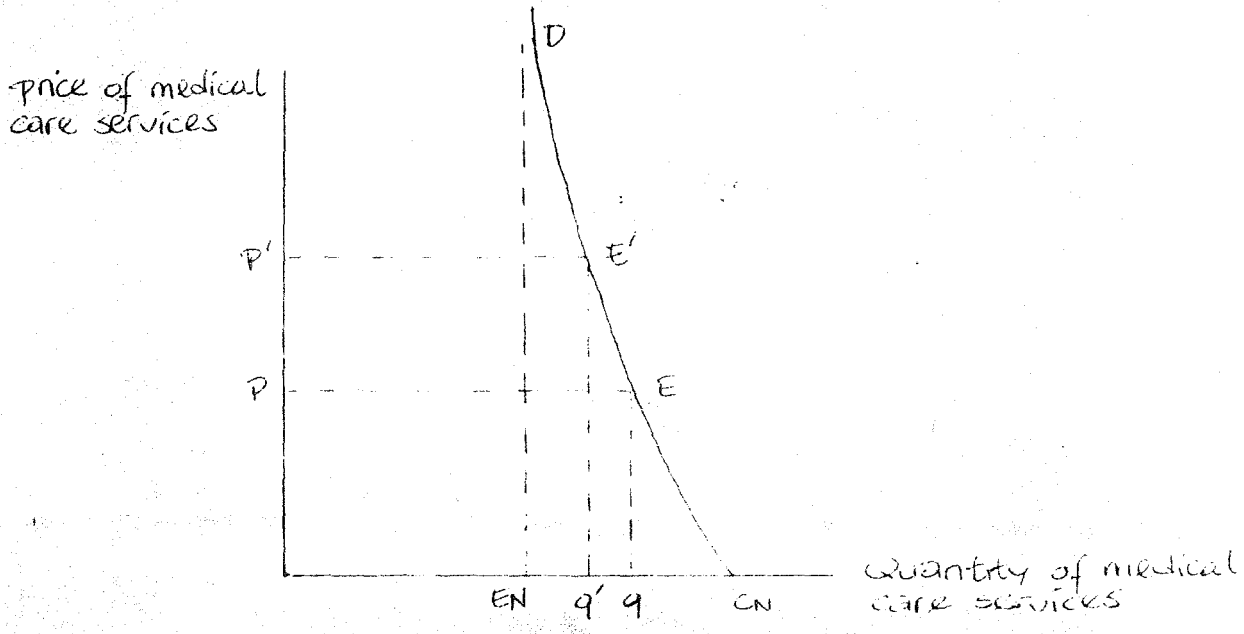
$$D_O = D_T = D_{IF_1} + D_{IF_2} + D_{M_2} + D_{M_2}.$$

The above analysis of Berki, on the demand structure for medical services show that price and income are determinants only in a subset of observed demand, namely D_{IF_2} and D_{M_2}. Studies of price and income elasticities of demand of medical care, therefor will underestimate the total demand, because there are components within the demand structure which are price and income inelastic. An analysis of literature on elasticities of demand show that the are very low, Feldstein and Severson found that price elasticitie largely are not significant from zero, or even negative for both

hospital services and physician services, as these studies ignore other determinents within the demand structure(47).

When we consider the D_{IF_2} (patient-originated non-emergency case) component of the demand, the empirical evidence points a downward sloping demand curve for health services, where individual seem to seek less care as price rises and more care as price falls.

The demand curve for medical care services for individual patient can be shown as follows(48).



The economic analysis up to this point is no different from that for other goods and services, for which there exists a down ward sloping demand curve. There are, however, two distinctive features of the demand curve for medical services. First, there is a finite intercept at the quantity axis (CN) which has the interpretation of the amount of health care demanded as the price falls to zero. Second, there is a minimum level of medical care which the demand curve approaches in an asymptotic fashion as price increases to very high levels.

(47) M.S.Feldstein, "An Aggregate Planning model of the health care sector", Medical Care, V, (1967), pp.369-381.

(48) M.D.Intriligator, Issues in the Economics of Health, (New York: MacMillan Co, 1958), pp.4-6.

The first special feature of the demand curve is the finite intercept CN; which can be interpreted as clinical need. This is the amount that a clinical expert might recommend if there were no charge for care. This is larger than the care demanded at a positi price (above argument of no money price), but the point to be made here is that the quantity demanded at a zero price is nevertheless finite. There is an upper limit to the amount of health care that individuals will seek even when its cost is zero, there are limits to the amount of health care that can be utilized. For example, certain groups that receive free care, such as those in armed services, do not utilize infinite amounts of health care. Nor, do physicians and their families. Yet, another example is extremely wealthy individuals, for whom the price of health care, relative to their income or assets is very small. While such individuals may demand a large amount of care, it is not an unlimited amount. Probably the most extreme case is the president of a country, with his own personal physician available at all times and with unrestricted access to hospital care. Even in this extreme case the demand for care is finite.

The second special feature of the demand curve is the minimum asymptotic level, labelled EN, which can be interpreted as economic need. This is the amount of care that the individual woul seek even if the price were very high (but still affordable given the income of the individual). It is a measure of need, the D_{IF_1} of the individual in emergency and severe conditions. The level of care provided at this point is, to a large extent, that minimum needed to preserve life and basic health, all other medical care having been dispersed within the face of an extremely high price of care. The amount of health care labelled EN can be interprete as the minimum need, while that labelled CN can be interpreted as the maximum need. The former is that level of care chosen as price rises very high; while the latter is that level chosen as price falls to zero.

The other determinant of the level of demand for medical care is the income (Y) of the individual. Some basic research on income elasticity showed that this elasticity is positive and high. In an analysis on OECD countries it has been found that income elasticity is as high as 1.4(49). A similar study conducted

(49) OECD Studies in Resource Allocation, Public Expenditure on [illegible] No. 4 (July, 1977, p.29.

in U.S.A also indicated an elasticity greater than one(50). Rising level of expenditures on medical care show that a large percentage of family income is spent on this item, but whether this is due to increased consumption or rising costs of medical care is an unsolved issue. One of the peculiarities associated with the consumption of certain medical care services (curative services as inpatient care), is that increased consumption of it, like that of leisure, not only reallocates the patient's income, but in the absence of income security such as sick-pay reduces it. The patien who stays in hospital, loses the income that can be earned in thos days. Thus, illness is, not only risky, but a costly risk in itself apart from the cost of medical care.

With the help of the above analysis on demand of medical care, we have shown the central role of the physician in generatin demand. The consumer must be related to the physician or hospital from whom he has asked service and must act according to the requirements stated by the two. Due to the centrality of physician services, demand for laboratory services, for hospital services, for personnel of medical care, and for drugs arise as derived demands. So, supply of medical care, somewhat determine the demand as physicians determine demand according to their perception of need of the patient, whether the patient consumes medical care or not. Thus, a complete seperation of demand and supply (the two blades of Alfred Marshall's scissors), ceases to be valid as the factor's affecting one side can no longer be supposed to be independent of the factors affecting the other: a necessary prerequisite for the valid application of demand/supply analysis: Therefore supply increases, instead of reducing the excess demand (as mediated by doctors), result in a two-way influence cycle. Al government does act as a demand creator with the ideas of "Social State", free service to the uninsured and poor, creation of nursing homes for the aged and needy and enforced care for those who have epidemic diseases. Thus; demand for medical care is a very complicated subject, interrelated with many agents, institut in the society, each influencing the other for the creation of demand.

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(50) OECD Studies in Resource Allocation, Public Expenditure on

3.6. SUPPLY CONDITIONS

The supply curve of health care refers to the amounts, providers such as hospitals and physicians are willing to make available at alternative prices. In competitive theory, the supply of a commodity is governed by the net return from its production compared with the return derived from the use of the same resource elsewhere. There are several significant departures from this theory in the case of medical care. The most striking departure from competitive behaviour is restriction on entry to the field. Friedman and Kuznets have argued that the higher income of physicians could be attributed to this restriction(51).

Most obviously, entry to the profession is restricted by licencing. Licencing, of course, restricts supply and therefore increases the cost of medical care. Reder has a thorough analysis of the effect of supply on costs of medical care service; the monopolistic practice in the physician market where competitiveness is discouraged through ethics of the profession helps to push up the costs of physician's services(52). It is defended that restriction of entry through licencing helps to guarantee a minimu of quality where consumers can be sure that services will be at least offered by a professional who has passed through a definite course of training. But there are certain disadvantages of licenci the licencing laws, though they do not effectively limit the numbe of physicians, do exclude all others from engaging in any one of the activities known as medical practice. As a result, costly physician time may be employed at specific tasks for which only a small fraction of their training is needed, and which could be performed by others less well trained and therefore less expensive. Also, medical training is costly, in relation to time and also of resources devoted to the education process. An interesting propos is that physicians should pay for their costs in the education process in a later period where they enjoy the benefits derived

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(51) A.J.Culyer, "Is Medical Care Different?", extract from "The Nature of the Commodity 'Health Care' and its Efficient Allocation", by the author, Oxford Economics Papers, XXIII, p.193.

(52) M.W.Reder, "Some Problems in the Measurement of Productivity in the Medical Care Industry", Production and Productivity i the Medical Care Industry, ed. Victor R.Fuchs, (National Bureau of Economic Research, Columbia University Press; 1969 XXXIV, p.121.

from their training, from their earnings in the profession. This is somewhat accomplished by compulsory service in rural areas, before a practician can gain the title of a specialist. But this issue is a politicised problem, which is not easily solved as it involves many social considerations.

Before passing on to the pricing of physicians' service, brief mention must be made of the geographical distribution of the physician supply. The determinants of this distribution patte has been explored in a number of econometric studies conveniently summarized in Feldstein(53). Broadly speaking, these suggest that physicians tend to gravitate toward culturally attractive locations, preferably endowed with a medical education complex, and characterised by high per-capita incomes (that is, high abili to pay for physician services). These locational preferences are hardly suprising; they are those of highly educated professionals in general. Thus, the rural areas are underdoctored whereas in large cities, the oversupply of doctors forces them to employ unprofessional tactics (fee-splitting with hospitals; over-doctoring of patients) meaning that use of treatment which is highly complex and costly but whose outcome is not certain or untried.

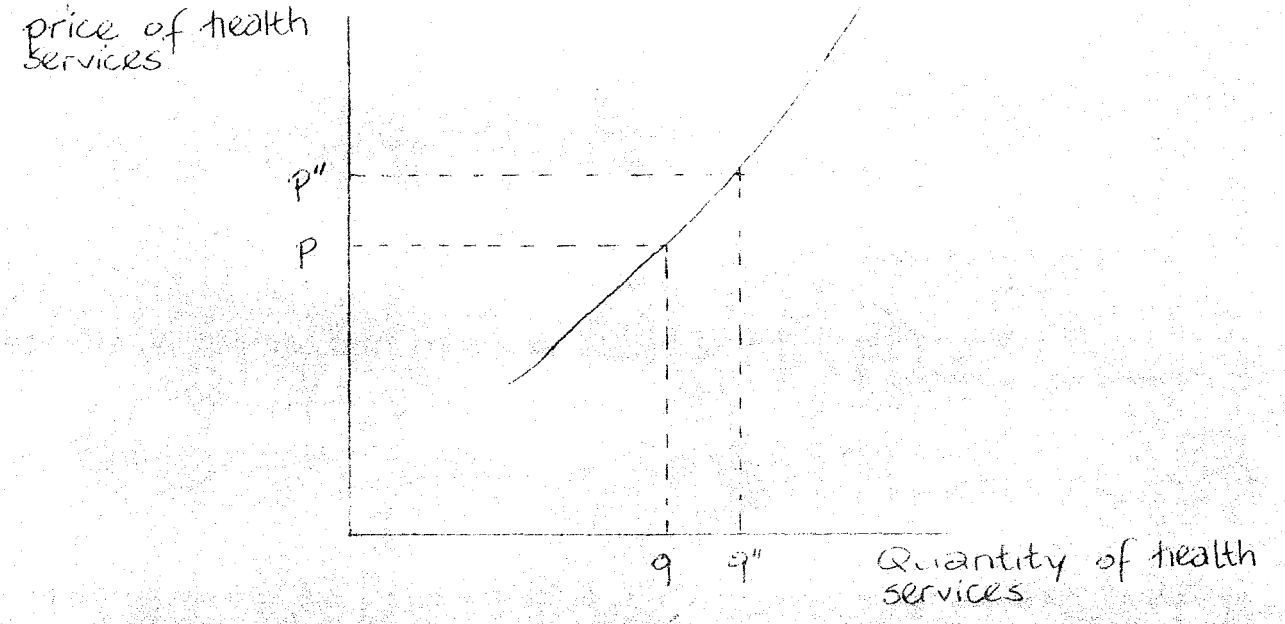
In Turkey, a similar and even more serious phenomenan is observed from the analysis of statistics. In region one (Kırklareli, Edirne, Istanbul, Tekirdağ) number of physicians were 8215 where population per physician was 700 in 1980. In the same year; number of physicians was 165 in Bitlis, Hakkari, Muş and Van and population per physician was 7 176(54). This inequity leads to certain social issues. In medical care sector, price can not act as the equating force of supply and demand in the market, because legal restrictions are imposed on the price of many medical services, as the price of hospital beds and services. Also, the market for medical care moves away from the competitive phenomena as state enters into the picture with the social obligation of giving service to the needy and the poor. The insufficiency on the supply side is hampered by the migration of physicians to other

(53) M.S.Feldstein, Econometric Studies of Health Economics, Discussion Paper, No: 291, (Cambridge, Mass, Harvard Institu of Economic Research), April 1973, p.83.

(54) Sağlık ve Sosyal Yardım Bakanlığı; "Distribution of Physici by Region", Türkiye Sağlık İstatistik Yıllığı, 1981 Başbakan lık Basımevi, Ankara,1980, 95.

West European countries, medical care service falls below the average in regions where income distribution is below the country average(55). Incentives (ranging from "compulsion" to financial inducements or fringe benefits are used in many countries to promote rural service by physicians, especially recent graduates. In this connection, it is important to provide adequate supporting staff and equipment for physicians working in rural posts. An important characteristic of the supply of medical service is that the elements that make-up supply must exist as a group for it to be efficient. This means that to give high quality service, highly specialized personnel must come together to perform a team work. A surgeon must have highly specialized nurses during the operation process; if not, the quality of service may fall, resulting in serious consequences that could lead to death. Yet, our country's experience shows that most rural health manpower is often transient and does not provide long-term continuity of service.

The supply curve of medical care can be shown in the following figure



(55) Marie M. Colart, La Sante, (Paris: Hatier, 1977), p.42.

At point A, providers are making available, the quantity q at price p. As price rises to "p" the providers are willing to make available additional amounts, increasing the quantity supplied to "q". This positive responsiveness to price is the result of many possible changes, such as physicians' finding it profitable to employ more aides, hospitals using more nurses, use of more efficient techniques, and greater use of new and improved equipmen While, there is a positive response to price increases, this response is very limited. The supply curve tends to be quite steep because of the difficulty of substituting other inputs for physicians and hospitals, and the difficulties in using new techniques and equipment. The supply curve is referred to as one that is highly inelastic in not showing large responses to price increases.

Another important feature of the supply curve is that it has tended to be constant, or nonshifting. The enormous expense of new facilities and new health manpower, combined with the substantial political, legal and economic constraints on the entry of new providers, has led to a supply curve that is both inelastic and constant, exhibiting neither any significant responsiveness to price nor any appreciable change over time (not taking change in technology over the centuries, but change with in a few years).

In concluding the discussion on the supply of medical care service, we have to stress the fact that as on the demand side, the controlling force is the number of physicians. Not only logic, but also statistics show that there is a high correlation between the health level of a country and the number of physicians, that the country possesses. WHO (World Health Organization) states that as the average number of physicians within a region or a country increases, the rate of mortality is decreased(56).

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(56) Marie M.Salort, La Santé, (Paris: Natiér, 1977), p.42.

3.7. PRICING OF MEDICAL CARE

Medical care sector is one of the most complex industries within the economy. When a survey is conducted regarding the systems by which medical care is provided in different countries, it can be seen that these can be summarized in three groups. Let us briefly label these as system A and system B and the third, a combination of the two.

System A (U.S.A. with medicare and medicaid)	System B (Britain in NHS and Sweeden) (national health system)
1- Seeks to satisfy consumers in a market situation in which access to health care is part of the reward system of the society, hence determined by willingness and ability to pay	Seeks to promote the general level of health in a community in which access to health care is the right of every citizer who seeks to benefit therefore.
2- Consumers insure and gain access to insured services (when required) at a reduced price at the point of consumption+market prices of private components.	Consumers pay through the general tax system and pay nothing (or a nominal fee) at the point of consumption.
3- Private ownership of the means of production mostly by non-profit making organizations+private profit oriented institutions.	Public ownership of the means of production
4- Minimal governmental control over budgets and resource distribution.	Central control over budgets and some physical direction of resources.

The third system as in Turkey, consists of both the public sector and of the private sector. It can be seen that medical care sector is highly regulated industry, with government inserting pressure on prices of medical supplies (as hospital care, drugs). On the other hand, in market environment, still characteristic of private medical practice in most countries, individual physicians are free to set their own fees, subject only to the constraints of the market. A variety of alternative theories of physician

pricing has been suggested in the literature. With some simplifications, these theories order themselves into the following grid.

	A Fees clear the market for Physician services	B Fees do not clear the market for physician services
I Physicians are price-takers	The physician sells his services in a competitive local market and reacts to market-determined local fee schedules (I A)	There are price-ceilings, or fee schedules which are set by third-party payers, and the individual physician reacts to these fees (I B)
II physicians are price setters	(II A) The physician enjoys a monopoly in the market for his services and sets his fees as a single-price (fixed fee-schedule) or price-discriminating (sliding-scale fee schedule monopolist)	(II B) The physician takes whatever cases he likes, organizes his practise to suit his tastes, and sets his fees so as to generate a given target income related presumably, to the income distribution of his locality.

These alternative theories clearly have varying implications for economic models of physician behaviour and in particular, for models of the supply of physician services. The subject matter is therefore of great interest to health manpower forecasters.

In so called target income models (type II B), the physici is assumed to work under conditions of chronic excess demand (Feldstein 1970)(57) which imputes him discretionary power over his fees. If the physician uses a single fee schedule applied to all his patients, the fees for individual services are probably determined on the basis of some full-cost pricing formula with a profit-margin set to yield the desired overall income(58). Alternatively, it may be assumed that the physician uses his discretionary power to tailor his fees to his individual patients' abili

(57) M.S.Feldstein, "Rising Price of Physicians' Services", Revie of Economica, XXXVII (May, 1970), pp.139-162.

(58) U.E.Reinhardt, An Economic Analysis of Physicians' Services, (Yale University, 1968), Appendix A.

to pay - that he uses a so-called sliding-scale fee system. On t surface such a system may strike one as price discrimination. Un conditions of excess demand, however, it is more akin to a user- tax system under which the individual user's taxes are a functio of his or her ability to pay and taxes are set at levels to yiel a given target. Incidentally, under target-income pricing, an increase in a region's physician population ratio would be expec ed either not to affect physician fees at all, or to push them u ward. The strong positive correlation between physician fees and physician density in Reinhardt findings of the United States is consistent with the target income hypothesis.

Excess demand models may well be descriptive of the real world, especially, if we look at physician/population ratios. Ec nomists find such theories troublesome from an analytic viewpoin The problem is that, whatever his pricing formula may be, the in vidual physician in these models is not subject to an effective market constraint on the demand side. His choice of input-output rates for his practice are thus likely to be based on a mixture of personal, social and medical considerations, and may not be linked at all to observable economic variables. So, in this case it is extremely difficult to guess what his fees will be and how his target income is chosen. Kessel (1958) has pointed out with great vigor that not only is price discumination incompatib with the competitive model, but its preservation in the face of large number of physicians is equivalent to a collective monopol Kessel has argued that price distribution is designed to maximi profits along classic lines of discriminating monopoly-whether th leads to maximization of profit by physicians or to equal payment for all income groups in optimum allocation is a major controver which is not resolved in the literature.

In a competitive market (I A), the physician employs the going pricing scheme and uses the market-determined local-fee schedules. This model assumes that if one physician raises the price of the service, he will be out of the market because of th workings of the perfect market mechanism. But it is impossible t assume such an ideal situation due to 1) consumer ignorance of quality and quantity of products in the market, 2) restrictions of entry into the market. So, in most eases the consumer is iden tifying price with the quality of the product or service due to

high level of uncertainty of the product. Also, in most cases, th physician cannot quote a fixed price for treatment in advance. Yo go to the doctor with a pain in your chest and you want to buy a cure. He cannot quote you a price for a cure until he has done some work; he does not know whether you have indigestion or a heart attack. Thus, in buying a cure, a patient buys a sequence of services whose consumption is uncertain at the outset. This uncertainty aspect is one factor where price is not an important element in the determination of demand for medical care, contrary to the competitive pricing model.

In (I B), there are certain price-ceilings or fee schedule which are set by third-party payers, and the individual physician reacts to these fees. This is the feature in Turkey, where patients from certain banks, go to private physician's offices, and their fee is paid by the bank to the physician who is working on a contract basis with fixed fee schedules. Thus, in this model the transaction is between the physician and third-party payers.

4. HOSPITALS WITHIN THE MEDICAL CARE SECTOR

From the above discussion on characteristics of medical care, it is apparent that there are many unique characteristics that effect the market structure of medical care and differentiat it from an economic good. The main factor that characteri es medical care is the centrality of the physician in determining both supply and demand. The physician, on the supply side, determines the quantity of service the consumer (the patient) has available for his consumption, furthermore, on the demand side, the physician decides how much the latter should consume. So, it appears that the physician is the unique figure in the market. But, considering the problem as such is simplification of the issue of medical care. Because medical care also consists of institutions, organized to provide a highly personalized service to individual patients, with the skills and efforts of a number of widely divergent groups of professional, semi-professional and non-professional personnel together with highly technical equipment, drugs and hotel services including beds and meals. The maintenance of health as related to medical care has been, for the most part, the responsibility of individual physicians and hospitals. The process by which social institutions react on the patient and the doctor to seek care in institutions is shown below:

Community Institutions Which Affect Citizens' Health and Attitudes	Individual Professions Which Provide Personal Health Care	Institutions Providing Personal Health Care
police department →	→ alcholics, anonymous synannon etc.	- mental facilities
state and local health departments →	→ chiropodists	- emergency facilities
schools →	→ optometrists	- home care
churches →	→ dentists	- outpatient facilities
unions →	→ laboratory clinicians	- general inpatient facilities
industrial health units →	→ citizen	- rehabilitation facilities
mass communication media →	→ x-ray technicians	- nursing homes
welfare agencies →	→ physical therapists	- specialized facilities
blue cross, insurance and other financial institutions →	→ pharmacists	- other volunteer and government care agencies
	↑ DOCTOR	
	→ nurses	
	→ councelors and related professions	
	→ prosthetists	
	→ psychologists	
	→ speech therapists	
	→ social workers	

FIGURE 2- THE RELATION OF SOCIAL INSTITUTIONS WITH THE PHYSICIAN AND THE PATIENT(59).

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(59) "Standards of Hospital and Hospital Care", Cento Conference on Hospital Administration, (Tehran: April 28-May 8, 1964) p.

In this figure, "the hospital" as a single entity is not shown, but the functional services are shown as manpower and facilities available to the physician. The doctor has been shown in a central position as befits his importance. He alone has the legal authorization to both diagnose and prescribe for any illness. He directly controls a very large fraction of the interaction between the citisen and other professionals and completely controls the use of certain professions such as laboratory technicians. In addition, with only minor exceptions, a doctor is necessary to place the citizen in contact with any of the care institutions. It is with these portions of the process, where the doctor draws upon the services of other professionals and the supporting facilities, that the hospital is directly concerned. In general, a hospital is an organization of manpower and facilities which is brought into the process of medical care by the doctor. The extent of facilities and services included in the hospital varies with the individual institution. At the least, the hospital will include an organized medical staff relationship with the doctor, employee relationship to most of the professions in the right section of the figure and general impatient facilities. Regardless of how large the scope of activities of a given hospital its roles are (a) to fill the demands for specific services made upon by the individual doctors treating individual patients and (b) to an increasing degree, to provide services and equipment for the systematic review and improvement of the process by which the doctor discovers and meets the patient's needs.

With the increasing importance of preventive and social medicine and new technological developments on curative treatments, the role of hospital within the community has widened. The growing realization of the thin line of demarcation between health and disease, of the relationship between social and material environment and the individual's mental and physical well-being has broadened the scope of functions of the hospital. The hospital is now regarded as an integral part of the health organization, the function of which is to provide and preventive. This is the view expressed by WHO experts on the organization of medical care within the hospitals.

Hospitals are subdivided into hospitals related to ministries (public hospitals) municipal hospitals, university hospitals and private hospitals. The private, for profit or non-profit hospital (hospitals related to foundations or associations) has been largely ignored within the literature on health economics. This can be due to the fact that these employ only a small percentage of beds in the total health sector when compared with large university hospitals or municipal hospitals.

TABLE 7- Activities of Hospitals by Organization in USA 1970

	TOTAL	Non-Prolit	For-Prolit	State and Local Government
Hospitals	5.859	3.386	769	1.704
Beds	848.232	591.937	52.739	203.556
Admissions	29.251.655	20.948.080	2.030.669	6.272.906
Patient days	241.458.815	173.154.540	13.903.215	54.401.060
Outpatient visits	133.544.672	90.922.193	4.698.200	37.854.279

a) Sylvester E.Berki, Hospital Economics, (Lexington Books, Studies in Social and Economic Process, 1972), p.xvi.

4.1. SERVICES OF HOSPITALS

We can state that the hospital can be conceived as a flexible set of departments within an institutional setting which produce a mix of multidimensional services. The services can be categorized as (a) consumption and investment, b) medical and hotel type services, (c) inpatient and ambulatory, (d) personal and community. So, it will not be wrong to state that hospitals are multiproduct firms. The analysis will depend on the focus of interest. Our focus of interest is the assessment of the hospital's role in satisfying patient preferences by producing those services which the patient considers desirable and which, therefore, enter his preference function, so its output is correctly seen as a bundle of consumption goods.

Classification schemes of services of hospitals may be based on morphological principles, giving use to their categorization by the organ systems at which they are directed. In such a scheme services are seen as medical, dental, optometric etc.., or at a higher level of specilicity, as internal, neurological, orthopedic, thoracic, orthodontic, ophthalmic, etc. Most hospitals have

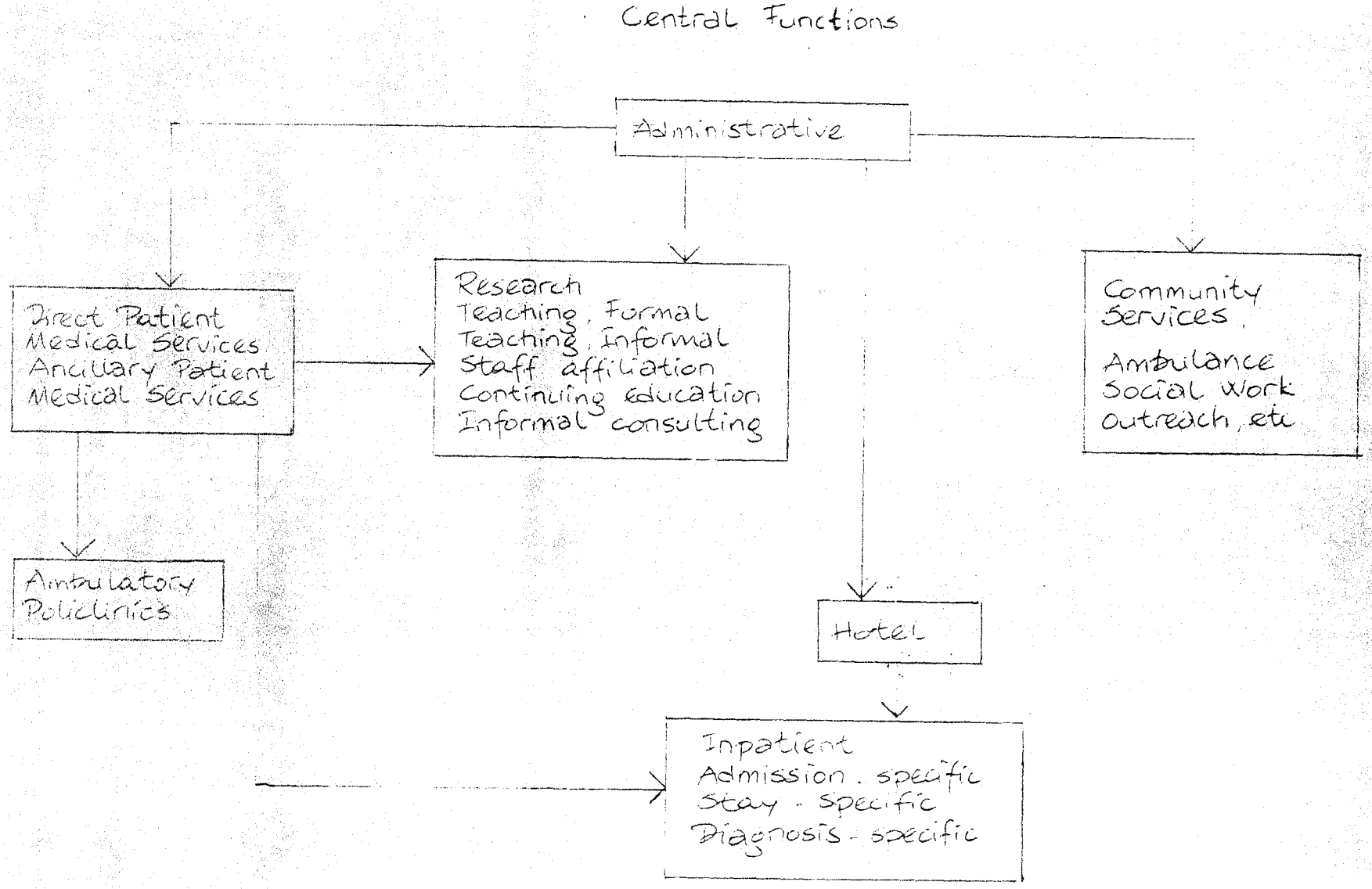

FIGURE 3- HOSPITAL OUTPUTS(60)

(60) Sylvester E.Berki, Hospital Economics, (Lexington Books, Studies in Social and Economic Process, 1972), p.46.

This percentage of private hospitals is even smaller in Turkey.

TABLE 8- ACTIVITIES OF HOSPITALS BY ORGANIZATION: 1978 data:

Hospitals	Number of Hospitals	Number of Beds		Outpatient	Patient Days
		Staff	Existing		
Total	776	86.526	84.104	23.705.845	16.499.030
Ministry of Health	586	54.294	52.485	10.555.9666	8.823.704
Ministry of Social Security	68	14.095	14.139	10.481.754	4.709.077
Other Ministries and Public Org.	31	3.347	2.179	864.190	418.944
Universities	8	8.954	10.560	919.443	1.643.042
Municipolities	6	2.795	1.795	558.803	350.990
Private Associations and privates	63	1.944	1.849	305.520	341.007
Foreigners	8	650	479	12.155	115.896
Minorities	6	447	618	8.014	93.370

a) Sağlık ve Sosyal Yardım Bakanlığı, "Activities of Hospitals by Organization", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977-80.

segmented their services according to this system.

It is useful to clossify services according to their primary purpose. In this taxonomy by function, we can identify seven basic categories of services(61).

1- Preventive: Designed to minimize the likelihood of events or conditions resulting in the diminution of attainable health levels.

2- Diagnostic: Designed to identify such conditions in individual humans, usually, termed disease.

3- Therapeutic: Services which are expected to terminate successfully episodes of acute illness or to minimize the severity and impact of chronic conditions.

(61) Sylvester E.Berki, Hospital Economics, (Lexington Books, Studies in Social and Economic Process, 1972), p.XVII.

4- Maintenance: Services designed to maintain attained health levels.

5- Ameliorative: Processes whose purpose is to reduce the psychological and physiological discomforts of incurable conditions and to ease the process of dying for terminal patients.

6- Research: Activities whose fundamental long-term objectives are improvement in the processes of prevention, diagnosis a therapy and,

7- Medical Education: Activities designed to disseminate accepted medical knowledge and the techniques for the production of the first five categories, the preventive and curative processes.

Although it is thought that the private hospitals do not contain all these services, it is nevertheless true that all of these services are at least given at a small scale than the university hospitals. For example, in one private hospital, students from med cal university participate in operations of aesthetics to learn certain skills and procedures. Also, in the same hospital, research on hand aesthetics is being conducted by a group of practioners.

4.2. OBJECTIVES OF THE HOSPITALS

That the hospital's objectives are complex and multiple in nature is recognized by many. Codman and MacEachern(62), both posite a fourfold definition of functions in terms of,

(a) care of the sick and injured,

(b) medical education and the maintenance of medical standards in the community,

(c) prevention of disease and the promotion of health,

(d) advancement of medical research. Codman also emphasize the externalities of hospital service which he talked of as "by product".

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(62) Sylvester E.Berki, Hospital Economics, (Lexington Books, Studies in Social and Economic Process, 1972), p. 21.

There are many other attempts in literature to come to a meaningful objective function for the hospitals as profit-maximization encompasses most of the businesses. Kaitz(63) who considers the hospital to be an "anomaly from an economic and managerial point of view somewhere between the price-oriented private sector and the tax-oriented public sector, "states that profit maximization is inappropriate and would substitute for it the somewhat less specific notion that" hospitals seek to optimize some differing, and for must institutions, ill defined goal subject to certain financial constraints". One hospital administrator that we have talked to, stated "we don't care if we make no profit, it is only important that we break even and continue to give health service without any debts". One other stated that they try to maximize the number of patients that are treated during a period, where the well-known axiom "a filled bed is a billed bed" operates. Reder(64) has suggested that the apparent objective is to maximize the weighted number of patients treated (per period of time) the "weights" being the professional prestige of doctors attending them". In this analysis, the professional prestige of doctors attending is an indirect indicator of the expected quality of care provided by the hospitals. This formulation of the objective function is insightful since it appears to hint at the recognition of the physician's central role in its specification. Lee(65) suggests that the hospital production process and the ruling objective functions can best be understood in terms of Veblenian concept of "conspicuous consumption". He states that each hospital considers itself to be a member of some group of hospitals which it considers to be its peers in terms of the scope of services, prestige, reputation, and excellence (e.g. all the prenatal clinics can be seen as one group). To maintain membership, it must engage in the production of services in scope and quality dimension equivalent to or similar to those produced by

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(63) E.M.Kaitz, Pricing Policy and Cost Behaviour in the Hospital Industry, (New York: Praeger Publishers, 1968), p.62.

(64) M.W.Reder, "Some Problems in the Economics of Hospitals", American Economic Review (May, 1965), 480.

(65) Lee Maw Lin, "A Conspicuous Production Theory of Hospital Behaviour", Paper Presented at the Conference of the Western Economic Association (August, 1970), p.4.

its peers and must do so in a manner that makes it known. Hence it will tend to maximize its "conspicuous production".

Newhouse(66) develops a model of hospital where the organization tries to maximize quality where quality is denoted by an unspecified "vector of characteristics" and quantity by simple unweighted patient days. He assumes that an increase in the quality of the hospital's output will increase the demand for that hospital's service. That is similar to what most administrators of private hospitals that we have talked to stated; hospitals wish to maximize their long-term growth, they wish to prosper and expand by giving good health care service.

Perchansky and Rosenthal(67) have formulated that the majority of demands for hospital service are physician originated Whether to maximize their incomes by the use of social capital or to shape the hospital to their private professional needs, the physicians are central decision makers in the process of care and will attempt to shape the hospital's objective function to their purposes. In addition to the physicians, there are Board of directors or trustees, and the administrators. Stevens(68) has maintained that "different components of the management structure may entertain different and sometimes not compatible objectives." He concludes that private practitioneers "in attempting to maximize their incomes" want to use these facilities as a necessary adjunct to their non business operations(69).

If the literature on the objectives of hospitals agrees on a central point, it is that the objectives are vague, ill defined, contradictory and sometimes non-existent. Basil S.Georgopoulos and C.M.Floyd(70) have an interesting analysis in which they have

(66) J.P.Newhouse, "Toward a Theory of Non-Profit Institutions: An economic model of a hospital", American Economic Review, LX, (1970), pp.64-74.

(67) R.Perchansky and G.Rosenthal, "Productivity, Price and Income in the Physicians' Services Market-A Tentative Hypothesis", Medical Care, (October-December, 1965), 21.

(68) C.N.Stevens, "Hospital Market Efficiency: The Anatomy of the Supply Response", Empirical Studies in Health Economics, Proceedings of the 2nd Conference on the Economics of Health, ed. Herbert E.Klarman and Helen H.Jaszi (Baltimore, Md.: John Hopkins Press, 1970), p.8.

(69) Ibid.

(70) S.B.Georgopoulos and C.M.Floyd, "The Hospital as an Organization", PatientS, Physicians and Illness-A Source book in Behavioral Science and Health, ed. E.Gartly Jaco (New York:

combined the objectives of the hospital with the organizational and administrative structure within the hospital. They state that the main objective of the organization is to render personalized service-care and treatment-to individual patients, rather than the manufacture of some uniform material object. And the economic value of the organization's products and objectives is secondary to their social and humanitarian value. To the hospital and to its members, the patient's needs are always of supreme importance; also there is a high degree of agreement about the principal objective of the hospital among the members, as doctors and nurses (many of them at least should) look upon their profession as a sacred calling, so immediate personal comfort and satisfactions, and even material rewards are defined by their members as less important than giving good care to the patient-and meeting a higher order of obligation to mankind. Apart from this primary objective, a hospital has other additional objectives including its own maintenance and survival, organizational stability and growth, financial solvency, medical and nursing education and research, and various employee related objectives. But these are subsidary to the key objective of service to the patient.

4.3. ADMINISTRATION OF THE HOSPITALS

It has been stated that the hospital is a human rather than a machine system(71) and even though it may possess elaborate and impressive-looking equipment, or a great variety of physical and material facilities, it has no integrated mechanical-physical systems for the handling and processing of its work. The patient is not raw material that passes passively through an ordered progression of machines and assembly-line operators. At every stage of his short stay in the hospital, he is mainly dependent upon his interaction with the people who are entrusted with his care and upon the skills, actions, and interactions of these different people. To do its work, the hospital relies upon extentive division of work, specialization and differentiation of a highly interactional character. The care process is carried out by a large number of cooperating people whose backgrounds, education, training skills and functions are as diverse and heterogenus as

(71) S.B.Georgopoulos and C.M.Floyd, "The Hospital as an Organization", Patients, Physicians and Illness-A Sourcebook in Behavioral Science and Health, ed. E.Cartly Jaco (New York: Collier, Macmillan Limited, 1972), II, pp.155-171.

can be found in any of the most complex organization in existence. Much of the work is not only specialized but also performed by highly trained professional groups -the doctors- who require the coordination and assistance of many professional and non-professional personnel. In addition to medical staff, there is the nursing staff (highly departmentalized and specialized), consisting of graduate professional nurses in supervisory or nonsupervisory positions, practical nurses, and untrained nurses aids. In addition to these two groups, there is the hospital administrator (a doctor or a manager) and a number of administrative-supervisory personnel who head various departments (nursing, dietary, admissions, maintenance, pharmacy, medical records, housekeeping, and are in charge of the employees in these departments. There are also a number of medical technologists and technicians who work in the laboratory and x-ray department, and a number in clerical and secreterial positions. Apart of all these staff there are a board of trustees who has overall formal responsibilities.

Because of this extensive division of labour and specialization of work, every person working in the hospital depends upon some other person or persons for the performance of their own organizational role. Doctors can only perform their functions by the support of nurses, technicians, and others. So hospital personnel do not and cannot function seperately or independently of one another. So such a high degree of interdependence, requires a highly developed coordination of all the specialized functions, and activities of many departments. From the administrative point of view, the hospital should develop a rather intricate and eloborate system of internal coordination.

Second but equally important factor in the administration of the hospital is that it constantly deals with matters of life and death, matters which place a heavy burden of responsibility on the organization and its members. Thus, error and negligence is prevented by adherence to strict formal rules and authoritarian discipline. The emphasis on formal organizational mechanisms and procedures and on directive rather than democratic controls, the hospital is a bureaucratic structure, which manifests itself in relatively sharp patterns of superordination and subordination, with expectations of strict discipline and obedience and distinct status differences among organizational members.

So in analysis of the organization and administrative structure of any hospital, these two characteristics; a) bureaucratic structure, b) high degree of coordination must be taken into consideration.

4.4. THE HOSPITAL'S OUTPUT (HOSPITAL UTILIZATION INDICES)

The output of the hospitals, are best reflected by the satisfactions consumers drive from improved states of health. But such satisfactions are not directly measurable. The literature presents six-basic approaches to the definition of hospital output, or indices of measurement of hospital utilization(72).

4.4.1. Utilization Indices

1- Hospital Beds: A hospital bed is one regularly maintained and staffed for the accommodotion and full-time care of a succession of in-patients and is situated in wards or areas of the hospital in which continuous medical care for in-patients are provided. The total number of such beds constitutes the normally available bed complement of the hospital.

2- Admissions: Admissions refer to the number per year of acceptances by a hospital of a patient who is to receive medical care while in residence therein and who is expected to remain for one or more nights. Normal, healthy, newborn babies should not be counted as in patient admissions but babies requiring special care should be included among the admissions.

3- Discharges and Deaths: The annual number of discharges includes the number of patients who have left the hospital (cured, improved) etc., the number who have transferred to another health or social institution, and the number who have died.

4- Bed Days or Patient-Days: "Bed day or "patient day" is the unit of measure denoting the service rendered to one in-patient in the hospital census between one day and the succeeding one. Sometimes the day of admission and the day of discharge are counted

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(72) R.LLewelyn Davies and H.M.C. Macaulay, Hospital Planning and Administration, World Health Organization, (Geneva, 1966), pp 30-31.

as one day. In other cases, a full day is counted only when admission is before mid-day or discharge is after midday.

5- Indices Relating to the Hospital: Average length of stay (L) This index indicates the average period in hospital (in days) per patient admitted. Ideally, this figure should be calculated as follows: cumulative number of bed days of all discharged patients (including those dying in hospital) during one year divided by the number of discharged and dead patients. This calculation takes into account the bed days of patients in the year (or years) previous to the one under consideration, but disregards the bed days of patients who were still in hospital at the end of the year. It may be said, therefore, that the result of this method of calculation represents the true average length of stay per patient; and it is recommended that this method be used, at least in long - stay hospitals.

However, various countries or various institutions obtain the figure for the average length of stay in hospital in different way. The following are some of the formulas currently in use:

a) Total number of bed days in the year divided by the number of admissions in the same year: $L = H/A$.

b) Total number of bed days in the year divided by the number of discharges and deaths in the same year: $L = H/D+d$.

c) Total number of bed days in the year divided by half the sum of admissions and discharges (including deaths) in the same year:

$$L = H \underset{1/2}{\times} \frac{1}{(A+D+d)} = 2 \times \frac{H}{A+D+d}$$

It will be noted that these three methods result in a figure representing the average length of stay per patient per year which is not the same as the average period of stay per patient admitted. In hospitals in which the patient's stay is usually short, the two figures are practically identical, and either may be used; in hospitals in which patients stay for relatively long periods, or in cases in which changes in bed complement

have occurred during the year, the average length of stay is correctly calculated by the first method described above.

d) Bed-Occupancy Rate (O): The figure expresses the average percentage occupancy of hospital beds. It is calculated by dividing the daily average number of beds occupied (obtained from the daily census of occupied beds) by the bed complement (nominal number of beds in the establishment) and multiplying by 100:

$$O = \frac{N}{B} \times 100 = \frac{H}{365 \quad B} \times 100$$

The bed occupancy rate reflects the ratio between beds used and beds provided. Opinions differ regarding the appropriateness of using this mode of presentation, and some would prefer to use as a denominator the actual number of bed used (including any additional beds) rather than the bed complement. On the other hand, it would appear preferable to use the bed complement as a denominator since a bed occupancy rate of 100 or over would call the attention of administrators to a disproportion between the number of beds provided and the number used. Furthermore, it sometimes happens that the need for additional beds is only seasonal in nature, in which case a month-by month analysis would enable administrators to plan ahead of meeting this contingency. A persistently high occupancy rate all through the year would, on the other hand, call attention to a possible shortage of beds.

Occupancy rate should not be thought of solely as a measure of administrative efficiency. Although it is reasonable to expect that services such as "cold orthopaedic surgery" in which admissions can be controlled, should achieve high occupancy rates, such as 90 %, there are other services, such as accident care and children's services, in which a fairly low occupancy rate is necessary, perhaps 75 % to ensure that emergency admission is always possible. Thus, the establishment of occupancy rate is an instrument of medical and social policy.

e) Turnover Interval (T): The turnover interval expresses the average period, in days, that a bed remains empty, in otherwords, the average time elapsing between the discharge of one patient and the admission of the next. This figure is obtained by subtracting the actual number of hospitalization days from the

potential number of hospitalization days in a year and dividing the result by the number of discharges (and deaths) in the same year:

$$T = \frac{B \times 365 - H}{D+d}$$

The turnover interval is zero when the bed-occupancy rate is 100 and becomes negative when the bed-occupancy rate is over 100. In order to be meaningful, the turnover interval should be calculated seperately for the various types of hospital and especially, for the various wards of the hospital. A very short or negative turnover interval points to a shortage of beds, whereas a long interval may indicate an excess of beds or a defective admission mechanism.

4.4.2. Factors Influencing Hospital Utilization

The manner in which a certain community utilizes the hospital bed and the extent of such utilization are influenced by many factors that depend on the social, economic, educational, and cultural characteristics of the people and on the attitudes and special habits of the medical profession. With regard to the latter, it may be presumed that the doctor orders or advices admission to a hospital primarily for medical reasons; however, that is not always the case. Very often the people themselves influence the decision for or against hospital admission. Thus, in less developed countries, fear of the hospital or unwillingness to seperate from the family may be strong arguments against hospital admission, whereas in more sophisticated communities the hospital "habit" may be such that a person may bring pressure to bear on the attending physician for admission to the hospital, even though there may not be objective reasons for this course of action.

In view of such considerations, studies on hospital utilization must be interpreted with caution, since some figures do not truely reflect the quality or efficiency of medical services. Nevertheless, because of rising cost of hospital care, such studies are valuable in pointing out the directions in which economy may be effected without influencing the quality of care.

The following are some of the factors that affect the

utilization of hospitals(73).

1- Availability of Hospital Beds: It has been observed in the economically developed countries that the larger the number of available hospital beds, the larger the volume of hospital utilization; but it is unlikely that these two trends are really correlated. They are the result of factors that are linked to socio-economic development, such as better health education, increased health consciousness, larger protection by social security and higher standards of living, leading to an increased number of demands for hospital care. A saturation level is eventually reached especially for maternity services and some specialized departments. In some cases, there is a direct relationship between the bed/population ratio and the utilization indices, such as admission rates, bed-occupancy rate, per person hospitalization rate and others. If the bed complement is very great, high bed/population ratios may be accompanied by a low bed-occupancy rate and/or a high turnover interval.

2- Methods of Payment for Hospital Services: There are two methods of payment for hospital services direct and indirect. In the former, payment is made directly by the utilizer of the hospital services in the latter, services are paid for through prepaid programmes, sickness insurance, general taxation, and other indirect measures. Hospital utilization is greatly influenced by the method of payment. It has been found that payment by third - parties (insurance schemes) has resulted in an over utilization of hospital services, resulting in long waiting lines for the real needy and the sick.

3- Age of the Population: A population with a high-expectancy (and a consequently higher proportion of aged persons) tends to raise the volume of hospitalization. The effect of age on utilization indices is reflected in an increase in the per person hospitalization rate and in the average length of stay per patient.

4- Service-Coverage and Bed Distribution: A high bed/population index does not always indicate a full coverage of the popu-

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(73) R.LLewelyn Davies and H.M.C.Macaulay, Hospital Planning and Administration, World Health Organization, (Geneva, 1966), pp.32-35.

lation, this depends on the geographic distribution of hospital beds rather than on the total number of beds, and an even geographic distribution increases hospital utilization by making the hospitals more available to all the people. On the other hand, a large number of beds concentrated in urban areas may still mean a low admission rate for the country as a whole, in as much as large sectors of the rural population may not be able to take full advantage of the hospital because of the distances involved.

5- Availability of Extramural Medical Services: The type, extent and quality of extramural medical services affect hospital utilization in various ways. A well organized domiciliary medical service can, by caring for patients in their homes or clinics, reduce the load on the hospital. However, in developing countries these services also tend to uncover hitherto undiscovered sickness in the community, which can give rise to a completely new demand for hospital services.

An important role is played by the out-patient department of the hospital. A good consulting out-patient department with diagnostic facilities may greatly reduce the number of admissions to the hospital.

6- Hospital "Bottlenecks": Another important factor in hospital utilization, connected with the hospital itself, is what might be called hospital bottlenecks, or in other words, the efficiency of the hospital's supporting services. x-ray department, laboratory services, operating room services, and others. Shortage of personnel, space and equipment in these departments results in a prolonged average hospital stay and a lowering of the admission rate. Improved efficiency in these departments increase the admission rate and thereby increases the cost per day. This results in decreased hospital stay, however, and may decrease the cost per person treated. Similarly, the administrative services, such as the admission and discharge procedures, may act as bottlenecks and adversely affect the efficiency of the hospital.

7- Medical Customs and Social Patterns: The customs or attitudes of the medical profession affect hospital utilization. Thus, early ambulation, which has been adopted in many countries, has resulted in a lower average stay in hospital. With regard to obstetrics, customs differ greatly from country to country. In

some countries, the medical profession, or the women concerned, insist on hospital deliveries for nearly all cases whereas, in other countries, hospital deliveries are confined to abnormal cases and possibly, primiparas. In addition, the length of hospitalization in normal obstetric cases varies from two or three days in some countries to up to fourteen days in others.

The demand on hospitals is also affected by social and cultural patterns of the population, as previously suggested.

8- Supply of Physicians: The number of doctors in a country influences hospital utilization in a number of ways. On the whole, the pattern of hospital utilization is less influenced by the number of doctors than by factors such as the attitude of the medical profession toward hospitalization and the organizational patterns of medical care.

Other factors being equal, the number of doctors influences the admission rate as follows: In areas with a very small supply of doctors, the admission rate tends to be low, as large sectors of the population have no access to medical practioners, and much illness remains undetected. As the number of doctors increases, more cases of illness are detected and the hospital admission rate rises. A point of maximum rise is reached when the physician/population ratio is such that there is practically complete coverage of the population, but the number of patients per doctor is high. Thus, the over-burdened practioneer tends to refer to the hospital cases that, had he more time, he could deal with efficiency on an outpatient basis or at home. A further rise in the number of doctors diminishes the patient load and allows for more medical work outside the hospital.

9- Research and Training: Hospitals with programmes of research or training, or both, tend to be more selective in their admission policy. On the other hand, the average length of stay in these hospitals tends to be longer because there are many specialized departments, such as neurosurgery, orthopaedics and neuropsychiatry, that select serious cases.

10- Existence of Private Hospitals: The private hospital is also selective in its admission policy. Usually receiving minor or curable cases (situation somewhat different in Turkey which will

be examined in detail). Therefore, complicated cases are mostly referred to general hospitals, which must keep them longer. Thus, in the private hospitals, the length of stay is generally shorter than in other hospitals.

11- Housing: The current trend for families to live in smaller houses or apartments has a definite influence on hospital utilization. Many admissions to hospital are due not so much to the need for hospital care as to the inconveniences encountered in caring for the sick person at home. Smaller housing units demand less home help. Therefore, the combination of shortage of space and shortage of home help is an important factor in the demand for hospital admission. This is particularly true of the elderly, who often cannot be kept at home when sick.

Morbidity: Hospital utilization is greatly influenced by the morbidity pattern of the community. The increased demand due to an outbreak of disease and the day-to day morbidity pattern both determine to a large extent, the type and volume of hospital admissions.

The above cited factors are those that influence utilization of hospital services. The work and the importance of the hospital ought not to be measured by the number of beds that are filled, but the service that is given to its customers, the patient. Consideration of the hospital bed as the sole yardstick of medical care activity belongs to the past, so the hospital must be taken as a whole, with all its contributions to the society, and this concept takes us to the preventation of marketing activity within the hospitals. Before starting an analysis of private hospitals, we should regard and examine the medical care sector in Turkey as a whole.

5- Medical Care Sector in Turkey: The 1961 constituion of the Republic of Turkey has assigned the state with the responsibility of securing means for every one to live a physically and mentally healthy life and to receive medical care. The state executes this duty assigned to it by the constitution, through the Ministry of Health and Social Assistance. Besides, the Ministry of Health and Social Assistance, other ministries, Economic State Enterprises, the Social Insurance Organization, Schools of Medicin municipalities and private establishments in accordance with

various laws issued for this purpose, contribute to carrying out some health services. As can be seen from the above analysis, medical care service in Turkey, is given by a variety of institutions, including private physicians who contribute independently to the health level of the country. In Public Health Law No 1593, the improvement of the health circumstances of the country, control of all diseases, and other harmful factors endangering the health of the people, securing the healthy growth of the coming generations and providing both medical and social assistance to the public are considered among the general services of the state. Also, the Ministry of Health and Social Assistance is assigned with the execution, (excluding health activities of the Ministry of Defence) of controlling the health services of all organizations.

To start an analysis of medical care service sector in Turkey, we must start with the development process. The 1921-1946 period due to his important contributions to the development of medical care service, is labelled as Dr.Refik Saydam (minister of health of that period) period(74). In this period, more emphasis was placed on preventive medical care services, and these were stated as the responsibilities of the state. Also, he encouraged local institutions, as "Numune Hastaneleri" in Ankara, Istanbul, Sivas, Erzurum and Diyarbakır, and also private institutions and municipalities in instituting hospitals. The mechanism of "state physicians", who were related to local governments, gained importance. These physicians were important in giving preventive service on epidemic diseases, as in malaria and syphilis prevention. The management of personnel working in public sector was related to Ministry of Health, and in 1924, with the law of "Compulsory Service in Medical Care", graduates of medical universities, had to work for four years in specific regions of the country.

Between 1946-1950, the First Ten Year Health Plan was prepared by Dr.Behçet Uz (minister of health). To distribute medical care services and personnel within the country, the country was divided into 7 health regions which would organize their activities

(74) M.R.Dirican, "Türkiye'de Sağlık Hizmetlerinin Örgütlenmesinin Kısa Tarihçesi", Atatürk Üniversitesi Tıp Bülteni, II, No: 7, (Erzurum, 1970), pp.13-21.

independently. Within the regions, for every 40 village, a health center with 10 beds was required with 2 physicians, 1 midwife, and 1 health personnel. In these centers curative and preventive services would be conducted together, and as these regions developed, a university would be instituted which would provide the increase in specialized personnel.

So in this plan, health planning was taken seperately from the organization of regional governments, thus curative and preventive medical care services were coordinated, and medical care service were taken beyond the urban centers to rural areas. After Behçet Uz, the plan was not followed up; only health centers were established in every region and these were operated as hospitals with rising costs.

Also, in 1946, Law No: 3308 gave responsibility to Social Security Institution to provide health services to its members. In the following years, Law No: 2219 stated that State Economic Enterprises, certain ministries and municipalities can establish medical care institutions to provide health service for their own personnel.

In 1950-1960 period: Minister of Health Dr.Ekrem Hayri Üstündağ tried to realize the socialization plan but he could not succeed. This period is characterized by a general neglect of preventive care services because activities of public sector were directed towards establishment of hospitals.

1960-1975 period: The constitution of 1961, with 48 and 49th articles, accepted health and social assistance services as responsibilities of the state within the concept of "welfare state".

According to 48th and 49th articles of the constitution and in accordance with the prepared plan, it was seen that medical care service must be organized. So, in Jan 5, 1961, (No 224) Health Services Socialization Law was accepted. So since 1963, socialization of health services was the main principle in coordination of medical services. It was thought that this socialization principle that started in 1963 in Muş, would cover the entire country in 1978, and in 1982, it was planned that development would reach a level where a social center would be instituted for

every 5000 people.

Today, in 1982, the socialization law is still in enforcement, but its success is largely questionable. In 1976 in 4th Five Year Development Plan, "Sağlık Sektörü Özel İhtisas Komisyonu Raporu" was published. In this report it was stated that the expected development was not realized in any of the target areas. So, as Recep Akdur(75) states, the medical care service organization looks like a three-headed giant; three factors that are interrelated within the medical care system-state physicians (hükümet tabiplikleri), health centers (sağlık merkezleri) and health houses of socialization process (sağlık ocakları) place the medical care sector in a crisis situation. As socialization process has not been developed over the entire country, the health care system looks like a zigzaw puzzle, with 49 different organizations giving medical care service with no coordination between them.

SERVICE AND PERSONNEL LEVEL IN THE SECTOR

Comparison of the number of personnel and number of institutions with other countries gives us an idea about the position of the medical care sector in TURKEY.

When we look at the statistical data; we can see that Turkey is among the six countries which have highest population / physician ratio, and population/bed ratio. It is apparent that there is a close correlation between national product of countries and these ratios. So, it can be stated that medical care sector cannot be analyzed seperatedly from the economical development of a country (TABLE 9).

From the also data on Table 10 it can be seen that very little increase has been achieved in the number of physicians relative to the population increase. Another striking fact is that in Turkey, a large percentage of doctors are specialists which creates problems by itself. The practicians are doctors, who are not constrained by care for certain illnesses but who should be the first ones to be contacted in case of sickness. As has been stressed in the Third Rive Year Development Plan, "The major difficulty in Turkey, in the

(75) R.Akdur, "Sağlık Düzenimiz ve Politikasında Kargaşa", Toplum ve Hekim, XII, (December, 1978), pp.39-54.

ABLE 9- DISTRIBUTION OF MEDICAL PERSONNEL AND ENSTITUTIONS

Country	pop- estimated (millions 1973)	death rate %	life expectancy at birth	national product (U.S. $)	physicians	nurses	midwives	health technicians	number	Beds	population /physician	popula /bed
SA	210.3	9.4	71	4.760	338.111	857.000	4.300	247.945	7.336	1.401.624	620.11	150.
est Germany	59.4	11.7	71	2.930	120.260	171.402	5.958	53.450	3.481	729.791	493.93	81.
rgentina	25.3	9	68	1.160	53.684	14.471	2.905	6.624	2.864	133.847	471.27	189.
razil	101.3	10	61	420	59.573	24.315	-	49.827	4.431	382.952	1716.4	264.
ulgaria	8.7	9.8	71	760	18.770	34.689	7.122	13.063	...	75.037	463.565	115.
lgeria	15.5	17	51	300	1.797	1.532	537	369	149	39.073	8625.48[2]	396.
ndonesia	132.5	19	48	80	7.027	1.099	12.165	1.977	1.115	83.696	18928.5	1596.
inland	4.8	9.6	69	2.390	6.701	22.810	1.071	3.937	379	71.115	716.31	67.
rance	52.3	10.6	73	3.100	77.882	190.776	9.050	...	...	...	671.52	..
ngland	57.0	11.9	71	2.270	64.600	130.347	18.658	29.439	31.308	417.249	882.35	136.
raq	10.8	15	25	320	6.883	3.535	1.688	3.172	187	22.942	1569.08	248.
ran	31.1	17	50	380	12.890	4.947	2.882	3.125	535	49.194	2412.72[5]	632.
pain	34.2	8.2	70	1.020	55.000	29.431	46.220	...	1.261	185.218	621.81	184.
srael	3.1	7	72	1.960	9.143	...	663	...	86	19.501	339.05	158.
weden	8.2	10.4	75	4.040	13.260	47.800	620	14.990	725	124.350	618.40	65.
taly	54.9	9.6	71	1.760	190.166	...	18.375	5.698	2.189	575.162	288.7	95.
apan	107.3	7	72	1.920	126.822	176.051	26.867	26.592	8.294	1.163.726	851.5	92.
ungary	10.4	11.4	67	1.600	21.127	41.246	2.208	19.251	218	90.104	492.26	115.
gypt	36.9	16	53	210	8.037	7.373	7.423	7.036	1.454	79.399	4591.27[3]	464.
akistan	68.3	18	-	100	17.929	6.010	6.352	...	1.345	33.948	3809.47	2011.
SSR	250.0	8.2	70	1.790	733.700	1.232.000	329.300	218.800	...	3.009.200	341.06	83.
rian	6.8	15	53	290	2.666	...	1.161	...	93	6.865	2550.6[4]	990.
rkey	38.6	15	54	310	21.714	8.907	12.975	10.851	807	85.872	1777.65[6]	449.
goslavia	21.2	9.1	67	650	24.920	10.229	6.073	10.869	490	127.646	850.7	166.
reece	9.1	8.3	69	1.090	18.421	4.604	3.224	...	722	58.501	494	155.

Sağlık ve Sosyal Yardım Bakanlığı, "Distribution of Medical Personnel and Institutions", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977, 398.

TABLE 10- DISTRIBUTION OF PRACTICIANS AND SPECIALISTS IN TURKEY

	Specialists		Practicians		TOTAL	
Year	No	%	No	%	No	%
1950	3.647	52.9	3.248	47.1	6.895	100.0
1955	4.836	50.2	4.802	49.8	9.638	100.0
1960	5.217	53.1	4.609	46.9	9.826	100.0
1965	6.657	61.1	4.238	38.9	10.895	100.0
1970	10.241	64.6	5.615	35.4	15.856	100.0
1973a	11.139	64.1	6.226	35.9	17.365	100.0
1975	12.698	58.48	5.943	27.37	21.714	100.0
1976	13.177	56.34	6.034	25.80	23.388	100.0
1977	14.724	61.55	6.399	26.75	23.920	100.0

a) Different statistics added giving no continuous data.

b) M.Rahmi Dirican, "Türkiye'nin Gereksinimi ve İnsan Gücü Planlaması Yönünden Uzmanlık", Ankara ve İzmir Tabipler Odası Bülteni, XVIII, 2, (Mart, 1977), p.13.

accessibility to physician care is the specialization of physicians. In Turkey, in addition to increased specialization, the number of specialized branches of medical care are also increasing".

In "Tababet İhtisas Vesikaları Hakkında Nizamname" issued on 1929, 15 specialization branches have been shown. In 1947, in another statement, branches increased to 45 and in 1955, to 37, in 1962, 59 and in 1973, the number increased to 64(76). This increase in specialization of medical care, falls short of the demand of community for medical care and brings forth certain problems which can be cited as follows:

1- Physicians, for the prevention of illness among the community at large, must give priority to preventive medical care; but as specialization requires more curative practices, community health programs are ignored.

2- Patients, thinking that it would be more beneficial for their care, go to the specialists, thus increasing the number of patients in specialist offices together with limiting the time of

(76) M.Rahmi Dirican, "Türkiye'nin Gereksinimi ve İnsan Gücü Planlaması Yönünden Uzmanlık", Ankara ve İzmir Tabipler Odası Bülteni, XVIII, 2, (Mart, 1977), p.13.

79. Hekimlerin sağlık bölgelerine göre dağılımı —

A. Bölge nüfusu (bin) — B. Bölge nüfusunun toplam nüfusa oranı — C. Hekim sayısı (1) — D. Bir hekime düşen nüfus
A. Regional population (thousand) — B. Regional population as percent of total population — C. Number of physicians (1) — D. Population per physician

Sağlık bölgesi ve il Health region and province		1973 (2)	1974 (2)	1975	1976 (2)	1977 (2)	1978 (2)	1979 (2)	1980
Toplam — Total	A	38 073	39 037	40 348	41 039	42 078	43 144	43 801	44 737
	B	100 0	100 0	100 0	100 0	100.0	100 0	100 0	100 0
	C	18 511	20 868	21 714	23 388	23 920	25 230	(3) 26 298	(4) 27 241
	D	2 057	1 871	1 858	1 755	1 759	1 710	1 666	1 642
I. bölge — I. region	A	4 370	4 563	4 834	4 980	5 204	5 440	5 699	5 749
Edirne, İstanbul, Kırklareli, Tekirdağ	B	11 5	11 7	12 0	12 1	12 4	12 6	12 8	12 9
	C	7 018	7 803	7 959	8 954	8 558	9 147	7 973	8 215
	D	623	585	607	556	608	595	715	700
II. bölge — II. region	A	2 120	2 170	2 238	2 275	2 329	2 386	2 538	2 572
Bolu, Kocaeli, Sakarya, Zonguldak	B	5 6	5 6	5 5	5 5	5 5	5 5	5 7	5 8
	C	588	594	643	702	746	800	643	681
	D	3 605	3 653	3 481	3 241	3 122	2 983	3 947	3 777
III. bölge — III. region	A	2 043	2 076	2 120	2 144	2 179	2 214	2 374	2 393
Balıkesir, Bursa, Çanakkale	B	5 4	5 3	5.3	5 2	5 2	5.1	5 3	5 3
	C	635	607	673	670	757	883	628	666
	D	3 217	3 420	3 150	3 200	2 879	2 507	3 780	3 593
IV. bölge — IV. region	A	3 907	3 996	4 118	4 182	4 279	4 378	4 539	4 613
Aydın, Denizli, İzmir, Manisa, Muğla	B	10 3	10 2	10 2	10 2	10 2	10.1	10 2	10 3
	C	2 307	2 769	3 011	3 235	3 250	3 307	3 071	3 375
	D	1 694	1 443	1 368	1 293	1 317	1 324	1 478	1 367
V. bölge — V. region	A	1 853	1 878	1 911	1 929	1 955	1 982	2 022	2 033
Afyon, Bilecik, Eskişehir, Kütahya, Uşak	B	4 9	4 8	4 7	4 7	4 6	4 6	4 6	4 6
	C	434	430	455	542	540	627	589	634
	D	4 270	4 367	4 200	3 559	3 620	3 161	3 433	3 207
VI. bölge — VI. region	A	1 154	1 180	1 215	1233	1 261	1 290	1 331	1 334
Antalya, Burdur, Isparta	B	3 0	3.0	3.0	3 0	3 0	3 0	3 0	3 0
	C	231	246	248	261	353	407	453	537
	D	4 996	4 797	4 899	4 724	3 572	3 170	2 938	2 484
VII. bölge — VII. region	A	3 970	4 096	4 271	4 366	4 509	4 660	4 811	4 966
Ankara, Çankırı, Kastamonu, Kırşehir, Nevşehir, Yozgat	B	10 4	10 5	10.6	10.6	10 7	10 8	10 9	10 2
	C	3 762	4 961	4 932	5 453	5 527	5 900	5 745	5 816
	D	1 055	826	866	801	816	790	837	785
VIII. bölge — VIII. region	A	1 791	1 831	1 886	1 914	1 957	2 000	2 047	2 074
Konya, Niğde	B	4 7	4 7	4 7	4 7	4 7	4 6	4 6	4 6
	C	259	273	259	234	278	275	258	281
	D	6 915	6 707	7 282	8 179	7 040	7 273	7 934	7 381
IX. bölge — IX. region	A	2 620	2 658	2 709	2 735	2 775	2 816	2 876	2 911
Amasya, Çorum, Ordu, Samsun, Sinop	B	6.9	6 8	6.7	6 7	6 6	6 5	6 5	6 5
	C	347	334	454	482	525	522	522	553
	D	7 550	7 958	5 967	5 674	5 286	5 396	5 510	5 264
X. bölge — X. region	A	1 948	1 978	2 018	2 039	2 070	2 103	2 129	2 153
Kayseri, Sivas, Tokat	B	5 1	5.1	5.0	5 0	4.9	4.9	4 7	4 8
	C	314	276	332	303	454	496	560	611
	D	6 204	7 167	6 078	6 729	4 560	4 240	3 802	3 524
XI. bölge — XI. region	A	3 713	3 858	4 057	4 163	4 325	4 494	4 626	4 733
Adana, Gaziantep, Hatay, İçel, K. Maraş	B	9 8	9.9	10.0	10 2	10.3	10 4	10 4	10 6
	C	773	886	961	1 002	1 012	1 235	999	1 352
	D	4 803	4 354	4 222	4 155	4 274	3 639	4 631	3 501
XII. bölge — XII. region	A	1 990	2 012	2 040	2 056	2 078	2 100	2 057	2 077
Artvin, Giresun, Gümüşhane, Rize, Trabzon	B	5 2	5.2	5.1	5 0	4 9	4 9	4 6	4 6
	C	303	320	342	342	419	411	362	723
	D	6 568	6 288	5 965	6 012	4 959	5 109	5 710	2 873
XIII. bölge — XIII. region	A	1 625	1 663	1 715	1 742	1 783	1 826	1 786	1 802
Adıyaman, Bingol, Elazığ, Malatya, Tunceli	B	4 3	4 3	4 3	4 2	4 2	4.2	4 0	4 0
	C	238	233	282	242	292	331	302	330
	D	6 828	7 137	6 082	7 198	6 106	5 517	5 914	5 461
XIV. bölge — XIV region	A	2 026	2 079	2 150	2 187	2 244	2 302	2 362	2 391
Diyarbakır, Mardin, Siirt, Urfa	B	5 3	5 3	5 3	5.3	5 3	5 3	5 3	5 3
	C	602	576	493	434	563	436	355	383
	D	3 365	3 609	4 451	5 039	3 986	5 280	6 654	6 243
XV. bölge — XV region	A	1 994	2 025	2 068	2 090	2 124	2 158	2 162	2 152
Ağrı, Erzincan, Erzurum, Kars	B	5 2	5 2	5 1	5.1	5 0	5.0	4 8	4 8
	C	602	452	576	447	547	334	632	647
	D	3 312	4 480	3 590	4 676	3 883	6 461	3 421	3 326
XVI. bölge — XVI region	A	925	956	998	1 020	1 054	1 089	1 171	1 184
Bitlis, Hakkâri, Muş, Van	B	2 4	2 4	2 5	2 5	2 5	2 5	2 6	2 7
	C	98	108	104	85	99	119	131	165
	D	9 439	8 852	9 596	12 000	10 647	9 151	8 939	7 178

(1) Devlet hesabına ve serbest çalışan hekimleri kapsar.
(2) Türkiye nüfusu, toplam nüfus artış oranına göre hesaplanmıştır.
(3) Çalışma yeri belli olmayan 3 075 hekimi de kapsar.
(4) Çalışma yeri belli olmayan 2 272 hekimi de kapsar.

(1) Covers all physicians working in public and private sectors.
(2) Calculations are based on the rate of increase of total population.
(3) Covers also 3 075 physicians whose work place is not known.
(4) Covers also 2 272 physicians whose work place is not known.

a) Sağlık ve Sosyal Yardım Bakanlığı; "Distribution of Physicians b Health Regions", Türkiye Sağlık İstatistik Yıllığı, 1981, Başbakanlık Basımevi, Ankara 1980, p.95.

doctors who can give better care to those who are really in need of specialists attention.

3- Due to certain reasons, (equipment and personnel), it is a high probability that specialists do not function outside the urban areas. Even if they did; in rural areas, they could not find the equipment and personnel to help in their specialized activities.

So, specialization is a major factor in determining the number of physicians working in rural areas. When a comparison in rural and urban statistics is made, it can be seen that unbalanced distribution of physicians all over the country is still continuing. For example 67.7 % of existing physicians were in Ankara, Istanbul and İzmir (22.3 % in Ankara, 34.7 % in Istanbul and İzmir). Population per physicians was: 520 in Ankara, 510 in Istanbul, 670 in Izmir, 8.230 in Kars, 6.250 in Malatya, 7.170 in Van, 14.220 in Gümüşhane, 8.800 in Hakkari, 2.740 in Diyarbakır, 3.360 in Aydın, 2.850 in Kütahya and 6.760 in Burdur (See Table 11 on "Physicians by Health Regions").

In addition to the mal-distribution of man-power in the medical care sector, a large percentage of physicians are functioning privately, which brings the question of whether medical care service is determined in the private market -that is, if most medical care service is privately financed- which contradicts the propositions of the welfare state. It can be stated that due to the malfunctioning and uncordination of the public sector, private sector has gained importance in Turkey to fill in the gaps in the supply of medical care.

From the figures on Table 12, it becomes apparent that 34.7 of physicians are in the private sector. When we examine the Social Security organization, we see that the number of insured in 1976 was 8.054.875 (including families and retired). The same report on activities of SSK states that the number of physicians (specialists, practicians, assistants) is 3.589 and the physician/population ratio is 2.500(77). The optimal number of patients (outpatients) that a physician can look after has been stated as 40.

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(77) İzmir Tabip Odası Özlük İşleri Bürosu, "SSK ve Hekim Sorunları", Toplum ve Hekim, Türk Tabipler Birliği Yayın Organı, I, (1978), p.15.

But in SSK cliniks, the number increases to 80-100 to 130(78). The same situation applies to SSYB where the number of physicians is very low, so among the inpatients, 1 physician gives service to 225 inpatients; in SSK to 130 inpatients, in other ministries and public organizations, to 20 inpatients(79). There is large inequality among institutions. In private hospitals, according to our analysis 3:1 ratio can be found in patient/physician relationships. It can be seen that although SSYB has the largest population burden, it has a low number of physicians. This inequality in the number of physicians affects the quality and quantity of service given by institutions, resulting in waiting lines, hostility between the physicians and patients and in general great dissatisfaction of the patient. The situation for other health personnel is not different, 27.5 % is situated in three large cities. Also there are 33.348 assistant health personnel in relation to 20.868 physicians, which result in 1.57 assistant personnel per physician.

TABLE 12- DISTRIBUTION OF PHYSICIANS BY ESTABLISHMENTS

Establishments	1975		1976		1977		1978	
	Number	%	Number	%	Number	%	Number	%
Ministry of Health and Social Assistance	4.673	21.6	4.847	20.8	5.264	22.1	5.652	22.4
Ministry of Social Security	3.524	16.3	4.645	19.8	4.310	18.1	4.588	18.2
Other Ministries	423	1.9	406	1.8	449	1.8	612	2.4
Universities and Public Economic Enterprises	3.237	14.9	3.295	14.1	3.723	15.6	4.987	19.8
Municipalities and Other Local Organizations	592	2.7	723	3.1	642	2.6	641	2.5
Free Practising	9.265	42.6	9.472	40.4	9.532	39.8	8.750	34.7
T O T A L	21.714	100	23.388	100	23.920	100	25.230	100

a) Sağlık ve Sosyal Yardım Bakanlığı, "Distribution of Physicians by Establishments", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977, p.51.

(79) Recep Akdur, "Sağlık Düzenimiz ve Politikasında Kargaşalık", Toplum ve Hekim, Türk Tabipler Birliği Yayın Organı, XII, (December, 1978), pp.39-54.

Personnel	1975	1976	1977	1978
Nurses	8.907	10.148	12.584	13.774
Auxillary Nurses	5.899	6.418	7.275	7.192
Midwives	12.975	13.873	16.785	16.219
Health Technicians	11.021	11.517	11.183	11.141

a) Sağlık ve Sosyal Yardım Bakanlığı, "Distribution of Health Personnel in Turkey", Türkiye Sağlık İstatistik Yıllığı, 1975 - 1978, Başbakanlık Basımevi, Ankara, 1977, p.61.

It becomes apparent that distribution of health care personnel is unequal among institutions; also the number of auxiliary personnel has not increased throughout the years thus creating a shortage problem. The trained nurses either work in private institutions or independently, this factor reinforces the inadequacy of medical care sector (Table 14).

The Ministry of Health is given the duty of carrying out curative health with the Public Health Law No: 1593, and by the law for Ministry's Organization No: 3017. The Ministry is assigned with establishing every kind of hospital, permitting for opening hospitals run by other general and specialized institutions at the outside of the Ministry of National Defence and the Universities. Also the ministry has a right to control, confirm and supervise them. In 1980 in the country, there were 827 hospitals excluding 44 military hospitals. Number of hospitals (except military hospitals, 291 health centers, 49 maternity hospitals, 39 chest diseases, 3 bone disea, 1 leprosy, 3 trachome, 12 mental diseases, 2 veneral diseases, 2 oncology hospital, and 425 general hospitals.

Table 15 presents the distribution of hospitals by organization. The largest segment in hospital sector belongs to SSYB and SSK. As SSK has a budget independent from that of ministries, its financial affairs are relatively better than that of SSYB and municipalities. According to public records its economic being cousists of 40 billion liras in 1977, giving service to 12 million citizens. The hospitals related to SSYB and municipalities and even those related to universities are in a financial crisis due to deficits in the budgets, they try to survive by donations from the citizens. For this purpose, for example,

TABLE 14- DISTRIBUTION OF AUXILIARY HEALTH PERSONNEL BY ESTABLISHMENTS

Establishments	Year	Nurses		Midwives		Technicians	
		Number	%	Number	%	Number	%
Ministry of Health and Social Assistance	1975	10.950	73.9	11.636	89.6	5.961	54.1
	1976	12.264	74.1	12.506	90.1	6.154	53.4
	1977	13.802	69.4	13.264	79.0	6.185	55.3
	1978	15.314	73	14.012	86.3	6.270	56.3
Ministry of Social Security	1975	2.368	15.9	406	3.2	373	3.3
	1976	2.664	16.1	451	3.3	386	3.3
	1977	3.755	18.9	475	2.8	345	3.1
	1978	3.414	16.3	568	3.5	441	3.9
Other Ministries	1975	69	0.5	1	0.0	50	0.5
	1976	131	0.8	19	0.2	120	1.1
	1977	113	0.6	14	0.1	134	1.2
	1978	179	0.9	17	0.1	93	0.8
Universities and Public Economic Enterprises	1975	1.198	8.2	49	0.4	139	1.3
	1976	1.257	7.5	36	0.3	136	1.2
	1977	1.639	8.3	31	0.2	276	2.4
	1978	1.833	8.7	57	0.3	175	1.6
Municipality and Other Local Organizations	1975	190	1.2	415	3.2	210	1.9
	1976	170	1.1	364	2.6	186	1.6
	1977	210	1.1	338	2.1	192	1.7
	1978	184	0.9	252	1.5	209	1.9
Free Practising	1975	31	0.3	468	3.6	4.288	38.9
	1976	30	0.4	497	3.5	4.535	39.4
	1977	340	1.7	2.663	15.8	4.051	36.3
	1978	42	0.2	1.313	8.1	3.953	32.5
Total	1975	14.806		12.975		11.021	
	1976	16.566		13.873		11.517	
	1977	19.859		16.785		11.183	
	1978	20.966		16.219		11.141	

a) Sağlık ve Sosyal Yardım Bakanlığı; "Distribution of Auxiliary Health Personnel by Establishments", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara 1977, p.61.

ACTIVITIES OF HOSPITALS BY ORGANIZATIONS

tals	Year	Number of hospi-tals	Num.of beds		out-patient	Number of discharged			Number of deaths			of operations			Number of births	Patient days Total	Averag Pengtl of stay
			Staff	Exis-ting		Total	Male	Female	Total	Male	Female	big	middle	small			
	1975	798	81264	77209	18163978	1653483	679533	973950	45928	24216	21712	134566	155230	201786	344648	15221200	9
	1976	790	82945	78612	20986360	1742743	704214	1038529	48732	28103	20629	134604	154382	216771	388226	16300567	9
	1977	772	83027	78163	23744478	1862233	750916	1111317	50080	30120	19960	146347	195131	206567	412360	16485803	9
	1978	776	86526	84104	23705845	1868752	732449	1136303	46886	29681	19205	136983	204869	208721	441222	16499030	9
	1975	593	52499	47298	8297460	1126970	419930	707040	32879	18992	13887	74604	79104	142375	219880	10611165	9
Health and	1976	601	53320	48022	10590141	1151979	428318	723661	29922	17344	12578	75562	88871	133435	240945	10801164	9
tance	1977	581	54319	49303	12015800	1111089	424052	687037	30762	18823	11939	76834	101322	124434	262149	9792171	9
	1978	586	54294	52485	10555966	1038533	337366	665167	26203	16037	10166	64861	108743	115111	274228	8823704	9
	1975	68	12756	12711	7488689	302540	157276	145264	6168	4191	1977	23715	57330	35998	80151	2333034	8
Social	1976	67	13886	15730	7959648	391862	187122	204740	9755	5243	4512	22716	44878	45807	81737	2966645	7
	1977	65	12007	12426	8887741	417038	200709	716329	8207	5180	3027	25564	46202	42051	91436	3254276	7
	1978	68	14095	14139	10481754	490075	216137	273938	9163	5728	3435	31031	47922	45333	97719	4709077	8
	1975	34	2761	1860	814218	32259	12520	19739	509	108	401	2104	2629	5928	6122	220496	7
ries and	1976	28	3203	2025	684690	32603	14664	17939	627	320	307	2151	1201	8541	6268	321514	10
izations	1977	32	3152	2152	814307	43574	19708	23866	925	593	332	2194	3236	8529	2701	426656	10
	1978	31	3347	2179	864190	34027	17140	16947	683	457	226	2087	2911	7223	3489	418944	12
	1975	5	7004	11125	738201	76969	31690	45279	3976	405	3571	13344	4249	6112	10349	1326896	16
	1976	7	7004	7920	1051676	81117	35992	45125	4199	2731	1468	15570	6655	16292	12180	1400125	16
	1977	7	7671	9532	1303260	137746	38880	98866	6816	3572	3244	21670	25458	18664	18446	1927203	13
	1978	8	8954	10560	919443	139744	56786	82958	7909	4660	3249	16217	23025	24107	18342	1643042	11
	1975	6	2464	1530	656894	58004	27140	30864	853	176	677	5646	4672	4186	13732	241195	4
es	1976	6	2370	1725	497698	36738	16649	20089	1865	1001	864	6519	4244	4036	14710	320343	8
	1977	6	2750	1750	502165	66081	25952	40129	1173	617	556	5004	4395	4134	20363	421524	6
	1978	6	2795	1795	558803	46305	16185	30120	994	553	441	4732	3859	6527	25196	350990	7
	1975	78	2226	1520	49091	36033	18907	17126	656	123	533	11776	3949	5344	12987	258762	7
and privates	1976	67	1844	1810	55964	26620	12095	14525	1066	725	341	8743	4293	6972	30773	260231	9
	1977	67	1844	1756	109452	52361	24980	27980	956	609	349	11868	11617	6697	16097	367153	
	1978	63	1949	1849	305520	101101	42970	42970	2877	1594	1283	14694	15350	8594	19847	341007	12
	1975	8	570	425	40891	40891	8203	5956	440	125	315	2150	2168	1042	1145	128475	9
	1976	8	529	480	41342	41342	4854	10177	716	433	383	2188	3036	1088	1345	130256	8
	1977	8	529	430	41772	41772	10160	14562	662	425	237	2173	1907	1517	895	113390	8
	1978	8	650	479	12155	12155	4804	6891	585	397	188	2106	1685	918	805	115896	9
	1975	6	984	740	78534	78534	3867	2682	447	96	351	1227	1129	801	282	101177	14
	1976	6	789	900	105201	105201	4520	2273	582	306	276	1155	1201	600	268	100289	14
	1977	6	764	820	69981	69981	6475	3147	579	303	276	1040	994	541	273	183430	18
	1978	6	447	618	8014	8014	5061	2151	472	255	217	1255	1374	708	596	96370	13

e Sosyal Yardım Bakanlığı, "Activities of Hospitals by Organizations", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık , Ankara 1977, pp.80-81.

Zeynep Kamil Ana ve Çocuk Sağlığı Koruma Derneği has been established in association with Zeynep Kamil Hospital; Haydarpaşa Numune Hastanesi Yardımlaşma Derneği and Haseki Hastanesi Kalkındırma Derneği can be cited as further examples of associations based on donations. Due to the weak budget of SSYB (2.9 % of the general budget has been segmented for health services) most of the additions to hospitals have been realized by these associations. In Zeynep Kamil Hastanesi related to the municipality of Istanbul, a building consisting of 500 of 850 beds of the hospital has been realized by the mentioned association. Also, the same association has built Zeynep Kamil Sağlık Koleji with a capacity of 300 students, a child center with a capacity of 125 children, and a couference room with 450 people capacity. From 1958, all the repairs of the hospital has been done by the same association. The situation is not very different in Haydarpaşa Nümune Hastanesi related to SSYB. In 1971, the number of beds available was 550 and not one bed has been added in the recent years by SSYB. The Haydarpaşa Numune Hastanesi Yardım Derneği has finished a new center with 230 bed and another center with 480 bed capacity is still in the process of construction. The above examples show the financial crisis of SSYB and municipality hospitals, if it were not for the donations received from the community, the service of medical care would be more hampered than it already is.

The distribution of hospitals within the country is also unequal:

20 % of the hospitals are situated in three large cities Ankara, Istanbul, Izmir. The Table 16 is prepared to show this discrepency between regions:

The total of beds of three cities is 20 times greater than that of the total number of beds in nine cities chosen at random. The population/bed ratio in three big cities is 255.52 where as it increases to 1967 in nine cities. In the total, there is 425 person for one bed, so some regions are beyond the country average which shows that distribution of medical care is unevenly distributed among the regions.

From the 101.626 hospital beds, including 15.100 military hospitals, 62.7 % of the existing beds were in the hospitals of

the Ministry of Health, 16.3 % at the Ministry of Security, 10.3 % at the Universities and 3.2 % at the municipalities, 3.9 % at the other public organizations and 3.6 % at the hospitals of minorities, foreigners and private persons. It is apparent that 96.4 of the hospitals are in the public sector, showing the smallness of the private sector within the medical care service.

TABLE 16- DISTRIBUTION OF HOSPITALS AND BEDS/REGION

City	Hospital	Number of Beds	Population	Population/Bed
ANKARA	44	10.303	2.927.690	284.16
ISTANBUL	84	19.835	4.466.570	225.19
İZMİR	33	5.920	1.819.300	307.31
TOTAL	117	36.058	9.213.560	255.52
BİNGÖL	4	130	230.350	1771.9
BİTLİS	4	145	238.250	1643.10
GÜMÜŞHANE	4	155	298.600	1926.45
SİİRT	7	320	419.790	1311.84
HAKKARİ	2	60	140.860	2347.67
KARS	6	345	732.940	2124.5
MUŞ	3	210	283.390	1349.48
TUNCELİ	6	165	168.370	1020.42
VAN	4	220	422.970	1922.6
TOTAL OF NIME CITIES	40	1.750	2.935.520	1677.44

a) The below analysis is summarized from the statistical data in Türkiye İstatistik Yıllığı, 1975-1978, (Ankara, Sağlık ve Sosyal Yardım Bakanlığı), pp.86-93.

Out-Patient Polyclinics: In 1978, 23.705.845 patients were examined and treated at hospital policlinics (this figure covers more than one application of a patient). 44.5 % of the patients applied to the hospitals of the Ministry of Health, 44.2 % in hospitals of Ministry of Social Security: 3.6 % in other ministries and public organizations, 3.8 % in hospital related to universities, 2.3 % in municipal hospitals, 1.37 % by associations and private hospitals and hospitals related to foreigners and minorities. The policlinics are important because they decrease the burden of hospitals, and segment the needy from the less needy so that expensive hospital resources will not be spent for unneeding segments of the populations.

Inpatient Services: In 1978, 1.917.638 patients were examined and treated in the hospitals. 1.868.752 of these were discharged and 48.886 persons died. Patients accepted by the hospitals of the different organization were: 55.6 % of the Ministry of Health, 25.6 %, the Ministry of Social Security, 2.5 % of municipalities, 7.8 % of universities, 2 % of other public organizations and 6.5 % the minorities, foreigners and private organizations.

Bed Occupancy Rate: In 1978, the bed occupancy rate in all the hospitals of Turkey was 54 % in general. This rate differs as to the kind of hospitals. For example, 50 % in general hospitals, 14 % in health centers, 62 % in chest diseases hospitals, 69 % in maternity hospitals.

The bed occupancy rate differs by organizations. For example 46 % in hospitals of the Ministry of Health, 91 % in hospitals of Ministry of Social Security, 54 % in municipal hospitals and 51 % in private hospitals.

The bed occupancy rate of the hospitals in large cities having 300 and over hospital beds seems to be higher than the average. Particularly the unbalanced distribution of specialists within the country, large hospitals with technically advanced and specialised equipment and training hospitals being established in big cities, contribute to this effect.

Average Length of Stay (Day): Average number of days of a patient's stay in the hospital varies according to the hospitals, to kind of hospitals and the organizations to which they are attached and to diseases. In 1978, general average length of stay in the hospitals of Turkey was 9 days. This number in general hospitals was 7 days, in health centers 3 days and in maternity hospitals 3 days. The decrease in the average occupancy ratio shows the increase in the degree of technology in medical care service, also it can be seen as an efficiency ratio by which hospitals function.

From the above analyzis on quantity of physician and hospital services, it can be seen that there is inequality of distribution of medical care within the country. So, this results in

migration for medical care from villages to districts, from districts to city centers, and from small cities to large metropolitan centers. As a result of this migration, large hospitals are faced by long queues of patients who come from all over the country, waiting time for beds are increased, which result to dissatisfaction of the patients with the services of the public sector, and move to private hospitals and physicians. Thus, immigration from rural areas to centers is the main reason for excess demand faced by metropolitan hospitals. In regions, where the number of physicians are low, the doctor, instead of spending his limited time on cases which need concrete and lengthy care, prefers to dispatch the patient to metropolitan centers. In critical cases as the death of the patient would lower the prestige of the doctor dispatching to the centers gains impurtance. Also, if laboratory services are only available in state hospitals, those physicians who have no accessibility to public hospitals prefer to send their patients to large hospitals. Thus lack of medical equipment and accessibility to certain medical institutions encourage the migration process.

In rural areas, with the "Law For the Socialization of Health Services" numbered 224 enacted in 1961(80), a new method and implementation in carrying out health services has been accepted. As a basic new service, it will make it possible for the citizens in rural areas to have an equal chance of drawing benefit sufficiently from every kind of health service.

The implementation of socialized health services was started in Muş province in 1963, and covered 5 provinces and 1 training and research center in 1964. In 1978, this covers 40 provinces and 5 training and research centers.

In the provinces of the socialized health services, basic health units are health centers and health houses. Health centers cover 7-10 thousand population and has a health team under the administration of a physician and there are sufficient number of health technicians, nurses and midwives. Health houses covers 2500-3000 population. They are the subunits of health centers with only

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(80) T.C. Büyük Millet Meclisi, "Law for Socialization of Health Services", 224, (Ankara, 1961).

TABLE 17- POPULATION, HEALTH CENTERS AND HEALTH HOUSES IN SOCIALIZED PROVINCES

Total	Year	Population	Km^2 Area of Province	# of Health Centers	Per Health Centers		Number of Health House	Per Health House	
					Area	Population		Km^2 Area	Popul.
	1975	11.157.590	469.875	955	10.707	11.680	3.243	3.340	3.440
	1976	13.530.860		1.128	12.796	12.000	4.214	3.577	3.210
	1977	15.815.310		1.395	12.836	11.340	5.309	3.283	2.980
	1978	18.973.990		1.467	14.257	12.930	5.776	3.607	3.280

a) Sağlık ve Sosyal Yardım Bakanlığı, "Population Health Centers and Health Houses in Socialized Provinces", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977, p.360.

TABLE 18- PERSONNEL CONDITION OF HEALTH CENTERS

	Physicians		Health Technicians		Nurses		Widwives	
	Staff	Existing	Staff	Existing	Staff	Existing	Staff	Existing
1975	1.069	339	1.119	924	990	504	4.509	3.897
1976	1.292	392	392	1.363	1.202	567	5.594	4.598
1977	1.516	565	565	1.603	1.403	661	6.414	4.709
1978	1.792	784	784	1.916	1.629	917	7.431	6.292

a) Sağlık ve Sosyal Yardım Bakanlığı, "Personel Condition of Health Centers", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977, p.368.

one midwife serving.

The main duties of the health centers and health houses are services including family planning, control, prevention and treatment of communicable and epidemic diseases, vaccination, environmental health, health education and health registration.

Besides these preventive services, curative services such as patient's examination and treatment, delivery with intervention, small surgical interventions and necessary first aid and emergency service is undertaken by the personnel on duty and serious cases are sent to hospitals.

In rural areas outside the socialization area, the nearest physician that the patient can face is the state physician or municipality physician. In most places, these two are collected within the job of one physician with preventive health care, administrative services and legal services within the responsibility of the same physician. These physicians, as they are overburdened with the responsibilities cited above cannot spent much time on curative services, resulting in an insufficiency of supply.

From the above analysis, we see that medical care service in Turkey is given by several different institutions

1- Ministry of health and social Assistance:

a) hospitals,
b) polyclinics,
c) health centers,
d) health houses,
e) state physicians.

2- Ministry of Social Security

a) hospitals,
b) polyclinics.

3- Hospitals related to other ministries and public organization (e.g. hospitals related to public enterprises as Sümerbank).

4- Hospitals related to universities

5- Hospitals and clinics related to municipalities

6- Private sector - hospitals related to

a) associations and individuals,
b) foreigners,
c) minorities,
d) physicians working independently.

The number of organizations show the complexity of the medical care sector. Most of the problems associated with the inefficiency and inadequacy of medical care service stem from the segregation of these institutions, and from the absence of an overall health service plan. These problems of medical care sector are mostly related to the practice of socialization services.

The socialization model which is being practised in 46 cities has not been very effective, and has not solved many of the medical care problems. The reason for the inefficiency of socialization practise is that the process has been organized in the form of sending a physician and a group of health personnel to that area and instituting a health center within the region.

Whereas the aim of the socialization law was solving the health problem, including environmental health, housing, nutrition and drug problems within the socialization process, encompassing all other social issues together with the health problem.

Another problem which is seen in the practice of socialization process is the great gap between the actualization of the plan and the objectives which are stated. The actualization of targets stated in Five Year Plans are 40 %(81).

This is due to the shortage of personnel, not to lack of resources in instituting health centers. In 1978, within the

(81) T.C.Başbakanlık Devlet Planlama Teşkilatı, Dördüncü Beş Yıllık Kalkınma Planı 1979-1983, Başbakanlık Devlet Matbaası, Ankara, 1978, p.460.

socialization region of 37 cities and 5 educational centers, 36 % of roll of practicians, 45 % of nurse roll, and 58 % of health personnel is staffed. This great gap between objectives and actualization is the main reason for the inefficiency of the socialization process.

6- PRIVATE SECTOR OF MEDICAL CARE SERVICE

The analysis of private sector consists of two segments:

1- private hospital management
2- private office physicians

Private hospital management: When we examine the hospital sector as a whole, we can see that the share of private hospitals, in number and beds, contain only a very small percentage.

TABLE 19- NUMBER OF PUBLIC AND PRIVATE HOSPITALS

	Total		Public		Private	
	Hospital	Beds	Hospitals	Beds	Hospitals	Beds
1973	791	81.175	699	76.469	92	4.706
1974	799	83.693	705	78.563	94	5.130
1975	798	81.264	706	77.484	92	3.780
1976	790	82.945	709	79.783	81	3.162
1977	772	83.027	691	79.890	81	3.137
1978	776	86.526	693	83.485	83	3.041
1979	822	96.752	732	92.902	90	3.850
1980	827	99.117	737	95.249	90	3.868

a) Sağlık ve Sosyal Yardım Bakanlığı, "Number of Public and Private Hospitals", Türkiye Sağlık İstatistik Yıllığı, 1980, Başbakanlık Basımevi, Ankara 1980.

In 1980 private hospitals are only 10 % of the total number of hospitals and contain 3.9 % of total beds. Another interesting phenomena is that 61 % of the private hospitals are situated in three big cities Istanbul, Adana, Ankara, Izmir with 35 of private hospitals (39 %) in Istanbul. Dr.Nevzat Eren(82) states that the low number of private hospitals is due to the unprofitability of this type of hospital management. He summaries the popular view (not depending on any analysis) as: "The private hospitals are functioning for the objective of profit motive, and this conduct is certainly appropriate. Attainment of this objective together with high medical service leads to high costs and prices which very

(82) Nevzat Eren, "Ankara Kentinde Yaşıyan Halkın Saptanan Sorunlarına göre Sağlık Hizmetleri İçin Örgütlenme Önerileri", TC Başbakanlık Devlet Planlama Teşkilatı Yayınları; No DPT:1687, SPD.317 (September, 1979), p.17.

few people can bear in Turkey. Private hospitals cannot go beyond the profit motive because to do so would lead to their financial decay, as these hospitals have no financial subsidy other than the price paid by their patients for the medical services.

They have no apportunity to get donations or financial help from other sources. So to prevent the closing down of the hospitals, the only way is to decrease the quality of service in order to pull down high costs of operations".

He concludes that as this opinion is not verified by any analysis, it is not possible to state whether this point of view is right or wrong. But it can be seen that whatever the reason, the percentage of medical service given by private hospitals is so small that it is ignored totally by analists on health care.

TABLE 20- DISTRIBUTION OF PRIVATE HOSPITALS BY PROVINCES

Provinces	Number of Hospitals	Number of Beds	# of beds/hospital
Adana	7	165	24
Ankara	3	70	23
Antalya	1	20	20
Aydın	1	20	20
Balıkesir	2	60	30
Bolu	1	20	20
Bursa	1	45	45
Denizli	2	75	38
Diyarbakır	2	40	20
Eskişehir	3	54	18
Gaziantep	3	121	40.3
Hatay	2	22	11
Isparta	1	29	29
İçel	3	66	22
İstanbul	35	2401	68.6
İzmir	4	196	49
Kayseri	4	110	28
Kırşehir	1	15	15
Kocaeli	1	20	20
Konya	2	38	16
Malatya	2	70	35
K.Maraş	1	14	14
Sakarya	3	82	27
Samsun	2	63	32
Trabzon	1	25	25
Urfa	1	12	12
Ordu	1	15	15
	90	3868	average: 26

a) Sağlık ve Sosyal Yardım Bakanlığı "Distribution of Private Hospitals by provinces", Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977, p.80.

The above analysis shows us that most private hospitals are very small with 12-25 beds. As no statistical data on number of general hospitals or specialized hospitals such as maternity centers is present, we have to assume that the small hospitals consist of maternity hospitals which are specialized on gynecological operations and births. The private hospital sector consist of

a) hospitals owned by foreigners (9) 650 existing beds
b) hospitals owned by minorities (8) 447 existing bed.
c) hospitals owned by associations and individuals (73):

Hospitals related to associations consist of hospitals related to Verem Savaş Derneği (as Verem Savaş Derneği Erenköy Senatoryumu), Esnaf Hospital (hospitals owned by Artisan and Tradesmen Association and Darülaceze). The whole of hospitals owned by foreigners and minorities are situated in Istanbul.

Private hospitals are established by Law No: 2219 on June 5, 1933(83). This law states the opening conditions of private hospitals, their organization and functions. Law No: 2/11122 states the general characteristics of hospital buildings and their definition in accordance with the patients being accepted, the minimum required amount of personal and equipment and internal services of private hospitals. Private hospitals are controlled by Ministry of Health and Social Assistance, on the requirement that are stated in these two laws, and on the prices that they charge for their hotel services. So, in any analysis on the service structure of private hospitals, we have to take into consideration the legal requirements that restrict the operations of hospitals.

(83) Nedim Demirel, Faik Gözenman, İlhan Yiğit and Lütfü Tuncay, Sağlık Mevzuatımız, (İstanbul: Filiz Kitabevi, 1969), pp.795-828.

PART II

7. APPLICATION OF THE MARKETING CONCEPT TO THE OPERATIONS OF PRIVATE HOSPITALS

Marketing. Most of those in the medical profession who saw this term in the journal of Medical Association were wondering what this termo was doing in a journal dev ted entirely to medical subjects. It was suprising for most of them in 1977, when an entire issue was devoted to "Should we market medical care?"(84). The editor said: "Frankly, we are a little suprised ourselves. To most of the initiated, the term marketing harkens up images of product lines and profit charts, of Aquavelva and Mr.Whipple. It is definitely Madison Avenue"(85). But, when we view marketing as an integrated effort of the whole organization towards the satisfaction of the consumers and furthermore to the social goal of increasing social welfare, the term marketing does fit most of the aims of the hospital administrators. When we asked the administrators of private hospitals what the purpose of the hospital was the answers were of the following kind."We're in the business of serving the needs of our patients", or "Our primary purpose is to provide high-quality health care to the community that we serve". One administrator stated, "Our aim is not to make profit, we are trying to give health service in doing so let the patients pay for what they are getting". One administrator-proprietor stated "Of course we have to have profit if we want to survive but this does not mean that we are just businessmen exploiting the customer. They are not customers, they are patients, and we're not businessmen, most of all we're dedicated doctors, this has to make a difference". The above statements are marketing statements, regardless of how they are phrased, such statements clearly imply

(84) Editorial, "Should We Market Health Care", Hospitals, Journal of American Hospital Association, LI, (June, 1977), 51.

(85) Ibid.

a basic motive to serve patients. However, a comparison of this philosophy with reality seem to point up a basic contradiction; complaints from health care consumers are increasing as shown, for instance by the rising number of increasing criticisms in the media. All of which points to the basic fact of life; what is said philosophically or even practically does not get translated into actuality.

The implication is not that hospitals are failing to serve their patients, but that they are making marketing statements without really practising marketing. Moreover, many of the basic tools of marketing such as publications, public relations, and even research which have been used by decades by hospitals, have not usually represented a coordinated effort - an effort that is part of an over-all marketing program.

Today, hospitals, must look to the field of marketing in hopes of finding a fresh approach to solving the problems of maintaining a productive level, attracting physicians and resources, building strong community commitment and awareness of their existence and capabilities, and the like. Marketing by itself, of course cannot completely solve many of the problems faced by today's hospitals infact, given the extraordinary regulations that hospitals are subject to (far more than any business enterprise), a true market orientation, in an economic sense, is probably not possible.

We think that (and also the aim of this thesis is to prove that) the proper application of marketing principles and techniques can, however, to the extent that they are supported by top management, make a significant contribution. It is vital after all that hospital resources be used optimally, and marketing is one management system, perhaps the only one, that can help a hospital make maximum use of all its resources in delivering the kind of health care patients need and want, and in developing the kinds of programs and services that will attract and retain needed medical and supportive staff. Hospitals need, in fact, to gain a deeper knowledge and understanding of their markets - namely physicians, patients, employee, and the community - if they want to stay in the market, to optimize resource use and to provide the right services at the right place at the right price and at the right

time. So, our major aim is to analyze the operations of the hospitals from a marketing perspective, to see if they are using certain marketing techniques and tools in serving their customers, the patients.

Before starting an analyzis on marketing of services of private hospitals, it is necessary to segment the units of analysis. It has been stated in (Sector 5 of PART I) that the private hospital sector consists of:

1- hospitals owned by foreigners
2- hospitals owned by minorities
3- hospitals owned by associations and foundations (e.g. hospitals related to Sümerbank and Darülaceze).
4- hospitals owned by individuals or group of individuals (proprietor-owned hospitals).

Among the four groups stated above only hospitals owned by associations and foundations can be grouped as not-for profit institutions because the first group gives free-service to its personnel, and those in the second-group, give service to the community at large, and supported by the donations received from the society through the activities of the foundations. Others function on a direct payment based on profit-motive. So, we have eliminated hospitals, owned by associations and foundations from the analysis, considering those with motivation for profit, and whose survival depend on the payment received from the patients. We have also grouped hospitals owned by foreigners and minorities under the same group due to similarities in their establishments and objectives.

7.1. METHODOLOGY OF THE RESEARCH

The research consists of analysis of nine hospitals divided into two groups.

1- Hospitals related to foreigners and minorities (five hospitals (A,B,C,D) - One hospital is a mental clinic, and its analysis purely consist of its administrative structure as no research could be conducted on the patients).

2- Hospitals owned by individuals or group of individuals

(four-hospitals-one maternity home and three general clinics, F,H,I,J).

The main aim of this research was to examine if marketing concepts and tools are being used in the operations of private hospitals, as we consider them to be profit motivated. So, the first part of the research consisted of interviews with administrators and supervisiors, to gainiusight intoadministrative structure, objectives, product, price, distributive activities and promotional strategies of the hospitals in general. This part of the research tried to show the supply side of medical care services provided by private institutions. The second part of the research consisted of structured interviews (Appendix I) with patients who are still confined to the hospital to gain insight into the demand side of the service process. In this part of the research, we had to face certain limitations due to the restrictions imposed by hospital regulations. We could not base the analysis on a statistically significant sample size, because we could not state beforehand how many of the patients we could interview within a certain hospital or if we could interview any of them. We had to eliminate a number of hospitals from the analysis because the administration did not allow interviews with the patients, those that did, wanted strict confidence that no names will be mentioned. So, we had interviews with 96 patients, unevenly distributed among hospitals, as the choice depended on the administrative and medical personnel, influenced mainly by case-severity. So, the unrandomness of the sample size is a major limitation of the research. A second limitation is the difference that can arise between hospitals whose administrators allowed interviews to be conducted and those that forbid it. It can be stated that the first group is more motivated in research and in acceptance of new techniques and strategies which make them more marketing conscious. So, we cannot generalize the findings of the research to encompass all the private hospital sector.

The third part of the research consisted of unstructured interviews with 10 doctors and 8 nurses working within the hospitals, who act as a tie between the administrative, structure, and the consumer group. From, the group of doctors that were interviewed; only two were acting as active physicians (house physicians), the rest being independent physicians who have patients within the specific hospitals Nurses, being nearest to the patients on the supply side, complete the two sides of the

7.2. ESTABLISHLENT AND ADMINISTRATIVE STRUCTURE OF THE HOSPITALS

The foreign and minority hospitals were established during the late years of the Ottoman Empire (1890-1920 period); and were involved solely in the cure of their own citisens. In 1933, with the issue of Law 2219, the activities of foreign and minority hospitals were brought under the control of Ministry of Health and Social Assistance. The buildings and the site on which hospitals are located, are owned by foreign governments and in minority hospitals, the buildings and sites are owned by foundations to which the hospitals are related to. According to Law 2219. Article 9, the responsible administrator must be a Turkish director (physician or administrator). The foreign hospitals are related to foundations which are established in the foreign countries, whereas minority hospitals are associated with foundations connected with their churches. The relation between the hospital and the foundation is established through a Board of Trustées, which consists of trustées of foreign foundation, church members, important members of the foreign community who function in Turkey, the consulate members, and the medical director and/or the administrator. The Board of Trustées control the donations that are given to the hospitals, these are mainly in the form of equipment and drugs. The administrators have stated that in recent years, financial aid has been cut down, so the hospitals are now facing financial crisis trying to meet their operating costs through the fees paid by the patients. Funds that are needed to repair the buildings or to build new sections for the hospital cannot be provided by the fees, so most of the demand for financial aid to the board of trustées are of this nature which require a large sum of financial aid and which are mostly rejected by the board, bringing the hospital to a serious financial crisis. One hospital solved this problem by renting one building floor by floor to a group of practioners. Another used a promotional strategy on a large scale (especially to large corporations) for raising funds for adding a new section to the hospital.

The administration of foreign and minority hospitals show certain differences within the group. For minority hospitals, it can broadly stated that the director is a physician, controlling both administrative and medical processes. The foreign hospitals can be divided into three groups. In one group, the director is a

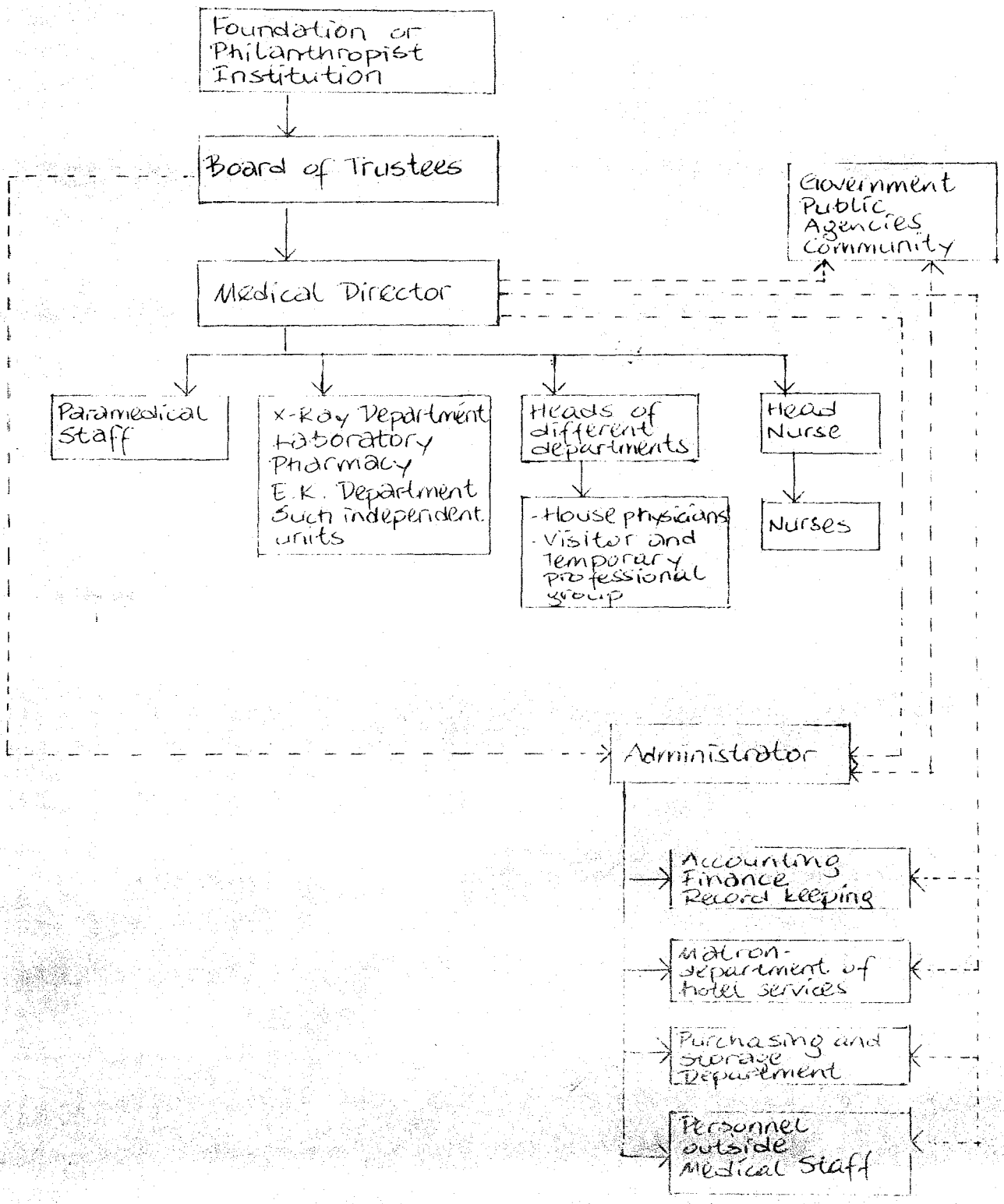
foreign physician who has responsibility for the medical matters of the hospital, whereas the Turkish administrator who is below the medical director is responsible to Turkish government, for financial activities. The second group consists of the director being a Turkish physician who is in charge of medical activities, the foreign administrator being on the same level with the director in the administrative structure, but being responsible to the Board of Trustées for financial matters. The third-group consists of the classical medical director (physician administrator) who has responsibility for both medical and administrative activities together with an assistant administrator in charge of accounting activities.

The organizational structure of foreign and minority hospitals is presented in Figure 4.

The figure 4 is a rough presentation of the administrative structure of the hospitals. The complexity of the structure is due to the highly differentiated, specialized and highly interrelated character of the work that is performed by the hospitals. In addition to above characteristics the work must be highly coordinated, because doctors, nurses and others in the hospital do not, and cannot, function seperatedly or independently of one another. The high interdependency requires the various specialized functions and activities of the many departments, groups and individual members of the organization to be controlled closely and with care. So, we can clearly state that the hospital is a highly formal, bureaucratic organization, relying on formal policies, formal written rules and regulations, and formal authority for controlling much of the behaviour and work relationships of its members. The formal organizational mechanism is reinforced by ethical rules of the profession, the respect felt for those who are older in the profession. So, senority plays an important role in the authority of the director and head of the services.

So, we can state that the emphasis on formal organizational mechanisms and procedures and on directive rather than "democratic" controls, along with a number of other factors, gives the hospital its much talked about "authoritarian" character, which manifests itself in relatively sharp patterns of superordination-subordination, in expectations of strict discipline and obedience, and in

FIGURE 4- Administrative Structure of FOreign-Minority Hospitals



distinct status differences among organization members. In some cases, the medical-director is the main ruling figure within the hospital (especially true in cases where the director is both a physician and an administrator). This authoritarian character is somewhat of a necessity; as the hospital connstantly deals with critical matters of life and death-matters which place a heavy burden of both secular and moral responsibility on the organization and its members. When human life is at stake, there is little tolerance for error and negligence. In addition to the authoritarian character, the self-discipline of the profession can be relied upon for the effective functioning of the organization. Also, the hospital is expected to be able to provide adequate care to its patients at all times, with the precision of a machine system. It is expected to perform well continually and to produce a machine like response toward the patient, regardless of such things as turnover, absenteesm and feelings of friendship or hostility among its personnel, or other organizational problems that it may be experiencing (a problem that the hospitals continously faced in recent years was conflicts with unions). So, to enable continuity and predictability of performance, directive and authoritarian control is a necessity that arises from the character of the service of hospitals. Georgopoulus and Mann state that "the authoritarian character of the hospital is partly the result of historical forces having their origins at a time when professionalization and specialization were at a primordial stage, and when nursing, medicine, and the hospital were all closely associated with the work of religious orders and military institutions"(86).

The medical director in most cases is responsible for medical activities of the organization. The strength of a hospital is the strength of the medical staff. Many a hospital is indifferently housed and owes its reputation solely to the quality of its medical staff. "Bricks and mortar and modern equipment, desirable, as they are, do not in themselves make a first-class hospital", stated one medical director. So, the relation of the physicians to the hospital are important and this in turn depends on the character and socio-professional relations of the director. An

(86) Basil S.Georgopoulus and Floyd C.Mann. "The Hospital as an Organization", Patients Physicians and Illness-A Sourcebook in Behavioral Sciene and Health, ed. E.Gartly Jaco. 2nd Ed. (New York: Collier, Macmillan Lmt. London 1972), 160.

interesting phenomenon that we observed in the analysis of hospitals and how different services are coordinated. One hospital, in the analysis, was specialized in plastic surgery due to the specialization of the medical director. As medical activity is a group practise, the director collects his staff and other specialists on the same subject within the hospital so, the hospital gains a specialized character. In another hospital, a mental clinic, the force and powerful character of the medical director is the sole entity that holds the hospital intact.

The medical-directors are appointed on a fulltime basis, or else the times and periods of their hospital attendance are very clearly defined and conscientiously observed; so that it is impossible to claim that their private work is permitted to conflict with hospital duties. It is also possible to state that the hospital takes the form of a private - office for the medical - director because all of them are known figures in their own fields thus, attracting patients to the hospital.

An important conflict within the literature on hospitals; is the location of all responsibilities and authority within the office of the medical - director. This problem is partly solved in foreign and minority hospitals when an administrator is present and responsible for the daily - activities of the hospital, such as budgeting, accounting, coordination of hotel functions (cleaning, catering, beds), personnel matters as wages, union relations, purchase of equipment and inventory control. But, still, there is no clear - cut boundary between the duties of the medical director and the administrator. Their responsibilities and authority overlap in such matters concerning financial activities, fund raising and relationship with the public and government. So, we cannot make a generalization about the responsibilities of either the medical - director or the administrator; it appears that they function as a two-headed entity, sometimes one gaining importance and sometimes the other.

In some cases, where the medical - director is also the administrator, it can be seen that the medical coordination becomes the duties of the heads of the different departments, because daily administration of the hospital overburdens the director, he, more or less losses his professional relations. The

different departments function on a parallel basis; each considered to be equal, and each follows its own line of practise without much reference to one another and the director, except on financial matters. The overlapping of authority and responsibility is prevented on a large scale by the professional ethics, that dictates respect for one another's duties and functions. But, still, the seperate heads of the departments of the hospital may be individually brilliant, but some kind of medical co-ordination is needed to make the hospital function as a whole and to bring the appropriate sum of its resources to bear on the needs of the individual patient. The WHO Expert Committee on the Organization of Medical Care, in its first report(87) decided unequivocally in favour of a medical administrator, employed full-time and preferrably, with clinical responsibilities so as to avoid his becoming a purely "office doctor" who loses contact with the developments in the field of medicine. It is also recommended by WHO committee, that the medical director should have as his deputy a layman thoroughly trained and experienced in hospital administration from the business or "hotel" angle. The deputy and the staff under him should assume responsibility for such matters as the general maintenance of the fabric of the building, and the operation of the kitchens, stores and laundry. In two of the foreign hospitals, the deputy assumes the above mentioned role; relieving the medical director of non-medical administrative duties and leave him free to advice on hospital policy; coordinate the medical services of the hospital and the heads of the respective departments. In the other two, the medical director is both an administrator and medical coordinator, where administrative burdens overshadow the rest.

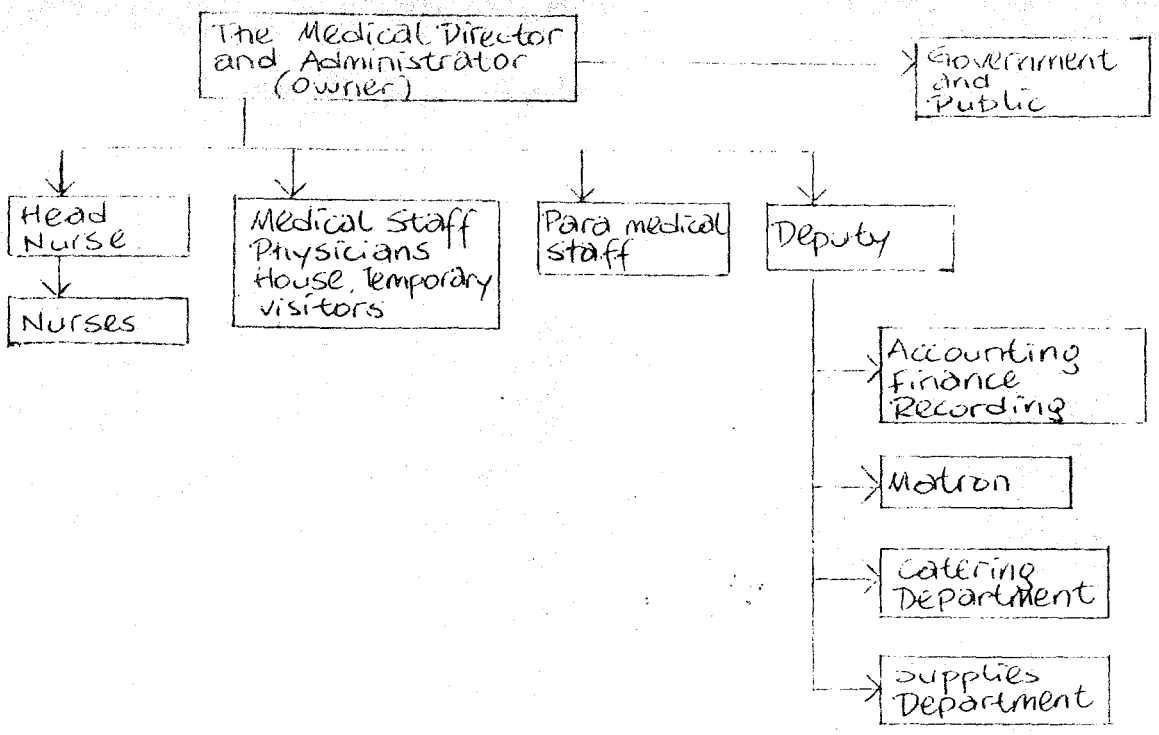
The activities of the nurses are supervised by the head-nurse, an experienced nurse in most cases, and a foreigner (the only foreign personnel to be found in these hospitals are among the nurses - only one medical director and an administrator was found to be a foreigner). A maternity nurse and a dietist is present who functions under the matron together with the catering department. In the hospitals, a catering officer is present who is familiar with the techniques of mass food management, including the purchase, storage, preparation and service of food; he works

(87) World Health Organization, Technical Report Series, 1951, 122.

in collaboration with the supplies department. The hospital is a consumer of many items, the supplies department is responsible for the purchase of food items, drugs, material for the laboratory and X-ray department and any other material that are needed for the theatre or medical service to the patient. The supply department is also responsible for the control of inventory of materials and drugs. The domestic staff (responsible for the hotel-type services cleaning, laundry) are related to the matron who functions in collaboration with the catering officer, head-nurse and the administrative/medical-director.

The private hospitals owned by individuals or group of individuals are different in establishment from the first group. They are established by a single physician or a group of physicians in the form of a limited corporation. An interesting phenomenon is that in Istanbul, there are 21 proprietor owned hospitals of which nearly 15 were established before 1960's. In the late years, only three have been established and two of them occupy the buildings of the hospitals that have closed down. An important problem in the establishment of hospitals is that suitable buildings and sites are not available and building of new hospitals is very costly and cumbersome. So, a cycle is created within this sector, a new hospital with a new owner taking over when an old one closes down. Another interesting phenomenon is that the hospitals' activities come to an end, and the building is left to rot when the owner dies. This shows that the hospital and the owner are interrelated in most cases; the hospital has not a different entity of its own, but it lives with the personality of the owner. In most cases, the hospital is known by the name of the owner, not the actual name that it carries (this phenomenon will be examined when we consider the marketing activities of the hospitals). In privately owned hospitals, the medical director's and the administrator's authority and responsibilities rest with the person of the owner. This non-delegation of authority and responsibility is the main reason why the survival of a hospital is related to the life of its owner. There is a deputy in the hospital who acts as a secretary to the medical director on such matters as accounting, inventory control and purchase decisions. The administrative structure of proprietor-owned hospitals can be summarized as follows.

FIGURE 5- Administrative Structure of Proprietor-Owned Hospital



If we examine the administrative structures of both group it can be seen that there is a main difference, the relation of the administrator deputy and the medical-director. In some fore minority hospitals, the duties of the administrator are clearly related with the business activities of the hospital. This clea definition of duties relaxes the burden of the medical-director matters of routine activities. This also is the prime reason f the continuation of hospital activities of foreign hospitals wh proprietor-owned hospitals come to a crisis with the death of th owner. Only one hospital has continued after the death of the owner, because the heirs were business-oriented and more involv in the medical profession.

7.3. OBJECTIVES OF HOSPITALS

One hypothesis of the research was that the private hosp tals (whether proprietor owned or foreign or minority owned) should be profit-motivated (as their survival depends on the

contradict this hypothesis as not even one of the medical-directors or administrators that we have interviewed has stated profit as the prime objective of the institution. The foreign and minority hospitals' administrators have defined their institutions as non profit community hospitals, the prime objective is the well-being of the community that they serve. One medical director has stated. "Our prime objective is not and never has been profit, we are institutions that give social service, in doing so, someone has to pay. If in our case, it is the patients, who bear the burden, it is not our fault but the fault of the health system in Turkey". The proprietor-owned hospital's objectives are not different from the cited examples. One administrator has stated that their objective is giving free or paid medical service to the needy, but never profit. It is apparent that the profit-motive is not acceptable to the directors or administrators of the private hospitals, as most of them are physicians, profit as a "word" clashes with the ethical considerations of the profession. One owner-medical-director has summarized this fact as follows, "As the directors of these institutions are mostly physicians, busines profit is not acceptable within the profession, as we are not oriented this way. We are professionals, as it states in the Hippocratic oath, who give service to the needy before thinking and planning of our own needs. The small number of private hospitals show the unprofitability of this line of operation; if it were not so, hundreds would be present as they are needed in the community".

The above examples show the disdain of commercialism prese in the profession. The members of the medical profession do not like to think of themselves as businessmen. Many have shown hosti lity to any suggestion that they are motivated by profit rather than service to the clients.

Also, as laws and code of ethics of Medical Association prohibit commercialism, restrictions imposed on private hospitals are many. Article 26 of Law 2219 dictates that fees associated with beds, meals and the service of doctors associated with the hospital (house physicians), together with small laboratory services and medical services are established by Ministry of Heal and Social Assistance. This brings an important restriction on th activities of hospitals.

Thus, professionalism of hospital services acts as an important barrier in restricting the activities of the institution as a business unit. Together with this ethical consideration, there is a strong antipathy towards the term "marketing" as most of the administrators and medical directors associate the term "marketing" with "selling". Their objectives are framed strictly in professional terms, "giving medical service to the community", the important orientation of marketing "sensing, serving and satisfying consumer needs through delivery of appropriate services through organized activities and programs in a manner consistent with creditable professional goals and norms"(88) is present within their definition of objectives, as medical service given to each patient is unique in itself, depending upon the specific illness, physical and psychological condition of the individual. Although administrators reject the use of marketing in their operations,most of what they are performing is part of marketing strategies.

7.4. CAPACITY AND PERSONNEL

The number of beds, or the capacity of foreign or minority hospitals has not shown much change in recent years. As there were not many additions to the buildings due to financial reasons, the limited space prevents any increase in capacity. The number of beds in foreign and minority hospitals is between 60-120. These hospitals are more of a general hospital with only certain wards, like geneocological or pediatric service, being absent. The service of hospitals can be segmented into two groups-inpatient services and policlinics, or outpatient departments. In foreign or minority hospitals, the policlinics is important, forming direc contact with patients, bringing the hospital close to community level. In policlinics, laboratory and X-ray departments gain importance. In addition to these two; the polyclinic services can segmented on a high level of specificity as internal, neurological orthopedic, thoracic, orthodontic, opthalmic, pediatric and geneco logical.

The inpatient services can be classified as:

1- Internal

2- Surgery

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(88) Philip Kotler and Richard A.Connor, Jr. "Marketing Professional Services", Journal of Marketing (January 1977), 72.

3- Geneocological and maternity services.

So, it would not be wrong to classify the service structure of hospitals as follows:

1- Diagnostic-designed to identify such conditions in individual humans, usually disease detection,

2- Therapeutic-services which are expected to terminate successfully episodes of acute illness or to minimize the severity and impact of chronic conditions.

3- Ameliorative, processes whose purpose is to reduce the physiological and psychological discomforts of incurable diseases and to ease the process of dying for terminal patients.

As can be seen from the analysis, research and medical education activities are absent within the private hospitals in general. Only in one foreign hospital, education of nurses is present as the hospital is associated with a Nurses' College. In another foreign hospital which is specialized in plastic surgery, the surgical team provides education for the assistant physicians.

In the second group of hospitals, the number of beds are smaller, ranging from 38 to 25. They tend to specialize in genocological and maternity services. The number of beds are not specified in the form of wards, so one can find an orthopedical case near the room of a patient with severe cancer condition. This is due to the fact that as the capacity is limited, the patients are served on a "first-come-first served basis". There is no capacity planning within the hospitals, in most cases, only one room is reserved for emergency cases, the room being the one used in policlinic services.

The personnel of hospitals can be segmented into two groups:

1- The medical personnel
   - active physicians (house physicians).
   - physicians working on a contract basis (temporary staff).
   - independent physicians (visitor staff).
   - nurses.

- paramedical personnel (working in X-ray department, laboratory, pharmacy and those within the surgical team).

2- Non-medical personnel - administrative debuty, office clerks, accountants, catering and cleaning personnel, receptionists, telephone operators, porters, drivers.

The Medical personnel (physicians + nurses) for foreign and minority hospitals is as follows: (A, B, C, D being the four hospitals in this category).

TABLE 21- MEDICAL PERSONNEL OF FOREIGN AND MINORITY HOSPITALS

A	B	C	D
Medical-director	Medical-director	Medical-director	Medical-director
visitor staff ┐ active staff 74 temporary staff ┘	2 specialized physicians as active staff	2 specialized physicians as active staff	2 specialized physicians as active staff
(does not give numbers for each category)	5-6 practioners as active	1 head nurse	1 head nurse
230 nurses (most performing their compulsory services due to the scholarships from Nurses College).	6 specialists-temporary staff	10 nurses	12 nurses
	1 head nurse		1 dietrician
	1 dietrician		3 pediatric nurse
	no fixed nurse staff changes according to need.		
	3 pediatrician nurse		

TABLE 22- MEDICAL PERSONNEL OF PROPRIETOR-OWNED HOSPITALS(88)

F	H	I	J
Medical-director	Medical-director	Medical-director	Medical-director
1 specialist as active staff	2 specialists in X-ray departments and laboratory	2 specialists as active staff	4 genocologists as active staff
4 practioners as active staff	6 specialists as active staff	1 head nurse	2 specialists in X-ray department and laboratory
2 head-nurses	1 head nurse the nurse-staff changes according to the need	12 nurses (staff specialized)	1 head nurse
2 specialized nurses		1 maternity nurse	15 nurses
7 staff-nurse		3 pediatric nurses	3 pediatric nurse

(88) The mental hospital is not included in the above-analysis bu will be included as a special case study, to the end of the

If the above tables are examined it can be seen that the number of active staff is at least that specified by Article 31 (a) of Law 1222 which states that for every 30 beds, one specialist must act as active staff within the private hospitals. In fact, in some hospitals, the ratio is higher, being one specialist/5 beds. This is an important factor which differentiates the service of private hospitals from that of public hospitals. In relation to the above factor, Article 12 of the same law dictates that the patients can invite their own specialists as visitor staff to the hospital(89) which is strictly forbidden in public hospitals. The presence of visitor staff is the prime factor that changes the composition of the service of private hospitals, which makes it more attractive to the patients (this issue will be analyzed in detail in product mix analysis of hospitals).

The active physicians (house physicians) of the hospitals direct the policlinic part of the hospitals. Also, they fulfill the night duty for the in-patients. In addition to the active staff; there are the temporary staff who have fixed schedules for polyclinic part of the hospital (e.g. from 9-12, or from 9-17 on alternative days). Also, the temporary staff, are assigned night duties on which they can be called at night when emergencies that the active staff cannot deal with arise. The radiologist in X-ray department, the bacteriologist in the laboratory are active staff in all hospitals. Also the hospitals have a pharmacist to organize the pharmacy section within the hospital.

In addition to the professional medical and nurses staff within the hospitals; there are paramedical staff who function in X-ray department, E.K. department, laboratory, pharmacy and who take part in surgery. The number of paramedical staff is between 6-20 in private hospitals, and they are specialists in their own fields.

The number of non-medical personnel is between 30-120 in private hospitals changing according to the number of beds and the number of services offered by the hospital. The ratio of personnel/

(89) Article 12: "Hususi hastaneler, almağa mezun oldukları hastalar için bu hastaların istedikleri hekimleri davete ve tedavinin bu hekimler tarafından yapılması kabule mecburdurlar". Nedim Demirel, Faik Gözenman, İlhan Yiğit and Lütfü Tuncay, Sağlık Mevzuatımız (İstanbul, 1969), 794.

patient is high compared with public hospitals which is an important factor that influences the quality of services of private hospitals.

7.5. MARKETING MIX STRATEGIES OF PRIVATE HOSPITALS

The above analysis is given as a short summary to show how the private hospitals function. As, our concern is the marketing mix strategies of private hospitals; more emphasis will be placed on its analysis. The idea of the marketing mix is represented by "the four P's" product, price, place and promotion. It is assumed that a hospital develops a mix strategy for each of the four elements on the basis of what it knows about its markets and of the marketing objectives it must achieve. The emphasis is placed on developing a mix combination that will simultaneously serve the best interests of the target market and the hospital.

7.5.1. Market Served by Hospitals

The tools of marketing are analysis that reveal possible market segments and the ability of an organization to concentrate on those segments that have the greatest need and the largest volume. In trying to determine the pattern of service utilization of hospitals; most administrators employ an historical audit of records. When the records of most hospitals are examined, it is observed that these records include a tabulation of patients admitted by diagnosis, by date, and by patient days for the given diagnosis; average length of stay by diagnosis and by physician; patients admitted by physician; demographic variables of patients, such as age, sex, occupation and geographic location; services performed according to the patient's diagnosis; and other pertinent information. The hospitals do not want to take information about income level because the patients can associate the question with the level of fee structure of the hospitals. Based on the historical audit of these records, the hospitals, give a rough estimation of the social-class of their patients. Some hospitals state that their patients belonged to upper or uppermiddle class structure. One hospital which is specialized in plastic surgery stated that customers belonged to every socio-economic class, from workers in Germany to businessmen in upper class.

Also, the demand for hospital services show seasonality. For some hospital services, there is a decrease in demand in summer as some diseases arise more in winter. For plastic surgery, due to summer holiday, students and workers on leave, increase the demand in these months.

The administrators of private hospitals have stated that there is no competition between hospitals as demand for hospital services is so great that the number of hospitals is not sufficient to meet this demand.

Another market segment that has a high potential for private hospitals are the business firms and other institutions with which the hospital works on a service contract basis. For example, certain banks through the service contract, send their personnel to certain hospitals, and the bill is charged to the bank. This service-contract changes the socio-economic characteristics of the consumers whereby more of middle class gains access to private hospital services.

In addition to patients as a market, there is the physician market which is in most cases the primary marketing target for most hospitals. The physician market consists of all the physicians within a certain vicinity, or certain physicians associated with university or public hospitals, or those physicians who have offices near a certain hospital. The relation of physicians with the hospital will be analyzed in greater detail in analyzing the marketing-mix strategies of hospitals.

7.5.2. The Hospital Product

Hospitals do not normally view their services as products. But, when a product is broadly defined as something that fulfills a need or want; the term fits comfortably in the hospital domain. Hospital services include both tangible goods as equipment, medicine, beds, meals and intangible services as delivery of care, time and activities of the professional group. The intangibility aspect of medical service seperates it from the conventional treatment of the product in economic theory, final output is that which yields satisfaction to the consumer. So the product of hospitals should be defined not necessarily in terms of its physical

dimensions, but rather in terms of those "characteristics that the buyer is really seeking". For hospital production, it can be argued that the consumer (patient) receives satisfaction from expected improvements of his health. In this formulation, the consumer does not purchase two office visits, five days of hospital case but rather the expectation that his level of health will be improved. Diagnostic services, for instance, usually reduce anxiety, increase chances of recovery and contribute to better health. The hospital administrators have stated their product as "health service to the community at large: So, the final product of hospitals can simply be stated as "improved health of the patient", through the coordinated activities of several group of people, physicians, paramedical group, nurses, house-work operators, with tangible goods as drugs, equipment, beds meals and the building in which the hospital is situated.

In the survey of literature on hospital outputs; it has been observed that there is no agreement on a general definition of "measurement of the product of the hospital". The general definition of final product as "improvement of the health level of the patient" is, unmeasurable. If we consider the cases which result in the death of the patient, is it possible to state that there is no product or that the product is of poor quality, as the diagnosis and care does not result in the improvement of the health level? A common argument is that the product of hospitals be measured in terms of capacity, as beds and patient days, or more simply as hospital days. But this does not take into consideration, the specialized services given during the treatment process, it is a gross definition. So, in attempting to define the product as whole, we have considered all the services that the hospital gives to improve the health level of the consumers. All these services and equipment are considered as intermediate products in our analysis to produce the final product as" improvement of health level of the patients". The intermediate products can be classified as follows:

I- Medical Services

a) the quantity and quality of physician service.
b) the quantity and quality of nurses service.
c) the service and attention of paramedical staff.

II- Other Services

a) meals, house-operating services (cleanliness, beds), telephones, lifts.

b) technical equipment, drugs, sheats, cushions etc.

An important question to be answered in the anaysis of the product is "how the hospital's product is shaped to meet the needs of the target market with finite availability of resources. One foreign hospital, rather than being all things to all patients, has differentiated its product as plastic surgery, some small hospitals have concentrated their resources on genocological services, thus differentiating their product, while other general hospitals, state their products on broader terms as general health care, leading to different specialized units.

As will be remembered from the analysis in section 3.4.1. of the thesis that deals with consumer ignorance and professional power, that physicians have the central role in medical care process, depending on their discretionary judgement and authority to diagnose and prescribe. It is possible to state that the physicians possess a virtual professional monopoly of an essential skill, so they are central to the delivery of medical care in a way that cannot be matched by any of the other elements in the system. They have this role partly because of their knowledge and skills and partly because of the patients' trust in their authority. In most cases hospital services can be defined as complementary godos to the services of the physician. The demand for these services depends on the diagnosis of the physician. Thus, the strength of the hospital depends on the strength of the medical staff.

Most private hospitals depend on the activities of visitor or temporary staff while active staff act as a substitute for the first group. The visitor or temporary staff are independent physicians who refer their patients to the hospitals. The important question of choice of the hospital by the physician or the patient is answered in the second-part of the research, it can be stated that in most cases the physician has the central role. So, to stimulate referrals to hospitals; physicians' needs must be determined and met by the hospital. The hospitals in the research do not employ any specific marketing programs for the physician

The influencial factor is through the social contacts of physicians with the medical director. The medical director especially in foreign hospitals, are reknown figures in their own fields, with professional and social prestige. This confidence and respect for a colleague acts as a stimulating factor for referrals to specific hospitals. In individually owned hospitals, the owner's social and professional contacts play an important role. Through friendship, some physicians prefer to refer their patients to their hospitals. One physician has stated "He's my friend (owner). I trust him in every way personally, so I trust his hospital".

Another important factor that influences the physicians is the quality of equipment and the expertise of the personnel within the hospital. The administrators have rejected any financial contracts with visitor staff. They state that the visitor staff receive their fees directly from the patients. One administrator has stated that those physicians whose fees are large, prefer to work with those private hospitals which give expensive services because there must be a correlation between the fees of the physician and that of the hospital". The patient psychology requires this correlation(90), he concluded. In addition to the above statement, there is the question of invoices as they relate to income taxation. Some hospitals do not record some surgical operations in their books, so that both the physician and the hospital pay lower income taxes. None of the administrators have accepted this fact but they concluded that some hospitals employ this technique to attract physicians, unethical as it is.

Some hospitals receive physicians as temporary staff; who have fixed schedules to receive policlinic patients within the hospital. These employ the hospital as their private offices, a small percentage of their fees are left to the hospital in some cases, in others there is no financial relationship between the hospital and the temporary staff but the hospital employ them in cases of emergencies and for night duties. So, both sides have benefits from the exchange of services.

So, the choice of hospital by physicians for the referra of the patients does not only depend upon the product offered by

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(90) The marketing of complementary goods. The price of complementary goods must be related to the price of the product which is an important marketing strategy.

the hospitals but also on socio-professional relations and financial considerations. It would also be possible to state that the above considerations are part of the"product" of the hospitals to make it attractive to physicians.

The second target group was defined as "patients" in general. Some foreign hospitals and a few of the privately owned ones, have service contracts with business firms, banks and other institutions. These organizations send their personnel to these hospitals and the fees are paid by the organization in question, usually according to a discounted schedule. Also; one foreign hospital gives check-up for all the administrators of the firms on a service contract basis. These group-contracts show that the hospitals adapt their product to the needs of their patients, giving specified services if necessary.

In addition to physician services; nurses services form substitutes for physician services. One of the most important recruitment problems faced by private hospitals is the limited number of specialized nurses within the medical care sector. The specialized nurses are mainly attracted through higher pays from the public hospitals. Most of the nurses have stated that they prefer to work in private hospitals due to better relations with the professional group and that they feel that their services are better appreciated both by the patients and the administration of the hospitals. In foreign hospitals; the quality of nurses' staff is very high, most consisting of specialized nurses. In one foreign hospital, the student-nurses perform their compulsory service arising out of the scholarships they received and in this hospital 2 nurses/patient is present, which increases the quality of the product. The administrator of the specific hospital, uses the abundance of nurse staff as an important product strategy in serving the consumers. In other hospitals, pay higher than that in the public hospitals attracts the specialized nurses to this sector so in private hospitals, it is not uncorrect to assume that nurse service acts as a substitute for physician service in some cases and forms an important part of the product.

The medical equipment in foreign hospitals comes in the form of donations from related foreign countries. So, these hospitals are in a better position financially in acquisition of modern [illegible] individually owned and minority hospitals face

financial bottlenecks in equipment and medical supplies. A major deficiency in individually owned hospitals is the lack of modern equipment. These hospitals try to fill these deficiencies by emphasizing human-intersive services in medical care, as better nurse services and closer professional attention.

In trying to define the product of hospitals, we have stated that most services act as intermediares to the formation of the final product. In addition to services offered by professional group interms of medical care; there is an important aspect that decreases the anxiety and boredom of the patients, which is the atteniton and interest that is shown during their stay in the hospital. As the number of personnel is high relative to patients, attention and sympathy shown to a single individual patient is high compared to that in public hospitals. As the personnel is paid in the form of tips, this attention factor gains importance. A major factor that must be considered in analyzing the product of the private hospitals, is the tipping mechanism between the personnel and the patient that influences the quality of the product of these institutions.

Among the services that the hospitals offer, a major factor can be summarized in the form of hotel-type services, beds, meals, cleanliness and also the availability of telephones, lifts that influence the stay of the patient within the hospital. These hotel-type services gain special importance in private hospitals as the patient wants to get the best for his money. Even the atmosphere of the hospital, "like my home", influence the satisfaction of the patients, and increase their comfort. The administrators of private hospitals have stated that major attention is given to hotel-type services, within their product strategies. One administrator has stated that due to the complaints of the patients and their relatives, he had to organize a tea-shop within the hospital. Another dimension of the product of hospitals, is the presence of accompaniment, which is not acceptable in all public hospitals. In product-mix strategies of private hospitals; the comfort of the person accompanying the patient, gains importance. Also, the scheduling of visiting hours is a major product decision within the hospitals. Most administrators have stated that a certain freedom in visiting hours is required for both the patients and their family so as they will not feel closed in with in the hospital.

From the above analysis; it becomes apparent that the product of hospitals (improvement of health of the patients) consist of many intermediary products in the form of intangible products (services) and tangible goods. The administrators, try to arrange their product mix strategies according to the demands of the patients; this arrangement is so specific that we can state that there is a specific product-mix for every individual patient within the limits imposed by the resources of the hospital in question.

Also, the private hospitals, are in a continuous search for new product ideas. One foreign owned hospital added a hand-plastic surgery unit as a response to the demands within the community. Another is expanding its Cobalt unit, while another is trying to establish EK and intensive-care units. There are a few examples of new-product decisions that are due to the demands of the patients and the community. One administrator summarized the above argument as follows. "We're trying to fill a gap within the health system, we're trying to do it as best as we can with our limited resources and restrictions imposed on our operations".

The heterogenity of products within the hospitals, creates a difficulty of attaining uniform standards. It is impossible to standardize output among several physicians for even the same client. There is no measure by which the quality of output can be compared (you cannot compare a dead patient, as a poor output as compared with a healthy one); complaints from the patients, their families and from the visiting staff act as checks for quality control. As the hospital personnel is in daily contact with the patients, they are in a better position to adjust their product in accordance with the demands. In private hospitals, most complaints are re-directed through the personnel to the head of departments and to medical-director or the adiminstrator. One foreign hospital had a questionnaire for the patients to state their ideas on the services offered by the hospital (Appendix II) but the continuation of the questionnaire was not possible because most of the patients left the hospital without filling-in the questionnair The same hospital holds meetings among the patients to take their views about the services offered by the hospital. The same meeting are published in the hospital's monthly magazine. So, most of the administrators of private hospitals are aware of the fact that they have to adjust their products in accordance with expected

standards, and they are taking decisions to correct the occurances that give rise to complaints.

7.5.3. Pricing Decisions

Pricing decisions are complicated for both businesses and hospitals. However, business organizations have for more control over pricing than hospitals do, because important restrictions are imposed on the hospitals through Law 2219. Article 12 states that the price of beds, meals and medical care which is needed according to the diagnosis, in addition to small laboratory services are controlled by the Ministry of Health and Social Assistance. An interesting phenomenon is that these prices are different in every hospital as composition of beds and definition of classes of rooms are different.

One hospital (A) has stated the following prices:

- Price of the room with one bed 2200 TL/day
  Price of the accompainment 1100 TL/day
- Price of the room with one bed and accompainment 3300 TL/day
- Price of the room with two beds (price/bed) 1600 TL/day
- Price of the dormitory with four or five beds (price/bed) 1000 TL/day

The above prices include three meals given to the patient, the price of meals/day for the accompaniment is 500 TL. In addition to these prices, the hospital charges 375 TL/day for medical coordination service, 400-for telephone rent, and an addition of 10 % of the total bill of the patient for administrative services (Appendix III).

Prices in other hospitals change between 2000 for 1 st class without accompaniment to 3000 and for 2nd class 1750-2500 with luxury room with accompaniment to 6000. The variations in the prices are due to the differences between the definition of 1st and 2nd class rooms. There is no clear-cut definition how these hospitals define the two categories. It is interesting to observe that what one called a luxury room, is in fact a first class room with a single bed in another hospital. An interesting phenomenon that is observed, is that in only two foreign hospitals, the costs

for medical coordination and for administrative services are added to the bill of the patient. In others, these items are absent in the price of hospital services. Also, every hospital employs a different procedure for the calculation of the price of surgical operations.

TABLE 23- PRICE STRUCTURE FOR SURGICAL CASES(91)

	B	H	F	J
very long and important operations	35.000	After 2 hours, for every half hour 500 TL.	After 3 hrs. 5000 added	
long operations	25.000	12.000	20.000 (for 2-3 hrs.)	25.000
medium operations	15.000	8.000	15.000	9.000
small operations		6.000	5.000	4.000
small interventions			biopsy: 10.000 theatre for birth: 15.000 fixed	theatre for birth 10.000
a septical	5.000			
septical	3.000			

The above table shows how four hospitals calculate the price of the operations performed in the theatre. In one foreign hospital (c), the physician states his fee together with the price of the theatre. For example, in a 25.000 TL surgical operation, stated by the physician, 15.000 is left to the hospital for theatre costs; in a 100.000 TL fee, 75.000 is left to the hospital while the rest belongs to the doctor, so nearly 3/4 of the total lee of physician is a price of hospital services in surgical cases. In another foreign hospital (A), there are no fixed percentages or principles in calculating the price of surgical cases. The administrator stated that if realized income is found to be below the expected then the prices of surgical cases are adjusted accordingly. The principle of calculation is that the first half hour is fixed, while for every fifteen minutes, the price of surgical case increases according to a classification of being in the 1st or 2nd group. Another administrator stated the calculation of price as follows: Opening price of the theatre 3000; for one hour, for every fifteen minutes 1000; from 1 to 2.5 hours, for every fifteen minutes 500; after 2.5 hours, for every fifteen minutes 250 TL is

(91) Price of drugs and of special material (as silk cords) not included in the above prices.

added to the price of the surgical operation. The price of the surgical operations (the price of hospital services during the operation as drugs, equipment, etc.) are computed in most cases through a certain mark-up on cost. The mark-up is flexible and changes according to the consumer-the patient-in question. -

It is apparent from the above mentioned price structure of hospitals that the institutions employ flexible pricing mechanism related to the specific service received by the individual patient. One administrator stated that for some services of specific hospitals, there is no specification of the market segment that the consumers belong to. For some hospitals, this fact is true, for plastic surgery, it is difficult to define a specific target market, as consumers belong to every socio-economic class; shopkeepers, workers in Germany, businessmen, students, artists and housewives. The research on consumer characteristics given in the second part of the analysis, shows that consumers belong to upper class or upper middle class for most hospitals. The administrators of private hospitals when asked about their target markets defined them to be upper-middle class consumers, so the prices of the products are adjusted according to the financial capacity of this group of consumers. But, also the hospitals use other mechanisms as contracts on group basis with several firms, deductions from the price if the patient asks for a discount, and also even free service in policlinics. One hospital has a discount mechanism by which patients with limited capacities can ask for a discount (Appendix IV) which is analyzed by the administration and the final decision is made by the medical-director. Also most hospitals have service contracts with several firms, banks and foreign institutions, where the personnel of these firms have free service from the hospital and the firm receives the bill for the services. Also, some hospitals have contracts with foreign insurance firms, where the patient stays in the hospital through his insurance coverage. Another interesting phenomenon especially in plastic surgery is to get part of the cost of the hospital through the foreign insurance coverage. The doctor states that the need for plastic surgery arose due to an accident, so the customer can have some part of the cost of the hospital refunded to him by his insurance. This is an important service that physicians perform for patients in order to decrease the cost of the operation and hospital, thus to increase the demand for their services. Also,

the hospitals use certain discounts for relatives of the physicians, nurses and other medical personnel, determined by the medical-director.

The fees of visiting physicians are independent of the price of hospital services. The price of services of assistant physicians in the surgery is determined by the team-doctor, and these are added to the price of the operations. In some cases, as can be seen in two foreign hospitals, hospitals take a percentage as 30 % or 40 % of the total fee of the physicians, the percentage being determined according to a contract between the physician and the hospital. This contract establishes a bond between the physician and the hospital, the physician can refer his patients without the fear of not finding a bed. So, the exchange is profitable for both sides.

The administrators have stated that as the prices of hotel services and certain medical services are determined by Ministry of Health and Social Security and as these are set below their operating costs, they try to break-even and attain a small profit-through the determination of prices of surgery, drugs and such services as X-ray department and laboratory. So, along-stay patient is not profitable for the hospital (lengthy bed occupancy increases the costs of hotel services), the increase in turn-over rate among the patients with shorter length of stay provides the financial support for the survival of the hospital as more surgical cases can be accepted to the hospital. So, the main portion of the total bill of the patient consists of such items as cost of surgical activities and drugs. One administrator stated that patients can easily be exploited as they are unaware of what services they have received during a surgical operation. One administrator summarized their pricing policies as follows "They (the patients) know that they are getting paid services, so they should be ready for what they get". In a foreign hospital, they present an agreement form (appendix III) which indicates the prices of differenet services, and which must be signed by the patient or his family. The administrator states that although all of them sign this form, there is always argument when the bill is presented on such items which are on the form. This hospital thinks that it is practicing a fair pricing policy through showing the prices beforehand but it does not take into consideration the anxiety, the fear present in

a sick person and his family on arrival to the hospital.

An informal pricing mechanism in private-hospitals is the "tipping" system of the personnel, nurses (specialized or on staff paramedical personnel, cleaning women), This typping system in most cases degenerates the quality of the services offered. A general expectation of the personnel is that they should be tipped for every service that they perform. The administrators are aware of the fact but they can do nothing as the patients have created this system within the hospital.

So to conclude the above argument, it can be stated that private hospitals use price policy as an effective tool in meeting the needs of different segments of the market.

7.5.4. The Place Decision

"Place" refers to the efficient distribution of goods and services through distribution channels, outlets, and sales territories. So that the products are, theoretically, convenient to the market. "Place" in business includes warehousing, inventory, wholesalers, transportation routes and fare structures, production facilities, and access to raw materials. In a hospital situation we cannot employ the same concepts due to intangibility of the product, and the relation of the consumer with the service-given. In hospitals, place can refer to the hours the admitting office is open, the 24-hour emergency department service, the distance from the hospital to the house of the related physicians, the location of satellite units, and the proximity of one department to another, emergency ambulance services, which enable the hospital to offer the right product in the right place. Most of the "place" factors provide time, place and possession utilities to satisfy target customers, in this case the patients and their visitors.

The sites in which the private hospitals are situated, are within the central districts of the city, so that most patients do not face transportation problem. The site is important because most patients prefer hospitals that are nearest to their home, so that their families do not face traffic problems. Most hospitals have parking areas that provide conveniences for the physicians, patients and their families. Some individually-owned hospitals

are situated within the central districts with no parking lots, only a small space is reserved for hospital cars, which create problems for the people who have a patient within the hospital or who come for outpatient-service. The administration of the hospitals can do nothing about it, due to traffic conditions. Also, the noise arising from the traffic is a major disturbance for the patients in most hospitals. Due to easiness of transportation, centrality of the hospital site gains importance from other considerations.

The out-patient departments or policlinics are situated within the first-floor of the hospitals, so that in-patients are not disturbed by the noise and on-goings of the policlinics section. The names of different units are placed on the doors, so that the visitors would not face difficulties in finding the units that they are seeking. Also, the reception desk provides information on the place of different activities and the room of the patients within the hospital to prevent lose of time in the search process.

The inpatients are situated within a different section. In most small hospitals, the beds are not arranged in the form of wards, so that you can find a serious case near a minor disease which create severe disturbances and anxiety for the patients. The administrators of these hospitals state that due to capacity limitations, it is impossible to seperate beds in the form of wards; only they try to group diseases according to severity, the choice in most cases is hampered by the unavailability of empty beds. In foreign-minority hospitals, there are certain wards as maternity, cardiac, intensive care units, but for other kinds of diseases there are shifts among the beds.

The laboratory-X-ray unit, and the pharmacy (units that are present in every hospital) are grouped near the policlinic section so that outpatients can also use their services.

The foreign hospitals, consist of two or three buildings. In one foreign hospital, the second building is rented to hand-plastic suregery, and to specialized physicians as private offices. These physicians can use the theatre and other equipment that the hospital has in the first building. So the hospital has specialists or team work when the need arises, within the hospital. [illegible] hospital has nurses college within the same site

as the hospital building, so that specialized nurses are near the emergency centers when the need arises. In foreign hospitals, catering and cleaning sections are situated in other buildings, so that odor of meals do not disturb the patients. In individually-owned hospitals all the units are situated within the same building so that position of the catering service presents a problem. In most of them, the kitchen is situated on the top floor so that smell does not spread through the corridors (especially bad-for patients who are on diet). The presence of catering department within the same building, is favourable, so that meals do not get cold before they are served to the patients, which is usually the case when catering department is outside the hospital building. The rooms of the personnel who are on duty are also situated on the top floor, so that the hospital has a crowded appearance, not a single corner left empty or unused. The patients in these hospitals face dust-bins in the corners, brooms and brushes behind the doors, and feel that they are within a house with crowded inhabitants.

The hospitals are ready for emergency cases at every-hour of the day. The on-duty personnel try to solve their problems by calling specialists from their houses if they are not present within the hospital. But, most of the small hospitals prefer to send a serious emergency case as cardiac to public general hospitals. The ambulance service is present in foreign hospitals although the number of ambulances is very small, one or two. In individually-owned hospitals, the ambulance service is not available they work in collaboration with private firms who give ambulance service.

Another interesting fact is that the lifts can be used only by the patients, and hospital personnel, so that visitors have to climb a great number of floors within the hospital, leading to discomfort and loss of time.

In discussion of the "place" decisions of hospitals we have to consider the "home care" offered by some hospitals.

Some foreign-hospitals offer private nurses for the convalescence period for the patient. The administrators state that this is a new decision that will bring hospital service to the home of the patient.

7.5.5. Promotion by Hospitals

The word "promotion" and the literal meaning it conveys is disdainful for all hospital administrators, as they consider it to be unethical within the profession, conveying a "selling approach" to their services. They consider their services as an offer to the community, for the benefit of the community. It is in fact true that the major difference between the hospital and business sector in promotion efforts is the use of selling. Selling assumes that the prospective customer will not buy unless it is first approached by a sales person with a sales presentation. For hospitals, the selling aspect is disdainful as they cannot develop a sales force to call on prospective patients. But, it is interesting to note that in most cases physicians act as sales-force for the hospital. We have stressed the centrality of the physician in the medical decision process, so that physicians act as referral links from the patients to the hospital services. In most cases, need for hospital services arise due to the decision of the physician in the diagnosis process. So the hospitals first promotional decisions are taken in connection with the attraction of physician services. In the interviews conducted with the administrators and the physicians, it was observed that several factors play an important role in the choice of a particular hospital by the physicians (in fact most physicians work in more than one hospital). The major factor that influence the referral of the physicians, is the social, and professional relationships with the medical director. The medical-director is the main figure that controls the relationship of the physician and the hospital. In most cases, the medical director is a reknown figure in his own field so that some physicians want to work in the same team. Also the professional esteem of the medical director is a stimulating force for referral to hospitals. The friendship patterns within the profession also play an important role in the choice of hospitals. Being from the same class with the medical director, or being a student of the same person is a recurring pattern that attracts physicians to the specific hospitals. So, in most cases the medical director uses his socio-professional relations in physician-patient referral system.

Most hospitals do not have a definite promotional strategy to attrack physicians. Some administrators state that "all the physicians can use our services". A new service as EK unit or

Cobalt unit is promoted to the physicians by word of mouth communication through the active participants who install the unit. In some cases, media as newspapers give the information to the community at large through no effort of the administrators. Other factors that attract physicians to the hospitals is the quality of the service and the personnel. One administrator stated that "the physicians work with us because they know that their patient will be looked after". The financial considerations are stated as the least important criteria for the choice of hospitals by the physicians.

The hospitals do not use any promotional strategies as advertisement in the media; newspapers and magazines. The "Thanks" published in papers and paid by patients act as a kind of advertisement but most administrators and physicians stated that these kinds of advertisements do not influence the demand for their services. One administrator stated that "the quality of service" of the hospital is the best advertisement that one can have. "If we have satisfied patients, it is enough promotion for the hospital". The above statement indicates that word-of mouth communication is the prime factor that influences the demand for hospital services. As can be seen from the analysis of search activity of patients in the second part of the research, patients are influence primarily by the choice of their doctors and secondly by the advice of their relatives and friends. So, patients who have stayed within the hospitals act as important communication channels for potential patients. So, when administrators state that the quality of their service is the promotion component of their strategy, they do not err in their belief.

So, we can conclude that in medical care consumption, word-of-mouth communication by previous patients is an important component in the promotion of both physician and hospital services. Most patients are attracted to the fame of the physician, and as he works in a particular hospital, they choose that hospital and its services. One specialist in plastic surgery, stated that most patients choose his and the hospital's services after seeing his product, "a beautiful nose, or a whole hand".

Some foreign hospitals recently have used certain promotional strategies to change their public image or to open to the community at large. The administrators, thinking that the hospital

has a far-away image from the community and its needs, employed certain techniques to show the interior of the hospital to potential customers. They organized health fairs, in the form of seminars, to attract the attention of both the physicians and the community. Also, the particular hospital has a montly magazine which includes the definition of their services, interviews with patients and the personnel and analysis of different departments, and their operations. The magazines are sent to other hospitals, ministries and public institutions, and delivered to patients and personnel. There are some of the primary steps in developing promotional strategies for hospital services.

Another group that the hospitals have directed their promotional activities is the donors. In foreign and minority hospitals donations received from individuals or institutions form the major financial source for their operations. One foreign hospital, in trying to add a new building to its structure, launched a big public campaign to collect donations. There is a public-relations administrator who is in charge of this campaign. The campaign is conducted in the form of written petitions to individuals or institutions. Two specific wards within the hospital are named after the donors who have furnished these sections. The same hospital employed the same kind of campaign in raising a scholarship fund for nurses college. Most of the donations are received from institutions with which the hospital has a service contract. So an overall promotional strategy as fund-raising and contract forming is directed towards several institutions, by the administrators of the specific hospital.

Other institutions have developed strategies in attracting certain institutions to form service contracts. The administrator has meetings with the heads of the institutions to present what services the hospital can offer for the personnel of the institutions. They show their equipment, present the medical personnel (show what advantages the hospital can offer) in short promote the hospital as a whole.

From the above analysis, it is apparent that private hospitals use certain promotional strategies in relation to their target groups, physicians, patients and donors. Although these strategies are not interrelated as an overall promotional strategy it is apparent that hospital administrators are aware of the importance

of building goodwill and a good public image in the mind of the community at large.

The analysis presented so far shows that most of a hospital's daily operations can be analyzed within a marketing framework. As medical care is much specialized depending on the specific diagnosis of the individual patient, every unit of hospital service is adjusted to the specific need of the individual, creating the product of the hospital; "increasing the health level of the patient". Private hospitals in trying to maximize the quantity and quality of patient care, the prestige of the institution and in some cases the physicians' incomes, employ many marketing tools although these are not coordinated in an over-all marketing program and although these are not regarded as marketing practises.

7.6. SURVEY OF ATTITUDES AND NEEDS OF CURRENT PATIENTS IN THE HOSPITALS

The second part of the study, consisted of a survey of attitudes and needs of current patients within the hospitals. The major limitation of the research was that the administrators limited the number of respondents by their own choice of patients, due to the importance of case severity. So the results can be biased as the sample is not based on a statistical-significant sample size and sample-distribution.

The survey was conducted in the form of structured interviews with the help of a Questionnaire presented in the Appendix I. Questions 15-21 were designed to get information about the demographic characteristics of the consumer group. The results of the research were tabulated seperatedly for the foreign and minority hospitals (A-B-C-D) and proprietor owned hospitals (F-H-I-J). This kind of tabulation is likely to show any differences that may result due to the services and characteristics of the hospitals. A second tabulation was made according to case severity, grouped as I (very minor, minor), II (medium), III (severe, very severe, and hopeless). It is assumed that case severity is an important factor influencing the behaviour of patients. Question 20, was filled in by the researcher, to show the socio-economic class of the respondent(92).

(92) James M.Myers, Roger R.Stanton and Arne F.Haug. "Correlates of Buying Behaviour. Social Class V.S.Income", Journal of Marketing, XXXV (October 1971), 8-15.

In this analysis, the main factor that was considered was the monthly family income and secondly education. It was not possible to take profession as an independent variable since a large percentage of the respondents were house-wives. The respondents were divided into five socio-economic groups as:

A. upper class (monthy income above 120.000 TL)
B. upper-middle class (income between 100.000-120.000 TL)
C. middle-middle class (income between 80.000-100.000 TL)
D. lower middle class (income between 50.000-80.000 TL)
E. upper lower class (income between 20.000-50.000 TL)

The educational factors were considered secondary as in some cases a patient with an income above 120.000 had primary school education. But also those with low income but with university education were placed at a higher social class, because there is a tendency to understate incomes by current patients due to the possibility that they will face high fees at the end of their stay within the hospital so the third tabulation of results was made according to social classes. A, B, C, D+E (the two lower classes were grouped together due to the small number of respondents in these groups).

As can be seen from Table 24, the consumers of medical services of private hospitals consist of mostly of upper middle-class-36 % of the total sample. Contrary to the expectations, there are patients also from upper lower class in E category. This can be explained by the general tendency of patients to understate their income and by the presence of service contract with most firms, where the patients do not pay any bills but the firm pays the fees of the hospital. So the patients can use the services of hospitals by the contract of their firms without which they cannot afford the cost of hospital services (Table 25).

When we examine Table 25, it is apparent that most patients belong to the lower income bracets, 41 % below 80.000 TL while 26 % have stated that they don't know their income level. The expenditures on sickness care have a peculiarity of their own, while current income decreases due to expenditures on current hospital services, expected future income also decreases due to the inability of the patient to work during his stay within the hospital. For most patients who have insurance or sickness pay;

BLO 24- DISTRIBUTION OF SOCIO-ECONOMIC GROUP OF PATIENTS TABULATED BY HOSPITALS

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.30	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
	y	10	45.5	5	100	2	11.1	3	42.9	20	38.5	2	14.3	1	9.1	8	72.7	5	62.5	16	3	36	37.5
	x	5	22.7			3	16.7	1	14.3	9	17.3	3	5.8	3	27.3	3	27.3	2	25	11	25	20	20.3
	0	1	4.6			6	33.3	1	14.3	8	15.4	4	28.6	3	27.3			1	12.5	8	18.2	16	16.7
	1	2	9.1			3	16.7	1	14.3	6	11.5	2	3.8	1	9.1					3	6.8	9	9.4
	2	4	18.2			4	22.2	1	14.3	9	17.3	3	5.8	3	27.3					6	13.6	15	15.4
TAL %			100		100		100		100		100		100		100		100		100		100		100
TAL A			22		5		18		7		52		14		11		11		8		44		96
SE			22		5		18		7		52		14		11		11		8		44		96

A-B-C-D: foreign-minority hospitals.
F-H-I.J: proprietor-owned hospitals.

ABLO 25- MONTHLY FAMILY INCOME OF PATIENTS - tabulated by hospitals -

	K.34																						
20.000- 30.000	y	1	4.6			6	33.3	3	42.9	10	19.2	1	7.1	3	27.3					4	9.1	14	14.6
31.000- 40.000	x					2	11.1			2	3.8			2	18.2					2	4.6	4	4.2
41.000- 50.000	0					3	16.7			3	5.8			2	18.2					2	4.6	5	5.2
51.000- 60.000	1													3	27.3					3	6.8	3	3.1
61.000- 70.000	2					1	5.6			1	1.9	1	7.1			1	9.1	1	12.5	3	6.8	4	4.2
71.000- 80.000	3	1	4.6			2	11.1	1	14.3	4	7.7	1	7.1	1	9.1	3	27.3	1	12.5	6	13.6	10	10.4
81.000- 90.000	4															1	9.1	1	12.5	2	4.6	2	2.1
91.000-100.000	5							1	14.3	1	1.9	1	7.1			1	9.1	1	12.5	3	6.8	4	4.2
01.000-120.000	6	1	4.6	2	40			2	28.6	5	9.6					4	36.4			4	9.1	9	9.4
21.000-140.000	7			1	20					1	1.9					1	9.1	1	12.5	2	4.6	3	3.1
41.000-160.000	8			1	20					1	1.9											1	1
61.000-180.000	9	1	4.6			1	5.6			2	3.8							2	25	2	4.6	4	4.2
	K.30																						
81.000-250.000	3	1	4.6							1	1.9											1	1
51.000-500.000	4	1	4.6							1	1.9											1	1
surance	5	1	4.6							1	1.9											1	1
.000 gvt takes care	6	1	4.6							1	1.9											1	1
tirement pension	7	1	4.6							1	1.9	3	21.4							3	6.8	4	4.2
answer don't know	8	13	59.1	1	20	3	16.7			17	32.7	7	50					1	12.5	8	12.2	25	26.0
TAL %			100		100		100		100		100		100		100		100		100		100		100
TAL A			22		5		18		7		52		14		11		11		8		44		96
SE			22		5		18		7		52		14		11		11		8		44		96

this does not present an important problem but those who have independent jobs like tradesmen, sickness both reduces the present and future income of the individual, resulting in use of assets. With this psychology of loss of earning power together with the anxiety of the fees that will face them when they leave the hospital, most patients show a tendency to understate their incomes or underestimate them.

Although illness behaviour can be analyzed interms of physiological needs (a physiological or organic malfunctioning of the body leads to illness) social factors also affect the choice of medical care patterns. In minor cases, especially in maternity cases, choice of medical care and hospital services can be summarized as conspicious consumption. Identification with a number of consumer's reference groups (social-economic class) is not, uncommon in most situations. If we examine the income structures of I and J hospitals which are mostly specialized in maternity cases, the pattern shows that in these cases hospital services are identified as status symbols or certain physician functioning within the hospital forms a stereotype of a certain class. Also, in foreign hospitals A and B, the income patterns show that most patients are from a higher income class. This is in accordance with the price structure of these hospitals. In hospital C, which is specialized in plastic surgery, due to the characteristic of medical care service, every income level is within the target marke of the hospital. Hospital H, shows lower prices together with the site being situated in a lower-income area than other proprietor owned hospitals, which attracts lower income groups. Also, cases with severe or hopeless diagnosis are more often found in lower income groups, showing the unimportance of money matters in sickness behaviour, where psychologically the patient is ready to sacrifice everything as the anxiety and fear of ilness increases (Table 26).

When education level is examined (Table 27) it can be seen that the largest group consists of patients with highschool and university education (57 %); an important factor that upgrades the socio-economic class of the patients. Those patients with primary school education (20 %) were mostly housewives, who report high monthly family income, thus they are situated within a higher socio-economic class than the one their education would suggest (Table 27).

TABLE 26- MONTHLY FAMILY INCOME OF PATIENTS - tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	K.34	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
20.000- 30.000	y	1	3.33	5	10	8	50	14	14.58					2	12.5	12	50	14	14.58
31.000- 40.000	x	1	3.33	3	6			4	4.16					3	18.8	1	4.2	4	4.2
41.000- 50.000	0	1	3.33	4	8			5	5.2					1	6.3	4	16.7	5	5.2
51.000- 60.000	1	-	-	3	6			3	3.12			3	15					3	3.12
61.000- 70.000	2	1	3.33	2	4	1	6.25	4	4.16			4	20					4	4.16
71.000- 80.000	3	7	23.33	2	4	1	6.25	10	10.41	6	16.7	4	20					10	10.41
81.000- 90.000	4	1	3.33	1	2			2	2.08	2	5.6							2	2.08
91.000-100.000	5	-		4	8			4	4.16	3	8.3	1	5					4	4.2
101.000-120.000	6	4	13.3	4	8	1	6.25	9	9.4	8	22.2					1	4.2	9	9.4
121.000-140.000	7	3	10	-	-	-		3	3.1	2	5.6					1	4.2	3	3.1
141.000-160.000	8	-		1	2	-		1	1.04	1	2.7							1	1.04
161.000-180.000	9	3	10	-	-	1	6.25	4	4.16	4	11.1							4	4.16
	K.30																		
181.000-250.000	3			1	2			1	1.04	1	11.1							1	1.04
251.000-500.000	4			1	2			1	1.04	1	11.1							1	1.04
insurance	5			1	2			1	1.04	1	11.1							1	1.04
3000 government looks after	6			1	2			1	1.04							1	4.2	1	1.04
retirement pension	7	2	6.66	1	2	1	6.25	4	4.16			4	20					4	4.16
no answer/don't know	8	6	20	16	16	3	31.25	25	26.04	7	19.4	4	20	10	62.5	4	16.7	25	26.04
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

TABLE 27- LEVEL OF EDUCATION OF PATIENTS - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.33	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
primary	y	5	22.7	1	20	7	39	1	14.3	14	26.9	3	21.4	3	27.3					6	13.6	20	20.8
highschool	x	2	9.1			2	11.1	2	28.6	6	11.5	2	14.3	1	9.1	3	27.3	1	12.5	7	15.9	13	13.5
college	0	9	4.1			5	28	4	57.1	18	34.6	2	14.3	3	27.3	5	45.5	5	62.5	15	34.1	33	34.4
technical	1											1	7.1	1	9.1	1	9.1	1	12.5	4	9.1	4	4.2
university	2	6	27.3	4	80	3	17			13	25	6	42.9	2	18.2	2	18.2	1	12.5	11	25	24	25
no education	3					1	5.6			1	1.9			1	9.1					1	2.3	2	2.1
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 28- CASE SEVERITY OF PATIENTS - tabulated by hospitals -

	K.37																						
very minor	y							1	14.3	1	1.9											1	1.0
minor	x	8	36.4	1	25	5	27.8	1	14.3	15	28.9	3	21.4	2	18.2	5	45.5	4	50	14	31.8	29	30.2
medium	0	11	50	2	40	9	50	3	42.9	25	48.1	8	57.1	8	72.7	5	45.5	3	37.5	25	56.8	50	50
severe	1	2	9.1	2	40	4	22.2	2	28.6	10	19.2	1	7.1	1	9.1	1	9.1	1	12.5	3	6.8	13	13.5
very severe	2											1	7.1							1	2.3	1	1.
hopeless	3	1	4.6							1	1.9	1	7.1							1	2.3	2	2.4
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 29- AGE STRUCTURE OF PATIENTS - tabulated by hospitals

	K.28																						
10-19	y	1	4.6					2	28.6	3	5.8	1	7.1	2	18.2					3	6.8	6	6.
20-29	x	3	13.6			1	5.6	2	28.6	6	11.5	1	7.1	1	9.1	4	36.4	4	50	10	22.7	16	16.
30-39	0	6	27.3	1	20	6	33.3			13	25	3	21.4	4	36.4	3	27.3	2	25	12	27.3	25	26
40-49	1	4	18.2	1	20	2	11.1			7	13.5	2	14.3	2	18.2	3	27.3	1	12.5	8	18.2	15	15.
50-59	2	5	22.7			3	16.7	2	28.6	10	19.2			1	9.1	1	9.1			2	4.6	12	12.
60-69	3			3	60	2	11.1			5	9.6	3	21.4	1	9.1			1	12.5	5	11.4	10	10.
70-79	4	2	9.1			3	16.7	1	14.3	6	11.5	3	21.4							3	6.8	9	9.
80+	5	1	4.6			1	5.6			2	3.9	1	7.1							1	2.3	3	3.
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

It has been stated that case severily of patients (as determined by physicians) is an important behavioral determinant. As can be seen from Table 28, 50 % of the patients are classified as medium-case severity with 32.3 % in minor cases. The severe, very severe and hopeless cases only consist of 16.7 % of the patients. The above results are in accordance with the objectives of private hospitals because they prefer to send the severe cases to public hospitals. "A dead patient is always a bad promotion for a hospital", stated one administrator. The findings of the research are also biased because we could not interview in some cases, the severe and hopeless cases, so it would be wrong to generalize that private hospitals' services only include minor or medium case severity. There is not much difference between foreign-minority owned hospitals and the second group, although foreign hospitals have better equipment and more capacity at their disposal (Table 28). The segmentation of patients according to age, shows that the highest percentag of patients is between 30-39, followed by 20-29 and 40-49 bracet, when the results are tabulated in the total. The same group has minor or medum-severe diseases. While severe conditions are between 60-69 age group. The tabulation of age groups according to socio-economic classes does not show any relationships, as family-income is important rather than individual income (Table 29,30 The percentage of female patients is greater than male patients which is due to the presence of maternity and genocologically specialized hospitals within the sample. If we do not consider the patients of this hospital, especiallay in foreign-minority hospitals, the percentage of males is greater (Table 31). Ther is not much correlation between the severity of cases and the sexes, as the number of female patients is greater, this makes the percentage of minor and severe cases higher in the female group (Table 32).

The other demographic characteristic that we have considered is the profession of the patient. The highest percentage was found to be house-wives group, due to the higher percentage of females in the sample. The second group consists of private businessmen, merchants, tradesmen and administrators of private firms, plus employees. The administrators and employees are present due to the service contracts with firms in the private sector. In one minority hospital, the number of public employees is high which shows that the membership to an ethnic group places more important role in the choice of the hospital than simply other demographical characteristics as profession (Table 33).

Frob Table 34, it can be seen that 63 % of women patients have been admitted for minor or very minor diseases - a situation

TABLE 30- AGE STRUCTURE OF PATIENTS - tabulated by severity of case and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	K.28	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
10-19	y	2	6.7	3	6	1	6.3	6	6.3			4	20	2	12.5			6	6.3
20-29	x	11	36.6	5	10			16	16.6	8	22.2	1	5	1	6.25	6	25	16	16.7
30-39	0	9	30	14	28	2	12.5	25	26.1	9	25	6	30	5	31.25	5	20.8	25	26.4
40-49	1	4	13.3	8	16	3	18.8	15	15.6	8	22.2	2	10			5	20.8	15	15.6
50-59	2	2	6.7	7	14	3	18.8	12	12.5	5	13.8	2	10	3	18.75	2	8	12	12.5
60-69	3	2	6.7	4	8	4	25	10	10.4	3	8.3	1	5	2	12.5	4	16	10	9.4
70-79	4			6	12	3	18.8	9	9.3	2	5.6	3	15	3	18.75	1	4	9	9.4
80-89	5	1	3.3	2	4			3	6.3	1	2.7	1	5	1	6.25			3	3.1
90-105	6															1	4	1	1.0
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

TABLE 31- SEX GROUPS OF PATIENTS - tabulated by hospitals -

		A		B		C		D		Total		F.		H		I		J		Total		General	
	K.32	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Male	y	13	59.1	4	80	8	44.4	2	28.6	27	51.9	6	42.9	7	63.6			1	12.5	14	31.8	41	42.7
Female	x	9	40.9	1	20	10	55.5	5	71.4	25	48.1	8	57.1	4	36.4	11	100	7	87.5	30	68.2	55	57.3
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 32- SEX GROUPS OF PATIENTS - tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	K.32	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Male	y	10	33.3	25	50	6	37.5	41	42.7	15	41.7	12	60	5	31.3	9	37.5	41	42.7
Female	x	20	66.7	25	50	10	62.5	55	57.3	21	58.3	8	40	11	68.8	15	62.5	55	57.3
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

ABLE 33- PROFESSION OF PATIENTS - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.29	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ousewife	y	7	31.8	1	20	8	44.4	2	28.6	18	34.6	7	50	3	27.3	8	72.7	2	25	20	45.5	38	39.6
ublic employee	x					2	11.1	3	42.9	5	9.6			2	18.2			1	12.5	3	6.8	8	8.3
anager (private sector)	0	1	4.6	2	40					3	5.8	1	7.1					1	12.5	2	4.6	5	5.2
radesmen	1	2	9.1			1	5.6			3	5.8											3	3.1
erchant	2	2	9.1	2	40	1	5.6			5	9.6			1	9.1					1	2.3	6	6.3
mployee (private sector)	3	2	9.1			3	16.7	1	14.3	6	11.5	1	7.1	2	18.2			1	12.5	4	9.1	10	10.4
rivate business	4	6	27.3			1	5.6			7	13.5	3	21.4			2	18.2	1	12.5	6	13.6	13	13.5
orker	5					1	5.6			1	1.9	1	7.1							1	2.3	2	2.1
o profession	6													1	9.1	1	9.1	1	12.5	3	6.8	3	3.1
tudent	7	1	4.6					1	14.3	2	3.9			1	9.1			1	12.5	2	4.6	4	4.2
etired	8					1	5.6			1	1.9			1	9.1					1	2.3	2	2.1
lectrical technician	9											1	7.1							1	2.3	1	1.0
	K.31																						
rtist	3																						
ournalist	4	1	4.6							1	1.9											1	1.0
OTAL %			100		100		100		100		100		100		100		100		100		100		100
OTAL A			22		5		18		7		52		14		11		11		8		44		96
ASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 34- PROFESSION OF PATIENTS - tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	K.29	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
housewife	y	19	63.3	16	32	3	18.8	38	39.6	12	33.3	10	50	5	31.25	11	45.8	38	39.6
public employee	x	2	6.66	4	8	2	12.5	8	8.3	2	5.55	1	5	6	37.5			8	8.3
manager (private sector)	0	1	3.33	2	4	2	12.5	5	5.2	4	11.11	1	5	-				5	5.2
tradesmen	1			2	4	1	6.25	3	3.1	1	2.77	1	5	1	6.25			3	3.1
merchant	2	2	6.66	4	8			6	6.3	5	13.88					1	4.2	6	6.3
employee (private sector)	3	1	3.33	8	16	1	6.25	10	10.4	2	5.55	3	15	1	6.25	4	16.7	10	10.4
private business	4	2	6.66	8	16	3	18.8	13	13.5	8	22.22	1	5	1	6.25	3	12.5	13	13.5
worker	5	1	3.33	1	2			2	2.1			1	5	1	6.25			2	2.1
no profession	6			2	4	1	6.25	3	3.1	1	2.77			1	6.25	1	4.2	3	3.1
student	7	2	6.66	2	4			4	4.2	1	2.77							4	4.2
retired	8					2	12.5	2	2.1					1	6.25	1	4.2	2	2.1
electrical technician	9					1	6.25	1	1					1	6.25			1	1
	K.31																		
artist	3																		
journalist	4			1	2			1	1									1	1
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

implying a high percentage of maternity cases. The highest percentage of public employees are in severe, very severe, hopeless conditions, showing the emergency cases which brought these patients to private hospitals. Two retired individuals are also in severe, very severe and hopeless group (with C and D+E category in socio-economic class) which shows the effect of emergency or severity of condition. It can be stated that as the two above mentioned groups have accessibility to public hospitals (without pay), the choice of private hospitals, stresses the importance of severity of diagnosis in the choice of hospital services (Table 34).

The other demographic factor that we have considered is the city in which the patient's home is situated. It was found that 85 % of the patients are in the same city in which the hospital is situated. 3 % come from two other major cities (İzmir-Ankara) while 5 % from other cities. The attracting factor of the hospital was found to be through the referral system of the physician. The patient first comes to the physician who refers the patient to a particular hospital. The referral system works more for the foreign and minority hospitals than for the proprietor-owned hospitals, which can be due to the consumer mix of hospital C. Hospital C is specialized in plastic surgery so it does not limit its operations to a single site but acts as a specialized unit for all the country. The absence of referrals to Hospital I and J which are specialized in maternity services, shows that for this service (a minor case) referral from city to city does not work. Also a group of people are referred from Germany, as a result of the contractual agreement between the insurance companies and the hospital (Table 35, 36).

The demographic characteristics of current patients of private hospitals can be summarized as follows: patients mainly from upper and upper middle class, with ages between 30-39, situated in Istanbul, mostly females (due to number of maternity cases in the sample) and housewives, with highschool education. Other professionals, are tradesmen, merchants, private businessmen with administrators and employees of private sector are predominant.

The second part of the interview was intended to ascertain the ailment that kept the patient in the hospital (Table 37).

ABLE 35- PERMANENT RESIDENCE OF PATIENTS - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.31	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
stanbul	y	17	77.3	5	100	15	83.3	7	100	44	8.46	12	85.7	10	90.9	11	100	8	100	41	93.2	85	88.5
thers	x	2	9.1			2	11.1			4	7.7			1	9.1					1	2.3	5	5.2
nkara-İzmir	0	3	13.6							3	5.8											3	3.1
Germany	1					1	5.6			1	1.9	2	14.3							2	4.6	3	3.1
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 36- PERMANENT RESIDENCE OF PATIENTS - tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	K.31	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Istanbul	y	28	93.3	42	84	15	93.8	85	88.5	30	83.3	16	80	16	100	23	95.8	85	88.5
Others	x	1	3.33	3	6	1	6.25	5	5.2	3	8.3	2	10					5	5.2
Ankara-Izmir	0			3	6			3	3.13	3	8.3							3	3.1
Germany	1	1	3.33	2	4			3	3.13			2	10			1	4.2	3	3.1
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

TABLE 37- THE DIAGNOSIS FOR HOSPITAL STAY - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		General	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
surgery	y	4	18.1	1	20	7	38.8	6	85.7	18	34.6	2	14.3	7	63.6	1	9.1	2	25	12	27.3	30	31.
internal	x	9	40.9			6	33.3			15	28.8	6	42.9	2	18.2					8	18.2	23	24
genecological and maternist	0	3	13.6					1	14.3	4	7.7			1	9.1	10	90.9	4	50	15	34.1	19	19.
physiotherapy	1																						
psychology	2					1	5.6			1	1.9											1	1
orthopedy	3	3	13.6	1	20	3	16.7			7	13.5	3	21.4							3	6.8	10	10.
thoracic-orthodontic	4	1	4.6	3	60	1	5.6			5	9.7			1	9.1			1	12.5	2	4.5	7	7.
traffic and work accident	5											2	14.3							2	4.5	2	2.
urology	6																						
ophtalmic	7	1	4.6							1	1.9							1	12.5	1	2.3	2	2.
neurology	8	1	4.6							1	1.9	1	7.1							1	2.3	2	2.
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

It was apparent that the majority of patients was confirmed to hospitals for surgery (31.3 %), 19.8 % of the patients consisted of maternity and genecological cases. This is in accordance with the objectives of the private hospitals because they prefer to take surgical cases as price structure of the theatre and other costs associated with the surgical operation, are profitable compared to other prices that are restricted by the Ministry. It was stated that the private hospitals do not prefer convalescent or psychological cases because these illnesses require long-term stays which restrict the high turnover of the patients.

It most foreign hospitals, the percentage of surgical operations is highest in contrast the high number of maternity-geneocological coses in proprietor-owned hospitals. This result is mainly influenced by the maternity home present within the analysis but also it can arise due to the bias of interviewing only minor or medium cases as maternity case. It is interesting to note that Hospital A, has a higher number of internal cases than surgical cases, which is due to the number of specialized units within the hospital as Cobalt, Cardiac units related to internal departments; as most of the internal cases are specified as serious, very serious and impossible cases, which require more specialized care and concrete attention (Table 38).

Question 2 was intended to differentiate the group that had used hospital services before as inpatients. It was found that 58.3 % of the patients had been in-patients before coming to this hospital (Table 39). The large majority 75 % of patients that had stayed in the hospital, consist of serious, and major diseases, showing a repetition with the diagnosis category and the stay within the hospital (Table 40).

The major percentage of patients who had experience with hospital services beforehand, stayed in the same private hospital or in another private hospital (32.7 %), followed by public hospitals, hospitals related to social security organization and militory hospitals. Also patients who had received medical care in foreign hospitals abroad, were segmented as an important group. In foreign-minority hospitals, the largest percentage of patients chose the same hospital to receive medical care, while in proprietor-Owned hospitals, there is a shift from another private hospi-

TABLE 38- THE DIAGNOSIS FOR HOSPITAL STAY - tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
		C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
surgery	y	8	26.7	19	38	3	18.75	30	31.25	11	30.6	2	10	8	50	9	37.5	30	31.25
internal	x	2	6.7	13	24	8	50	23	23.9	8	22.2	6	30	6	37.5	3	12.5	23	23.9
genecological and maternist	0	15	50	4	8			19	19.8	10	30.6	7	35			2	8.3	19	19.8
physiotherapy	1																		
psychology	2			1	2			1	1.04					1	6.25			1	1.04
orthopedy	3	3	10	7	14			10	10.4	3	8.3	1	5	1	6.25	5	20.8	10	10.4
———————	4	1	3.3	4	8	2	12.5	7	7.3	3	8.3	1	5			3	18.75	7	7.3
traffic and work accident	5	1	3.3			1	6.25	2	2.1			1	5			1	6.25	2	2.1
urology	6															1	6.25		
ophthalmic	7			1	2	1	6.25	2	2.1	1	2.8							2	2.1
neurology	8			1	2	1	6.25	2	2.1			2	10					2	2.1
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

LE 39- THE NUMBER OF STAYS WITHIN A HOSPITAL - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		General	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
st stay	y	11	50	3	60	8	44.4	5	71.4	27	51.9	1	7.14	3	27.2	6	54.5	3	37.5	13	29.5	40	41.7
vious stays within hospital	x	11	50	2	40	10	55.6	2	28.6	25	48.1	13	92.8	8	72.8	5	62.5	5	62.5	31	70.5	56	58.4
IAL %			100		100		100		100		100		100		100		100		100		100		100
IAL A			22		5		18		7		52		14		11		11		8		44		96
SE			22		5		18		7		52		14		11		11		8		44		96

TABLE 40- THE NUMBER OF STAYS WITHIN A HOSPITAL - tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	K.6	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
First stay	y	14	46.7	22	44	4	25	40	41.7	16	44.4	5	25	10	62.5	9	37.5	40	41.7
Previous stays within the hospital	x	16	53.3	28	56	12	75	56	58.3	20	55.6	15	75	6	37.5	15	62.5	56	58.3
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

TABLE 41- THE HOSPITAL IN WHICH THE PATIENT HAD STAYED PREVIOUSLY - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		Genera	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
SSK	y						7.7				3.2						42.9		12.5		9.2		7.
						1	10			1	4					3	60	1	20	4	10.8	5	8.
military	x		7.7		33.3		7.7				9.7						28.8				5.5		7.
		1	9.1	1	50	1	10			3	12					2	40			2	6.5	5	8.
university	0				33.3		7.7				6.5				11.1				25		9.2		8.
				1	50	1	10			2	8	1	7.7	1	12.5			2	40	4	10.8	6	10.
hospitals related to state enterprises	1						7.7				6.5												2.
						1	10	1	50	2	8											2	3.
another private hospital	2		38.5				15.4				25.8				44.5				25		27.5		25.
		5	45.5			2	20	1	50	8	32	4	30.8	4	50			2	40	10	32.2	18	32.
same private hospital	3		46.1		33.3		15.4				29				22.2				12.5		21.9		26.
		6	54.5	1	50	2	20			9	36	5	38.5	2	25			1	20	8	25.8	17	32.
public hospital	4						7.7				3.23				22.2				25		13.7		8.
						1	10			1	4	1	7.7	2	25			2	40	5	16.1	6	10.
municipal hospital	5						23.1				9.7												4.
						3	30			3	12											3	5.
hospital abroad	6		7.7				7.7				6.5						14.2				5.5		5.
		1	9.1			1	10			2	8	1	7.7			1	20			2	6.5	4	7.
hospitals related to foundations	7																14.2				5.5		2.
												1	7.7			1	20			2	6.5	2	3.
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
			118.2		150		130		100		124				112.5		140		160		117.3		123.
TOTAL A			13		3		13		2		31		13		9		7		8		37		68
BASE			11		2		10		2		25		13		8		5		5		31		56

TABLE 42- THE LEVEL OF SATISFACTION WITH THE PREVIOUS HOSPITAL - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		Genera	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
satisfied with everything	y	4	36.7	1	50	5	50	1	50	11	44	5	38.5	5	62.5	3	60	2	40	15	48.4	26	46.
dissatisfied with certain things	x	2	18.2	1	50	4	40	1	50	8	32	1	7.7	3	37.5	2	40	3	60	9	29	17	30.
uncertain/no answer	0	5	45.5			1	10			6	24	6	46.2							6	19.4	12	21.
do not remember	1											1	7.7							1	3.2	1	1.
TOTAL %		100		100		100		100		100		100		100		100		100		100		100	
TOTAL A		11		2		10		2		25		13		8		5		5		31		56	
BASE		11		2		10		2		25		13		8		5		5		31		56	

analyzed in accordance with the degree of satisfaction from service of a particular hospital, to see the shift of consumers from one institution to another (Table 41).

When the patients were asked if they were pleased with, the services of the hospitals that they had stayed in previously, 46.4 % stated that they were very satisfied with everything while 30.4 stated that there were things that they weren't satisfied and 214. % stated that they were undecided or don't remember. In foreign-minority hospitals, there was a much larger percentage of patients, who were displeased with the services of previous services while the satisfaction and dissatisfaction percentages differ in proprietor owned hospitals, as in I and J (Table 42, 43).

TABLE 43- DEGREE OF SATISFACTION WITH THE PREVIOUS HOSPITAL - tabulated by case severity and socio-economic class)

	minor very minor		medium		serious very serious hopel.		total		A		B		C		D		Total	
satisfied with every thing	8	50	13	46.4	5	41.7	26	46.4	12	60	2	13.3	2	33.3	11	73.3	26	46.4
dissatis-fact with something	3	18.75	10	35.7	4	33.3	17	30.4	5	25	6	40	2	33.3	4	26.7	17	30.4
undecided	5	31.25	5	17.9	2	16.7	12	12.5	2	10	7	46.7	2	33.3	1	6.7	12	21.4
do not remember					1	8.4	1	1.04									1	1.8
TOTAL %	100		100		100		100		100		100		100		100		100	
TOTAL A	16		28		12		56		20		15		6		15		56	
BASE	16		28		12		56		20		15		6		15		56	

In socio-economic class tabulation presented in Table 43 above, dissatisfaction greatest in B category, with a large percentage being undecided in the same class (Table 44).

In table 44; among the reasons cited for the satisfaction with services of previous hospitals, the primary importance was given to the interest of physicians followed by the interest of nurses and the qualification of medical service. Also, cleanliness of the hospital, with cleanliness and taste of meals and the sufficiency of medical personnel as physicians and nurses were stated as examples of reasons for the satisfaction of patients. As seen from the above analysis, the primary importance was given to the service of the medical staff compared by other services of hospital

TABLE 44- THE REASONS FOR THE SATISFACTION WITH SERVICES OF PREVIOUS HOSPITALS - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		Genera	
	K.9	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
interest of physicians	y	2	16.7 50	1	14.3 100	4	23.5 80	1	9.1 100	8	16 72.7	3	12.5 60	5	41.6 100	2	28.6 66.7	2	28.5 100	12	24.5 80	20	23. 76.
interest of nurses	x	2	16.7 50	1	14.3 100	3	17.7 60	1	9.1 100	7	14 63.6	3	12.5 60	2	16.6 40					5	10.2 33.3	12	14. 46.
the availability of physicians and nurses	0			1	14.3 100			1	9.1 100	2	4 18.2	1	4.2 20	1	8.3 20	2	28.6 66.7			3	6.1 20	5	5. 19.
cleanliness	1	2	16.7 50					1	9.1 100	3	6 27.2	1	4.2 20	1	8.3 20			1	14.2 50	3	6.1 20	6	7. 23.
qualification of medical service	2	1	8.3 25	2	28.6 200	4	23.5 80			7	14 63.6			1	8.3 20			1	14.2 50	2	4.0 13.3	9	10. 34.
permission for visitors	3							1	9.1 100	1	2 9.1					1	14.3 33.3			2	4 13.3	3	3. 11.
the limitation on number of visitors	4											5	20.8 100							5	10.2 33.3	5	5. 19.
not noisy	5	1	8.3 25					1	9.1 100	2	4 18.2	1	4.2 20	1	8.3 20					1	2.0 6.6	3	3. 11.
meals, clean and tasty	6					2	11.8 40	1	9.1 100	3	6 27.2	1	4.2 20							2	4 13.3	5	5. 19.
permission for accompaniment	7							1	9.1 100	1	2 9.1											1	1. 3.
number of patients/ bed small	8					2	11.8 40	1	9.1 100	3	6 27.2											3	3. 11.
regulatily on drug giving	9			1	14.3 100			1	9.1 100	2	4 18.2	1	4.2 20					1	14.2 50	2	4 13.3	4	4. 15.
	K.10																						
sterility of equipment	y																						
modernity and qualifications for technical equipment	x			1	14.3 100	1	5.9 20			2	4 18.2					2	28.6 66.7	1	14.2 50	3	6.1 20	5	5. 19.
X-ray and lab. qualified service	0							1	8.1 100	1	2 9.1											1	1. 3.
close attention in service	1											1	4.2 20					1	14.2 50	2	4 13.3	2	2. 7.
care given by doctors	2	1	8.3 25							1	2 9.1											1	1. 3.
no answers	3	6	25 75	1	5.9 20					7	14 63.6	7	29.2 140							7	14.3 46.6	14	16. 53.

ABLE 44- (Cont.)

	A		B		C		D		Total		F		H		I		J		Total		General	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
OTAL %		100		100		100		100		100		100		100		100		100		100		100
		300		700		340		1100		454.3		480		240		233.4		350		326.3		326.5
OTAL A		15		7		17		11		50		24		12		7		7		50		99
ASE		4		1		5		1		11		5		5		3		2		15		26

In this analysis, it is apparent that on the demand side, also, the physician plays an influencial and central role.

When we examine the tabulation of results according to severity of illness, we see that in every category, interest and quality of medical staff gains importance (Table 45).

In minor cases, and medium ones, noisyness of hospital, permission for accompaniment, number of patients/bed being small, regularity of drug giving and qualification of X-ray and laboratory services are considered to be satisfactory in previous hospitals, whereas serious cases are more interested with the medical aspect of the service. So, it can be stated that as the severity of case gets minor, the importance of other services or recognition of other services of the hospital gains importance. Also patients in minor categories have made more statements (33 compared to 11 in serious cases) about the reasons for satisfaction. When we tabulate the results according to socio-economic classes, there is not much difference in the results except that permission for visitors gains importance by A and B classes, showing that in these cases hospital services are viewed as cases of conspicious consumption. The reasons for the dissatisfaction with the services of previous hospitals are mainly insufficiency of medical care and uncleanliness of the hospital, followed by the dirtiness and untasteful character of hospital meals. Such factors as sterility of equipment, unmodern equipment combined with insufficiency of equipment, psychological atmosphere of the hospital and the inconvenience of the accompaniment are the factors which are mentioned together with dissatisfaction (Table 46). It was found that 52.3 % of the current patients had stayed in the same or another private hospital, while the remaining 47.7 had experiences in the public, military, university, municipalities, and other (SEE TABLE 41) so that the criticisms apply both to private medical sector as well as the public sector. When we view the criticisms associated with public sector, they are mostly in the form of insufficiency and lack of interest of the medical personnel, physicians and nurses, together with the uncleanliness of the hospital. Those who complain mostly about lack of medical service are among serious, very serious and hopeless cases and medium class, while minor cases complain from the uncleanliness of services. It is apparent that with the seriousness of diagnosis, the relative importance of hospital services is changing. As the serious case category needs more

TABLE 45- REASONS FOR THE SATISFACTION WITH SERVICES OF PREVISIONS HOSPITALS - tabulated by case severity and socio-economic class -

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
interest of physicians		22.8		14.1		2.0		27.8		13.7		16.7		16.7		34.7		23.6
	8	100	8	61.5	4	36.4	20	74.1	7	58.3	2	100	2	100	9	81.8	20	76.9
interest of nurses		14.3		8.8		10		16.6		9.8		16.7		16.7		11.5		14.2
	5	62.5	5	38.5	2	18.2	12	44.4	5	41.7	2	100	2	100	3	27.2	12	46.2
the availability of physicians and nurses		5.7		5.3				6.9		9.8								5.9
	2	25	3	23.1			5	18.5	5	41.7							5	19.2
cleanliness		5.7		70.3				8.3		7.8		8.3		8.3				7.1
	2	25	4	30.8			6	22.2	4	33.3	1	50	1	50			6	23.1
qualification of medical service		8.6		8.8		5		10.3		11.7		16.7				3.8		10.3
	3	37.5	5	38.5	1	9.1	9	34.6	6	50	2	100			1	9.1	9	34.6
permission for visitors		5.7				5		4.2		3.9						3.8		3.5
	2	25			1	9.1	3	11.1	2	16.7					1	9.1	3	11.5
the limitation on number of visitors		5.7		5.4				5.9				16.7		16.7		3.8		5.9
	2	25	3	23.1			5	19.2			2	100	2	100	1	9.1	5	19.2
not noisy		5.7		1.8				4.2		5.9								3.5
	2	25	1	7.7			3	11.1	3	25							3	11.5
meals, clean and tasty		5.7		1.8		10		6.9		3.9		16.7				3.8		5.9
	2	25	1	7.7	2	18.2	5	18.5	2	16.7	2	100			1	9.1	5	19.2
permission for accompaniment		2.8						1.4		1.9								1.2
	1	12.5						3.7	1	8.3							1	3.8
number of patients/bed small		8.6						4.2		3.9						3.8		3.5
	3	37.5					3	11.1	2	16.7					1	9.1	3	11.5
regularity on drug giving				3.5		10		4.7		5.9		8.3						4.7
			2	15.4	2	18.2	4	15.4	3	25	1	50					4	15.3
sterility of equipment										3.9						16.7		
									2	16.7					2	18.2		
modernity and qualifications for technical eq.						24.9		5.9		7.8				8.3				1.2
					5	45.4	5	19.2	4	33.3			1	50			5	19.2
X-ray and lab. qualified service		2.8				5		1.4						8.3				1.2
	1	37.5			1	9.1	1	3.7					1	50			1	38
close attention in service						10		2.4						8.3		3.8		2.4
					2	18.2	2	7.7					1.50		1	9.1	2	7.7
care of the doctors								1.2								3.8		1.2
							1	3.8							1	9.1	1	3.3
no answers				5.4		18.2		16.5		9.8		6.7				19.3		16.5
			3	23.1	11	18.2	14	53.8	5	41.7	2	100	2	100	5	45.5	14	53.8
TOTAL A		33		35		31		99		47		16		16		20		99

TABLE 46- THE REASONS FOR THI DISSATISFACTION WITH THE SERVICES OF PREVIOUS HOSPITALS - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		Genera	
	K.11	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
physicians disinterested	y					4	22.2 100			4	13.3 50											4	7. 23.
nurses disinterested	x					3	16.6 75			3	10 37.5							1	14.3 33.3	1	4.7 11.1	2	3. 11.
physicians nurses are few	0	1	50							1	3.3 12.5			1	16.7 33.3	1	12.5 50			2	9.52 22.2	3	5. 17.
not clean	1			1	20 100	1	5.5 25	1	20 100	3	10 37.5			1	16.7 33.3	1	12.5 50	2	28.6 66.6	4	19.04 44.4	7	13. 41.
medical services insufficient	2					3	16.6 75	1	20 100	5	16.6 62.5			1	16.7 33.3	1	12.5 50	1	14.3 33.3	3	13.63 33.3	8	15. 47.
too many visitors	3															1	12.5 50	1	14.3 33.3	2	9.09 22.2	2	3. 11.
too few visitors	4																						
noisy	5			1	20 100					1	3.3 12.5			1	16.7 33.3	1	12.5 50	1	14.3 33.3	3	13.6 33.3	4	7. 23.
meals dirty and untasteful	6					3	16.6 75			3	10 37.5							1	14.3 33.3	1	4.7 11.1	5	9. 29.
no accompaniment allowed																							
too many patients/ room	8					2	11.1 50			2	6.6 25			1	16.7 33.3					1	4.7 11.1	3	5. 17.
the distribution of drugs irregular	9					1	5.5 25			1	3.3 12.5					1	12.5 50			1	4.7 11.1	2	3. 11.
	K.12																						
nothing is steril	y			1	20 100			1	20 100	2	6.6 25			1	16.7 33.3					1	4.7 11.1	3	5. 17.
the technical equipment not modern and insuffi-cient	x							1	20 100	1	3.3 12.5					1	12.5 50			1	4.3 11.1	2	3. 11.
X-ray and lab. inadequate service	0			1	20 100			1	20 100	2	6.6 25										4.7	2	3. 11.
psychologically bad												1	100							1	11.1	1	1 5
the accompaniment uncomfortable																1	12.5 50			1	4.7 11.1	1	1 5
no answer/don't know						1	3.3 12.5			1	3.3 12.5											1	1 5
personnel serves				1	20 100					1	3.3 12.5											1	1 5

TABLE 46- (Cont.)

	A		B		C		D		Total		F		H		I		J		Total		General	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
TOTAL %		100		100 500		100 450		100 500		100 375		100 100		100 199.8		100 400		100 233.1		100 244.2		100 299.7
TOTAL A		2		5		18		5		30		1		6		8		7		22		51
BASE		2		1		4		1		8		1		3		2		3		9		17

medical care; they are critical about the services related to the professional group, while minor cases, can analyze other services of the hospital as the cleanliness element. In C socio-economic class, disinterest of physicians and cleanliness are the major categories for criticism, while in A category, the major criticisms are related with uncleanliness, noisy aspect dirtiness and untastefulness of meals, and insufficiency of medical care. In B category disinterest of the medical group plays important roles, while in (D+E) insufficiency of medical care is the major critical aspect. So, it is impossible to generalize criticisms according to socio-economic classes (Table 47).

As has been apparent from the above analysis, Questions 2 through 6, tried to find out which factors influence the change from one hospital to another. The change pattern is seen to be between the same private hospital or from another private hospital to the analyzed ones, also a major category of patients using other hospital services as (public hospitals, municipality hospitals, university hospitals etc.) preferred private hospitals as a second trial. It is possible to find a certain degree of brand loyalty in the consumption of private hospital services. those patients, accostomed to a certain hospital prefer to choose the same one on a second trial. Also, a large percentage of patients were satisfied with the services of the previous hospital, although some of them changed to another hospital. In this analysis, it is important to view the referral reasons to the present hospital. Question 7 was concerned with the reasons for the choice of the present hospital (TABLE 48). The largest percentage (16.8 %) stated that there is a bond of trust between the physician and the patient which determines the choice of medical services of private hospitals. In this analysis, it is seen that the physician is the main decidor in the medical process. So, the patient gives his full trust to the physician, the demand for hospital services becoming derived demands related to physician services. So the reason for physician-orientation of most private hospitals becomes apparent, as the consumer side of the exchange equation sees the hospital services as by-products of physician services, the primary marketing target of private hospitals should be the physicians. The second reason for the choice of private hospitals is that better service (in general) offered by the hospitals. Better service can be defined as elements that effect the choice of hospitals as frequent visits of the physicians. Cleanliness of the hospital, the atten-

tion, interest and helpfulness of the nurses, the comfort of the accompaniment and those factors that are seen on Table 48. Another factor that influence hospital choice is the recommendation of the hospital by the friends, relatives and the family. The third factor that affects the choice of private hospital is payment of fees by the firms. Thus, consumers who would not think of using the services of private hospitals for financial reasons, get the opportunity to do so when the firms pay the bill.

TABLE 47- THE REASONS FOR THE DISSATISFACTION WITH THE SERVICES OF PREVIOUS HOSPITALS (Tabulated by case severity and socio-economic class)

		minor very minor		medium		serious very ser. hopeless		Tabulated by case severity and socio-economic class Total		A		B		C		D+E		Total	
	K11	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Physicians disinterested			8.3		7.9		7.7		7.8				14.3		20				7.8
	y	1	50	2	33.3	1	11.1	4	23.5			2	33.3	2	100			4	23.5
Nurses disinterested					7.9				3.9				14.3						3.8
				2	33.3			2	11.8			2	33.3					2	11.8
Physicians-nurses are few			8.3		7.9				5.9				14.3				12.5		5.8
	0	1	50	2	33.3			3	17.6			2	33.3			1	25	3	17.6
Not clean			24.9		7.9		15.4		13.7		6.7		14.3		20		12.5		13.7
	1	3	150	2	33.3	2	22.2	7	41.2	2	4.0	2	33.3	2	100	1	25	7	41.2
Medical services insufficient					19.9		23.1		15.7		6.7				10		50		15.7
	2			5	83.3	3	33.3	8	47.1	2	40			1	50	4	100	8	47.1
Too many visitors					4.1		7.7		3.9		3.3				10				3.8
	3			1	16.7	1	11.1	2	11.8	1	20			1	50			2	11.8
Too few visitors	4																		
Noisy			16.6		4.1		7.7		7.8		6.7		14.3						7.8
	5	2	100	1	16.7	1	11.1	4	23.5	2	40	2	33.3					4	23.6
Meals dirty and untasteful			8.3		7.9		15.4		9.8		6.7		14.3		10				9.8
	6	1	50	2	33.3	2	22.2	5	29.4	2	40	2	33.3	1	50			5	29.4
No accompaniment allowed	7																		
Too many patients/room					11.9				5.9		3.3		7.1				12.5		5.8
	8			3	50			3	17.6	1	20	1	16.7			1	25	3	17.6
Distribution of drugs			9.3		4.1				3.9		3.3				10				3.8
irregular	9	1	50	1	16.7			2	11.8	1	20			1	50			2	11.8
	K12																		
Nothing is steril			8.3				7.7		5.9		3.3						12.5		5.8
	y	1	50			1	11.1	3	17.6	1	10					1	25	3	17.6
The technical equipment not					4.1		7.7		3.9		3.3				10				3.8
modern and sufficient	x	-	-	1	16.7	1	11.1	2	11.8	1	20			1	50			2	11.8
x-ray and lab. inadequate			8.3				7.7		3.9		3.3				10				3.8
service	0	1	50			1	11.1	2	11.8	1	20			1	50			2	11.8
Psychologically bad					4.1				1.9						10				1.9
	1			1	16.7			1	5.9					1	50			1	5.9
The accompaniment			8.3						1.9		3.3								1.9
uncomfortable	2	1	50					1	5.9	1	20							1	5.9
No answer/don't know					4.1				1.9						10				1.9
	3			1	16.7			1	5.9					1	50			1	5.9
Personnel serves unwillingly					4.1				1.9				7.1						1.9
	4			1	16.7			1	5.9			1	16.7					1	5.9

TABLE 47- (CONT.) (Tabulated by case severity and socio-economic class)

	minor very minor		medium		serious very ser. hopeless		Tabulated by case severity and socio-economic class Total		A		B		C		D+E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
TOTAL %		100		100		100		100		100		100		100		100		100
		600		416.7		144.3		300		600		233		500		200		300
TOTAL A		13		25		13		51		15		14		13		9		51
BASE		3		10		4		17		5		6		2		4		17

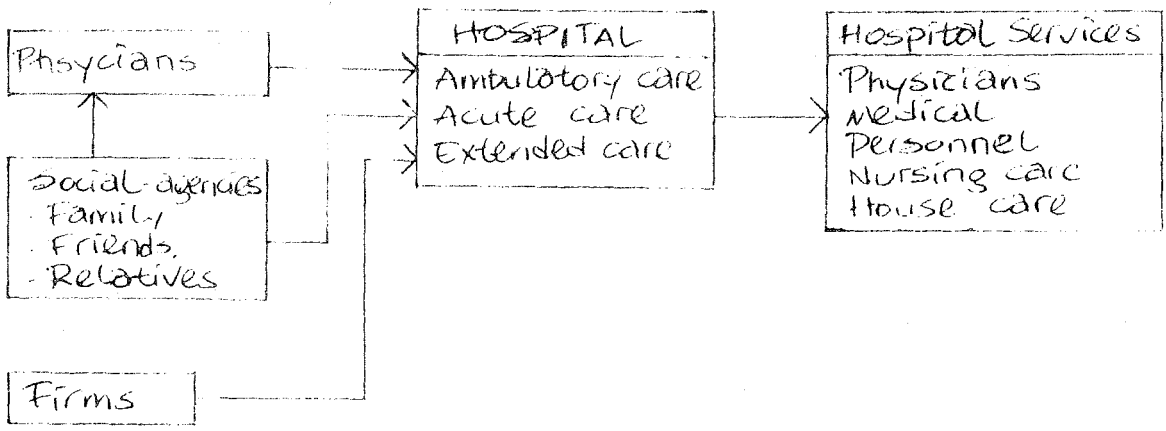
TABLE 48- THE REASONS GIVEN BY PATIENTS FOR THE CHOICE OF THE CURRENT HOSPITAL (More Than 1 Answer) - Tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.13	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Frequency of visits by physicians	y		9.5		15				7.9		8.3		10		5.3		21.7		10		12.0		9.8
		4	18.2	3	60			3	42.9	10	19.2	2	14.3	1	9.1	5	45.5	2	25	10	22.7	20	20.8
Nurses-helpful, smiling, concerned	x		9.5						7.9		5.8				5.3		8.7		5		4.8		5.5
		4	18.2					3	42.9	7	13.5			1	9.1	2	18.2	1	12.5	4	9.1	11	11.5
Physicians on night duty-adequate	0		2.4		15				5.3		4.9		5				4.3				2.4		3.9
		1	4.5	3	60			2	28.6	6	11.5	1	7.1			1	9.1			2	45	8	8.3
Nurses on night duty - adequate	1		2.4						5.3		2.5		5				4.3		5		3.6		2.9
		1	4.5					2	28.6	3	5.8	1	7.1			1	9.1	1	12.5	3	68	6	6.3
Silence	2				5		4.7		7.9		4.1												2.5
				1	20	1	5.5	3	42.9	5	9.6											5	5.2
My physician wanted it	3		19.1				19.1		5.3		11.6		14.9		36.8		21.7		25		24.1		16.8
		8	36.4			4	22.2	2	28.6	14	26.9	3	21.4	7	63.6	5	45.5	5	62.5	20	45.5	34	35.4
Better medical care	4		19.1		15				10.5		12.4		5		15.7		4.3		15		9.6		11.3
		8	36.4	3	60			4	57.1	15	28.8	1	7.1	3	27.2	1	9.1	3	37.5	8	18.2	23	23.9
There was no place in another hospital	5		2.4								0.4				5.3						1.2		0.9
		1	4.5							1	1.9			1	9.1					1	2.3	2	2.1
My family and acquiantances recommended it	6		9.5				23.9		7.9		9.9		14.9		10.5				5		7.3		8.9
		4	18.2			5	27.7	3	42.9	12	23	3	21.4	2	18.2			1	12.5	6	13.7	18	18.8
Company pay	7						19.1		5.3		4.9		10.0		10.5		4.3		10		8.4		6.4
						4	22.2	2	28.6	6	11.5	2	14.3	2	18.2	1	9.1	2	25	7	15.9	13	13.5
General cleanliness	8		9.5		10				10.5		8.17						4.3		10		3.6		6.4
		4	18.2	2	40			4	57.1	10	19.2					1	9.1	2	25	3	6.8	13	13.5
Meals and kitchen clean	9								7.9		2.5						4.3				1.2		1.9
								3	42.9	3	5.8					1	9.1			1	2.3	4	4.2
	K14																						
Accompaniment present and comfortable	y		2.4		5		4.7		10.5		5.8				5.3		4.3				2.4		4.5
		1	4.5	1	20	1	5.5	4	57.1	7	13.5			1	9.1	1	9.1			2	4.5	9	9.4
Close attention in medical care	x				10						1.7								5		1.2		1.5
				2	40					2	3.9							1	12.5	1	2.3	3	3.1
X-ray and lab works well	0		2.4								0.4												0.5
		1	4.5							1	1.9											1	1.0
Visiting hours are regulated adequately	1				5				2.6		1.7								5		1.2		1.5
				1	20			1	14.3	2	3.9							1	12.5	1	2.3	3	3.1
Heating is fine	2				5		4.7		2.6		2.5						4.3				1.2		1.9
				1	20	1	5.5	1	14.3	3	5.8					1	9.1			1	2.3	4	4.2
A relative stayed and was satisfied	3						4.7				0.4				5.3		4.3		5		3.6		1.9
						1	5.5			1	1.9			1	9.1	1	9.1	1	12.5	3	6.8	4	4.2

TABLE 48- (CONT.)

		A		B		C		D		Total		F		H		I		J		Total		General	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Comfort of lifts	4																						
Sterility of equipment	5				15						3.3												1.9
		1	4.5	3	60					4	7.7											4	4.2
Brought in emergency	6						4.7		2.6		1.7												0.9
						1	5.5	1	14.3	2	3.9											2	2.1
Near the home	7		2.4								0.4		5								1.2		0.9
		1	4.5							1	1.9	1	7.1							1	2.3	2	2.1
Physicians are dependable	8		4.8								1.7												0.9
		2	9.1							2	3.9											2	2.1
Acquianted by the physician	9						4.7				0.4		10								2.4		1.5
						1	5.5			1	1.9	2	14.3							2	4.5	3	3.1
Due to chance	K8 2												5								1.2		0.5
												1	7.1							1	2.3	1	1.0
No dampness	3						4.7				0.4												0.5
						1	5.5			1	1.9											1	1.0
Presence of cobalt unit	4		2.4								0.4												0.5
		1	4.5							1	1.9											1	1.0
Being a private hospital	5												5								1.2		0.5
												1	7.1							1	2.3	1	1.0
Stayed previosuly and was comfortable	6																						
No answer/undecided	7																4.3				1.2		0.5
																1	9.1			1	2.3	1	1.0
The owner of the hospital is an acquiantance	8						4.7				0.4		10								1.2		1.5
						1	5.5			1	1.9	2	14.3							2	4.5	3	3.7
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
			190.7		400		116.1		543.1		232.6		142.8		172.7		209.3		250		188.8		211.
TOTAL A			42		20		21		38		121		20		19		23		20		82		203
BASE			22		5		18		7		52		14		11		11		8		44		96

FIGURE 6- HOSPITAL REFERRAL SYSTEMS



Other services that influence hospital choice involve the size of medical staff on night duty, the functioning of laboratory and X-ray department, sterility of equipment, presence of cobalt unit. Other factors such as silence, cleanliness, the working of the heating system, the presence of lifts, the absence of humidity within the hospitals, are factors that are related with the general condition of the hospital. In addition to these factors, satisfaction of a relative with the services of the hospital, previous satisfaction with the services of the same hospital during the stay as an inpatient, acquaintance with the owner of the hospital and with a house physician play important roles in the choice process. Emergency and absence of a bed in another hospital and also coincidence act as important criteria that effect the choice process.

In foreign minority hospitals, better service gains primary importance over the choice of the physican in Hospital B and D, this factor is given twice the importance given to the choice of the doctor, whereas in Hospital A, equal importance is given to physician's choice and better service. In hospital C, which is specialized in plastic surgery, as the specialization of the physician is important the physician is the major decision- maker. In proprietor-owned hospitals, especially those which give maternity services, the choice of the physician, is twice as

important as better service. As maternity cases are grouped as minor cases, the quality of medical care is equalized with the primary surgical process performed by the physician (Table 49).

From the analysis of Table 49, it is apparent that the physician's choice plays an important role in cases of serious very serious and hopeless categories. In this state, the patient feels great anxiety and fear and depends with all his trust on the decision of the physician to solve his problem. So, in those cases, where severity of the diagnosis plays an important role, the centrality of the physician as the main decision-maker in medical care gains predominance. In minor cases; better service, frequency of physician visits, general cleanliness of hospital services and the presence and comfort of accompaniment are the major criteria for choice of hospital services. In socio-economic class division, in the last group (D+E), the choice of the physician is the primary criterion for determination of service consumption of hospitals. This shows the financial restraint on the choice of individual patients, as we move to category A, better service and choice of the physician become equally important. In D+E group, it is possible to state that if it were not for the choice of the physician, this group's choice of a hospital could have been different.

In analyzing the sources of information used by patients, in the choice of hospitals, we found that the majority of patients did not conduct any kind of research in gathering information about hospitals (59.4 %) (Table 50). 21 % used informal sources as relatives and friends, 13 % asked information from his family physician and only 4 % did active search as visiting all the hospitals and 2 % came in a case of emergency. So it is possible to conclude that 59.4 % who did not conduct any kind of research left the decision to the physician who had made the diagnosis, and who had taken the responsibility for conducting the medical care of the patient. It is important to note that no information was obtained from the media. The pattern for search for information for hospital services does not change for any individual hospital; in all cases the decision is left to the physician, only in proprietor - owned hospitals, active search for information is more predominant due to the presence of maternity cases. When we paired off the maternity cases with the result of Table 50, we saw that a majority (82 %), used active search

TABLE 49- THE REASONS GIVEN BY PATIENTS FOR THE CHOICE OF THE CURRENT HOSPITAL (more than 1 answer)
- tabulated by case severity and socio-economic class -

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	K.13	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
frequency of visits by physicians	y		11.6		10.1				9.8		8.17		12.2		7.7		7.6		9.8
		6	20	9	18	5	31.25	20	20.8	10	27.8	6	30	2	12.5	2	8.3	20	20.8
nurses-helpful, smiling, concerned	x		5.8		6.7				5.45		6.4		8.2						5.45
		3	10	6	12			11	11.5	7	19.4	4	20					11	11.5
physicians on night duty- -adequate	0		3.9		4.5				3.92		5.5		2.04		3.9				3.92
		2	6.7	4	8	2	12.5	8	8.3	6	16.7	1	5	1	6.25			8	8.3
nurses on night duty -adequate	1				5.6				2.96		2.7		4.08		3.9				2.96
				5	10	1	6.25	6	6.25	3	8.3	2	10	1	6.25			6	6.25
silence	2		3.9		3.4				2.4		2.7		2.04		3.9				2.46
		2	6.7	3	6			5	5.2	3	8.3	1	5	1	6.25			5	5.2
my physician wanted it	3		3.9		20.2				16.8		9.14		4.1		7.7		38.2		16.8
		2	6.7	18	36	14	87.5	34	35.4	10	27.7	10	10	2	12.5	10	41.7	34	35.4
better medical care	4		13.5		13.5				11.3		9.14		8.2		3.9		30.6		11.3
		7	23.3	12	24	4	25	23	23.9	10	27.8	4	20	1	6.25	8	33.3	23	23.9
there was no place in another hospital	5				2.2				0.9		0.92				3.9				0.9
				2	4			2	2.1	1	2.8			1	6.25			2	2.1
my family and acquitances recommend it	6		5.8		8.99				8.9		4.6		12.2		23.4		3.9		8.9
		3	10	8	16	7	43.8	18	18.8	5	13.9	6	30	6	37.5	1	4.2	18	18.8
company pay	7		3.9		7.9				6.4		1.8		12.2		11.7		3.9		6.4
		2	6.7	7	14	4	25	13	13.5	2	5.6	6	30	3	18.8	2	8.4	13	13.5
general cleanliness	8		9.7		5.6				6.4		8.6		6.12		3.9				6.4
		5	16.7	5	10	3	18.75	13	13.5	9	25	3	15	1	6.25			13	13.5
meals and kitchen clean	9		9.7		2.2				1.97		2.7				3.9				1.97
		2	6.7	2	4			4	4.16	3	8.3			1	6.25			4	4.16
	K.14																		
accompaniment present and comfortable	y		9.7		3.4				4.5		6.4		2.04		3.9				4.5
		5	16.7	3	6	1	6.25	9	9.4	7	19.4	1	5	1	6.25			9	9.4
close attention in medical care	x		1.9		2.2				1.46		2.7								1.46
		1	3.3	2	4			3	3.1	3	8.3							3	3.1
X-ray and lab. works well	0				1.1				0.49						3.9				0.49
				1	2			1	1.04					1	6.25			1	1.04
visiting hours are regulated adequately	1				2.2				1.46		1.8						3.9		1.46
				2	4	1	6.25	3	3.1	2	5.6					1	4.2	3	3.1
heating is fine	2		1.9		2.2				1.97		0.9		4.08		3.9				1.97
		1	3.3	2	4	1	6.25	4	4.16	1	2.8	2	10	1	6.25			4	4.16
a relative stayed and was satisfied	3		5.8						1.97		1.8		2.04				3.9		1.97
		3	10			1	6.25	4	4.16	2	2.8	1	5			1	4.2	4	4.16

TABLE 49- (Cont.)

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
		C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
comfort of lifts	4		3.9		1.1				1.97		2.9		2.04						1.97
sterily of equipment	5	2	6.7	1	2	1	6.25	4	4.16	3	5.6	1	5					4	4.16
brought in emergency	6				1.1				0.9						7.7				0.9
				1	2	1	6.25	2	2.1					2	12.2			2	2.1
near the home	7		1.9						0.9		0.9		2.04						0.9
		1	3.3			1	6.25	2	2.1	1	2.8	1	5					2	2.1
physicians are dependable	8								0.9		1.8								0.9
								2	2.1	2	5.6							2	2.1
acquianted by the physician	9		1.9		2.2				1.46				4.08		3.9				1.46
		1	3.3	2	4			3	3.1			2	10	1	6.25			3	3.1
	K.8																		
due to chance	2								0.49				2.04						0.49
						1	6.25	1	1.04			1	5					1	1.04
no dampness	3				1.1				0.49				2.04						0.49
				1	2			1	1.04			1	5					1	1.04
presence of cobalt unit	4								0.49				2.04						0.49
						1	6.25	1	1.04			1	5					1	1.04
being a private hospital	5		1.9						0.49				2.04						0.49
		1	3.3					1	1.04			1	5					1	1.04
stayed previously and was comfortable	6		1.9						0.49		0.9								0.49
		1	3.3					1	1.04	1	2.8							1	1.04
no answer/undecided	7				2.2				0.49		0.9						3.9		0.49
				2	4			1	1.04	1	2.8					1	4.2	1	1.04
the owner of the hospitals is an acquiantance	8		3.9						1.46		0.9		4.08						1.46
		2	6.7			1	6.25	3	3.1	1	2.8	2	10					3	3.1
TOTAL %			100		100		100		100		100		100		100		100		100
			173		178		318.8		211.27		303		245		162.3		109		211.27
TOTAL A			51		98		50		203		93		57		26		25		203
BASE			30		50		16		96		36		20		16		24		96

BLE 50- SOURCES OF INFORMATION USED BY PATIENTS IN THE CHOICE OF HOSPITALS (Tabulated by Hospitals)

	K15	A		B		C		D		Total		F		H		I		J		Total		General	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
nducted no research	y		45.8		20		88.4		85.7		63		78.6		72.7		15.4		55.6		55.3		59.4
		11	50	1	20	16	88.4	6	85.7	34	65.4	11	78.6	8	72.7	2	18.2	5	62.5	26	54.1	60	62.5
isited several hospitals	x		4.2								1.8		7.1				7.7		11.1		6.4		4
		1	4.6							1	1.9	1	7.1			1	9.1	1	12.5	3	6.8	4	4.2
sked my doctor	0		16.7		40						11.1						46.1		11.1		14.9		12.8
		4	18.2	2	40					6	11.5					6	54.5	1	12.5	7	15.9	13	13.5
sked acquiantances	1		33.3		20		11.1		14.3		22.3		14.3		27.3		23.1		11.1		19.2		20.8
		8	36.4	1	20	2	11.1	1	14.3	12	23.1	2	14.3	3	27.3	3	27.3	1	12.5	9	20.5	21	21.9
earned from the media	2																						
	3				20						1.8								11.1		2.2		2
ame due to emergency				1	20					1	1.9							1	12.5	1	2.3	2	2.1
	4																7.7				2.2		1
o answer																1	9.1			1	2.3	1	1.0
OTAL %			100		100		100		100		100		100		100		100		100		100		100
			109.2		100		100		100		103.8		100		100		118.2		112.5		106.9		105.2
OTAL A			24		5		18		7		54		14		11		13		9		47		101
ASE			22		5		18		7		52		14		11		11		8		44		96

as visiting all hospitals (Table 51). In Table 51, it is apparent that secondary to the decision-making of the physician, information gained from the relatives (informal channels) or through active search, has gained predominance. The use of relatives as source of information is absent in serious, very serious and hopeless categories. The place of the family doctor is not important compared with the decision-process of the physician in charge of the diagnosis. The use of relatives as sources of information in D+E socio-economic class is higher than other classes, showing the importance of informal channels in lower classes. The importance attached to physicion-decision falls down as we move from A to D+E category, where higher socio-economic classes are more influenced by professional channels of information.

Question 9 of the Ouestionnaire was an open-ended one asking for the reasons for the choice of private hospitals (in general) compared to the free-service offered by public and community hospitals. The results are listed on (Tables 52-53) as first mentions by the current patients. The high number of statements shows that, there are many different reasons which influence the choice of patients. Among the first answers, 27 % of the patients stated that up-keep of the medical personnel was good and careful. The second reason cited for choice was the general comfort offered by the hospital facilities. Cleanliness of the hospital and the service was stated as equal with the decision of the physician. When patients compared private hospitals with public ones, they stated that one could find place easily in private hospitals without waiting for one's turn to come in public hospitals. Also, contract of the hospitals with the firms plays an important role in the choice of private hospitals. We can group the choice criteria of patients in the following groups:

A- careful service and care pattern
- careful personnel.
- courteous behaviour towards the patients.
- experienced and very good physicians
- dependable physicians and being acquianted with physician
- better medical care
- private medical care possible.
- abundance of personnel.
- physicians can come at all times.

TABLE 51- SOURCES OF INFORMATION USED BY PATIENTS IN THE CHOICE OF HOSPITALS - tabulated by case-severity and socio-economic class

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
		C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
conducted no research	y	17	54.9 56.7	30	57.7 60	13	81.3	60	59.4 62.5	25	65.8	15	65.2 75	13	81.25	7	29.2	60	62.5
visited several hospitals	x	1	3.22 33.3	2	3.8 4	1	6.25	4	4 4.2	1	2.6	2	8.7 10			1	4.2	4	4 4.2
asked my doctor	0	3	9.7 10	8	15.4 16	2	12.5	13	12.8 13.5	5	13.2	2	8.7 10	1	6.3	5	20.8	3	12.8 13.5
asked acquiantances	1	9	29.4 30	10	19.2 20			19	20.3 21.9	5	13.2	4	17.4 20	2	12.6	10	41.7	21	20.3 21.9
learned from the media.																			
came due to emergency	3	1	3.22 3.3	1	1.9 2			2	2 2.1	1	2.6					1	4.2	2	2 2.1
no answer	4			1	1.9 2			1	1 1.0	1	2.6							1	1 1.0
TOTAL %			100 99.9		100 104		100		100		100 115		100		100		100		100
TOTAL A			31		52		16		101		38		23		16		24		101
BASE			30		50		16		96		36		20		16		24		96

TABLE 52- REASONS GIVEN BY PATIENTS FOR THE CHOICE OF HOSPITALS (FIRST REASON) (Tabulated by Hospitals)

		A		B		C		D		Total		F		H		I		J		Total		General	
	K16	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Careful and good care	y		38.9						21.9		27.8		27.8		23.1		15.4		36.4		25.5		27.4
		9	40.9	1	20	4	22.2	2	28.6	16	30.8	5	35.7	3	27.3	2	18.2	4	50	14	35	30	31.3
Cleanliness, carefulness of the hospital (general)	x		8.7								9.1		5.5				15.4		9.1		7.3		7.9
		2	9.1	2	40	1	5.6			5	9.6	1	7.1			2	18.2	1	12.5	4	100	9	9.4
Interested personnel	0		4.4								3.7												1.8
		1	4.6			1	5.6			2	3.9											2	2.1
Recommendation of the physician	1		8.7						11.1		5.5		16.7				15.4				9.1		7.3
		2	9.1			1	5.6	1	14.3	3	5.8	3	21.4			2	18.2			5	125	8	8.3
Comfortable	2		8.7						11.1		9.1				15.4		15.4		9.1		9.1		9.1
		2	9.1					1	14.3	5	9.6			2	18.2	1	18.2	1	12.5	5	125	10	10.4
Visiting hours	3										0.9												0.9
						2	11.1			1	1.9											1	1
Calm and not noisy	4										3.7												1.8
				1	20	1	5.6			2	3.9											2	2.1
Could find place/no waiting line	5		4.4								0.9		5.5		15.4		7.7				7.3		4.6
		1	4.6			1	5.6			1	1.9	1	7.1	2	18.2	1	9.1			4	10	5	5.2
Contract with firms	6								21.9		3.7		5.5								1.8		2.7
								2	28.6	2	3.9	1	7.1							1	25	3	3.1
Courteous behaviour towards patients	7								11.1		0.9		5.5						9.1		3.6		2.7
								1	14.3	1	1.9	1	7.1					1	12.5	2	50	3	3.1
Physicians are experienced	8		4.4								0.9		5.5		7.7						3.6		2.7
		1	4.6							1	1.9	1	7.1	1	9.1					2	50	3	3.1
Abundance of personnel	9												5.5								1.8		0.9
												1	7.1							1	25	1	1
Physicians are acquaintances and dependable	K6 0								11.1		0.9				7.7		7.7				3.6		2.7
								1	14.3	1	1.9			1	9.1	1	9.1			2	50	3	3.1
Recommendations of acquiantances	1								11.1		3.7												1.8
						1	5.6	1	14.3	2	3.9											2	2.1
Good and clean service	3		4.4								3.7		11.2		7.7				9.1		3.6		3.7
		1	4.6			1	5.6			2	3.9	2	14.3	1	9.1			1	12.5	2	50	4	4.2
Acquianted with the owners of the hospital	4												11.2								3.6		1.8
												2	14.3							2	50	2	2.1
Number of patients are small	5		4.4								0.9										1.8		1.8
		1	4.6							1	1.9									1	25	2	2.1
Medical care better	6										0.9												0.9

TABLE 52- (CONT.)

		A		B		C		D		Total		F		H		I		J		Total		General	
	K16	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Heals better	7																						
Private care is present	8		4.4								0.9												
		1	4.6							1	1.9											1	0.9
Satisfied for every service	9		4.4								0.9												0.9
		1	4.6							1	1.9											1	1
	K32																						
No difference	0										5.5												2.7
						3	16.7			3	5.8											3	3.1
Freedom of behavior and regulation	1																		1.8		1.8		0.9
																		1	25	1	25	1	1
Accompaniment is present	2																7.7		1.8		1.8		0.9
																1	9.1	1	25	1	25	1	1
One bed/room	3																						
Shorter stays within the hospital	4														7.7				1.8		1.8		0.9
														1	9.1			1	25	1	25	1	1
Emergency	6																						
Independent physcians can come	8																7.7		3.6		3.6		1.9
																1	9.1	2	50	2	50	2	2.1
Don't know	9		4.4								5.5		11.2		15.4		7.7		9.1		9.1		7.3
		1	4.6			2	11.1			3	5.8	2	14.3	2	18.2	1	9.1	5	12.5	5	12.5	8	8.3
	K36																						
Sterility of equipment	6										0.9												0.88
				1	20					1	1.9											1	1
Value given to individuals	7																						
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
			105						128.7		105.9		128.3		118.3		118.3		137.5		137.5		114.2
TOTAL C			23		5		18		9		55		18		13		13		11		55		110
BASE			22		5		18		7		52		14		11		11		8		4		96

TABLE 53- REASONS GIVEN BY PATIENTS FOR THE CHOICE OF HOSPITALS (First Reason) - tabulated by case-severity and socio-economic class -

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
careful and good care		15.3		36.6		31.1		27.4				38.5		12.1		37.6		27.4
	5	16.7	15	30	9	56.3	30	31.3	15	41.7	10	50	3	18.8	12	50	30	31.3
cleanliness carefulness of hospital (general)		3.02		12.2		13.8		7.9				7.6		12.1		12.5		7.9
	1	3.3	5	10	4	25	9	9.4			2	10	3	18.8	4	16.7	9	9.4
interested personnel				2.4				1.8				3.8						1.8
	1	3.02	1	2			2	2.1	1	2.8	1	5					2	2.1
recommend.of the physician		9.2		9.7		3.5		7.3				7.6		16				7.3
	3	10	4	8	1	6.25	8	8.3	2	5.6	2	10	4	25			8	8.3
comfortable		15.2		4.9		3.5		9.10				3.8		7.8		9.3		9.10
	5	16.6	2	4	1	6.25	10	10.4	4	11.1	1	5	2	12.2	3	12.5	10	10.4
visiting hours		3.02				3.5		1.8						4.01				1.8
	1	3.3			1	6.25	2	2.1	1	2.8			1	6.25			2	2.1
calm and not noisy				2.4		13.8		4.6						12.1				4.6
			1	2	4	25	5	5.2	2	5.6			3	18.8			5	5.2
could find place/no waiting line		3.02		2.4		3.5		2.7				3.8				9.3		2.7
	1	3.3	1	2	1	6.25	3	3.1			1	5			3	12.5	3	3.1
contract with firms		3.02				7.0		2.7										2.7
	1	3.3			2	12.5	3	3.1	3	8.3							3	3.1
courteous behaviour towards patients		3.02		2.4		3.5		2.7				3.8				6.24		2.7
	1	3.3	1	2	1	6.25	3	3.1			1	5			2	8.3	3	3.1
abundance of personnel								0.88						4.01				0.88
	1	3.02 3.3					1	1					1	6.25			1	1
physicians are acquitances and dependable		3.02		2.4		3.5		2.7				3.8		4.01		3.2		2.7
	1	3.3	1	2	1	6.25	3	3.1			1	5	1	6.25	1	4.2	3	3.1
recommendation of acquiantances		3.02		2.4				1.8						4.01				1.8
	1	3.3	1	2			2	2.1	1	2.8			1	6.25			2	2.1
good and clean service		3.02		2.4		7.0		3.7				7.6				3.2		3.7
	1	3.3	1	2	2	12.5	4	4.2	1	2.8	2	10			1	4.2	4	4.2
acquianted with the owners of hospitals		3.02				3.5		1.8						4.01				1.8
	1	3.3			1	6.25	2	2.1	1	2.8			1	6.25			2	2.1
number of patients are small		3.02						0.88						4.01				0.88
	1	3.3					1	1.0					1	6.25			1	1.0
medical care better		3.02						0.88				3.8						0.88
	1	3.3					1	1.0			1	5					1	10
meals better								0.88						4.01				0.88
							1	1					1	6.25			1	1

TABLE 53- (Cont.)

	minor very minor		medium		serious very ser.		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
private care is present				2.4				0.88								3.2		0.88
			1	2			1	1							1	4.2	1	1
satisfied for every service						3.5		0.88				3.8						0.88
					1	6.25	1	1			1	5					1	1
no difference		3.02		4.8		3.5		2.7				3.8				7.8		2.7
	1	3.3	2	2	1	6.25	3	3.1			1	5			2	8.3	3	3.1
freedom of behaviour and regulations		3.02				0.88												0.88
	1	3.3			1	1	1	2.8									1	1
accompaniment is present		3.02						0.88						4.01				0.88
	1	3.3					1	1					1	6.25			1	1
one bed/rooms																		
shorter stays within the hospital						3.5		0.88						4.01				0.88
					1	6.25	1	1					1	6.25			1	1
emergency																		
independent physicians can come		3.02				3.5		1.8				3.8				3.2		1.8
	1	3.3			1	6.25	2	2.1			1	5			1	4.2	2	2.1
don't know/no answer		6.1		12.2		3.5		7.3		8.5		7.6				7.8		7.3
	2	6.9	5	10	1	6.25	8	8.3	4	11.1	2	10			2	8.3	8	8.3
sterility of equipment				2.4				0.88						4.01				0.88
			1	2			1	1					1	6.25			1	1
value given to individuals																		
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL C		32		42		34		109		36		27		25		32		109
BASE		30		50		16		96		36		20		16		24		96

B- General service and care
- comfortable (general)
- calm and not noisy
- better meals
- freedom in behaviour and regulations
- one bed rooms
- presence of accompaniment
- shorter stay in the hospital
- medical care without waiting
- visiting hours.

B- Contract with firms
- no waiting line
- recommendations of relatives.

In minor cases, comfort of the hospital is given equal importance with the carefulness of medical care whereas, in serious cases, the major importance is given to quality of medical care with cleanliness and comfort of the hospital following. Also recommendation of the physician is important in medium cases. In socio-economic group tabulation; upper class (A) gives secondary importance to the comfort of the hospital following the quality of care within the hospital, whereas in group B and C, recommendation of the physicians are secondary to the quality of medical care. In group D+E, recommendation of the physician losses its importance leading to the importance of other sources of information.

The percentage of second and third mentions are shown on (Tables 54-55,56,57).

To summarize the findings of this part of the research, we can state that the most frequently mentioned choice criteria are:

(1) careful and good care
(2) and/or (3) general cleanliness, and carefulness of the hospital.
(4) interest of the personnel
calmness, not noisy hospital.

TABLE 54- REASONS FOR THE CHOICE OF THE HOSPITAL BY THE PATIENTS (2nd Reason) - Tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		Gener	
	K17	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Careful and good care	y	2	9.1	1	16.6 20			2	28.6	5	9.6			1	9.1			1	12.5	2	4.6	7	7
Cleanliness, carefulness of the hospital (general)	x	1	4.5			4	22.2	1	14.3	6	11.5	2	14.28	2	18.2	4	36.4	2	25	10	22.7	16	16
Interested personnel	0	4	18.2			1	5.5			5	9.6			2	18.2	1	9.1	1	12.5	4	9.1	9	9
Recommendation of the physician	1													1	9.1	1	9.1			2	4.6	2	2
Comfortable	2			1	16.6 20	1	5.5			2	3.9			1	9.1					1	2.3	3	3
Visiting hours	3							1	14.3	1	1.9											1	1
Calm and not noisy	4																						
Could find place no waiting line	5	1	4.4							1	1.9					1	1.9	1	12.5	2	4.6	3	3
Contract with firms	6																						
Courteous behaviour towards patients	7					1	5.5			1	1.9			1	9.1					1	2.3	2	2
Physicians are experienced	8					2	11.1			2	3.9											2	2
Abundance of personnel	9	1	4.4											1	9.1					1	2.3	1	1
Physicians are acquiantances and dependable	K35 y							1	14.3	1	1.9											1	1
Smaller number of patients	0					1	5.5	1	14.3	2	3.9											2	2
Better and cleaner service	1																						
Acquianted with the owners of hospitals	2																						

TABLE 54- (CONT.)

		A		B		C		D		Total		F		H		I		J		Total		Genera	
		A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Not too crowded	3					1	5.5			1	1.9							1	12.5	1	2.3	2	2.
Medical care better	4					1	5.5			1	1.9											1	1.
Meals are better	5			1	16.6 20					1	1.9											1	1.
Private service is present	6																						
No difference	8	1	4.5							1	1.9											1	1.
	K36																						
Accompaniments present	y															1	9.1			1	2.3	1	1.
Medical care without waiting	1													1	9.1					1	2.3	1	1.
Better baby care	3																	1	12.5	1	2.3	1	1.
Physicians can arrive at every hour	4					1	5.5			1	1.9											1	1.
Don't know/no answer	5	12	54.5	2	33.3 40	5	27.8	1	14.3	20	38.5	12	85.7	1	9.1	3	27.3	1	12.5	17	38.6	37	38.
Sterility of equipment	6			1	16.6					1	1.9											1	1.
TOTAL %			100		100 120		100		100		100		100		100		100		100		100		100
TOTAL A			22		6		18		7		53		14		11		11		8		44		97
BASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 55- REASONS FOR THE CHOICE OF THE HOSPITAL BY THE PATIENTS (2nd Reason) - Tabulated by case severity and socio eco class

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	K17	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Careful and good care	y	3	10	1	2	2	12.5	7	7.3	4	11.1	1	5	2	12.5			7	7.3
Cleanliness, carefulness of the hospital (general)	x	9	30	5	20	2	12,5	16	16.7	7	19.4			3	18.8	6	25	16	16.7
Interested personnel	0			7	28	2	12.5	9	9.4	5	13.9			2	12.5	2	8.3	9	9.4
Recommendation of the physician	1	1	3.3	1	4			2	2.0			2	10					2	2.0
Comfortable	2			2	8	1	6.3	3	3.1	1	2.8	1	5	1	6.3			3	3.1
Visiting hours	3			1	4			1	1.0	1	2.8							1	1.0
Calm and not noisy	4																		
Could find place no waiting line	5			3	6			3	3.1	2	5.6					1	4.7	3	3.1
Contract with firms	6																		
Courteous behaviour towards patients	7	2	6.7					2	2.8			1	5			1	4.7	2	2.9
Physicians are experienced	8			2	8			2	2.9							2	8.3	2	2.9
Abundance of personnel	9			1	4			1	1.0					1	6.3			1	1.0
	K35																		
Physicians are acquiantances and dependable	y	1	33.3			1	6.3	2	2.8			1	5					1	1.0
Recommendations of acquiantances	x															1	4.7	1	1.0
Smaller number of patients	0			1	4			1	1.0										
Better and cleaner service	1																		
Acquianted with the owners of hospitals	2	1	3.3	1	4			2	2.1			2	10					2	2.1
Not too crowded	3			2	8			2	2.1							2	8.3	2	2.1

TABLE 55- (CONT.)

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
		C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Medical care better	4			1	4			1	1.0							1	4.7	1	1.0
Meals are better	5	1	3.3					1	1.0	1	2.8							1	1.0
Private service is present	6																		
No difference	8	1	3.3					1	1.0							1	4.7	1	1.0
	K36																		
Accompaniment is present	y			1	4			1	1.0			1	5					1	1.0
Medical care without waiting	1			1	4			1	1.0					1	6.3			1	1.0
Better baby care	3	1	3.3					1	1.0							2	8.3	1	1.0
Physicians can arrive at every hour	4	1	3.3					1	1.0					1	6.3			1	1.0
Don't know/no answer	5	8	26.7	17	4	8	50	37	38.5	14	38.9	11	55	4	25	5	20.8	37	38.5
Sterily of equipment	6	1	3.3					1	1.0	1	2.8							1	1.0
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

TABLE 56- REASONS FOR THE CHOICE OF HOSPITALS BY PATIENTS (3rd REASON) (Tabulated by hospitals)

		A		B		C		D		Total		F		H		I		J		Total		Genera	
	K18	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Care is good and careful	y	1	4.6			1	5.6	2	28.6	4	7.7			1	9.1			1	12.5	2	4.6	6	6.3
Cleanliness (general)	x	1	4.6			1	5.6			3	5.8			1	9.1	4	36.4	1	12.5	6	13.6	9	9.4
Interested personnel	0	2	9.1	1	20	1	5.6			4	7.7			1	9.1	1	9.1			2	4.6	6	6.3
My playsician recommended it	1											1	7.2			1	9.1			2	4.6	2	2.1
Comfortable	2													2	18.2			2	25	4	9.1	4	4.2
Good visiting hours	3									1	1.9			1	9.1					1	2.3	2	2.1
Calm, not noisy	4					4	22.2			4	7.7			1	9.1			1	12.5	2	4.6	6	6.3
Could find place-no waiting line	5													1	9.1	1	9.1			2	4.6	2	2.1
Dependable and experienced physicians	8			1	20					1	1.9											1	1.0
	K37																						
Acquianted by physicians	y													1	9.1					1	2.3	1	1.1
Small number of patients	0					1	5.6			1	1.9											1	1.1
Better medical care	4																	1	12.5	1	2.3	1	1.1
Better meals	5					1	5.6			1	1.9											1	1.1
Satisfied in every way	7					1	5.6			1	1.9											1	1.1
Freedom in behaviour	9	K.38																1	12.5	1	2.3	1	1.1
Accompaignment possible	ȳ	1	4.6																				
One bed rooms	x	1	4.6			1	5.6																
Better baby care	3															1	9.1			1	2.3	1	1.1
Do not know/no answer	5	16	12.7	2	40	7	38.9	3	42.9	28	53.9	13	92.9	2	18.2	3	27.3	1	12.5	19	43.2	47	49
Value given to humans	7			1	20					1	1.9												
TOTAL %			100		100		100		100		100		100		100		100		100		100		100
TOTAL A			22		5		18		7		52		14		11		11		8		44		96
BASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 57- REASONS FOR THE CHOICE OF HOSPITALS BY PATIENTS (3rd Reason) - Tabulated by case severity and socio-economic clo

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	K18	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Care is good and careful	y	2	6.7	3	6	1	6.3	6	6.3	3	8.3					3	18.8	6	6.3
Cleanliness (general)	x	3	10	3	6	3	18.8	9	9.4	2	5.6	1	5	1	5.6	5	31.3	9	9.4
Interested personnel	0	3	10	2	4	1	6.3	6	6.3	3	8.3			2	11.2			6	6.3
My physician recommended it	1			2	4			2	2.1	1	2.8					1	6.3	2	2.1
Comfortable	2			3	6	1	6.3	4	4.2	1	2.8					3	18.8	4	4.2
Good visiting hours	3			2	4			2	2.1	1	2.8			1	5.6			2	2.1
Calm not noisy	4	2	6.7	2	4	2	12.5	6	6.3	1	2.8					5	31.3	6	6.3
Could find place no waiting line	5			1	2	1	6.3	2	2.4					1	5.6	1	6.3	2	2.1
Dependable and experienced physicians	8			1	2			1	1.0	2	5.6			1	5.6			1	1.0
	K37																		
acquianted by physicians	y	1	3.3					1	1					1	5.6			1	1.0
Small number of patients	0			1	2			1	1					1	5.6			1	1
Better medical care	4							1	1			1	5					1	1
Better meals	5	1	3.3					1	1	1	2.8							1	1
Satisfied in every way	7	1	3.3					1	1							1	6.3	1	1
Freedom in behaviour	9			1	2			1	1			2	10		1	1	6.3	1	1
Accompaignment possible	y	1	3.3					1	1	1	2.8							1	1
One bed/rooms	x			1	2	1	6.3	2	2.1			1	5			1	5.6	2	2.1
Better baby care	3	1	3.3					1	1									1	1
Do not know/no answer	5	14	46.7	27	54	6	37.5	47	49	19	52.8	15	75	8	50	5	20.8	47	49
Value given to humans	7	1	3.3							1	2.8							1	1
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

Question 10 was designed to find out the satisfaction of patients with the services of the hospitals. Different kinds of services were qualified as very good, good, medium, insufficient and very bad. The first attribute evaluated was the price asked for hospital services (Table 58).

As can be seen from the Table 58, 50 % of the patients stated that they did not know the level of requested fee, 22 % stated it as good, 12 % as medium and only 6 % as very bad. An interesting factor is that the patients in general do not know how much fee they will be charged for hospital services (we have to consider the fact that the respondents are current patients who have not received the bill yet); there is no research on the level of price structure of hospital services by a majority of patients. This situation is also apparent in Table 59, Where 46.9 % of the patients cannot quality the services with respect to the payments made (Table 59).

In hospital C, which is specialized in plastic surgery ignorance about prices of hospital services decreases because the physician states the price of the surgical process, and the cost of the hospital services beforehand. This is also apparent in I hospital which is a maternity hospital, where cost of maternity services are similar to those of other hospitals so that patients have an overall knowledge about the price structure of these services. The percentage of patients who state that requested price structure is very good, is only 1 %, where the severity of case does not make an important difference. The 1 % in the very good category belonged to C socio-economic class and medium case severity (Table 60).

27.78 % of patients in A category, found the prices as good, 19.44 % as medium, and 8.33 % as very bad. So, apart from the fact that 50 % do not know the prices, the next largest percentage, stated the prices as being good. So, it can be stated that there is not a major criticism about the price level of hospital services.

In table 59, the largest percentage 22.9 % stated that services compared with payment level are good, whereas only 2.08 stated as very bad. In three of the foreign or minority hospitals; there are no individuals who have stated that service compared to

TABLE 58- EVALUATION OF THE REQUESTED PRICE LEVEL OF HOSPITALS BY PATIENTS (Tabulated by Hospitals)

	A		B		C		D		Total		F		H		I		J		Total		Genera	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Very good							1	14.3	1	1.9											1	1.
Good	1	4.6	2	40	6	33.3	4	57.1	13	25	2	14.3	2	18.2	3	27.3	2	25	9	20.5	22	22.
Medium			1	20	2	11.1	1	14.3	4	7.7	2	14.3	1	9.1	4	36.4	1	12.5	8	18.2	12	12.
Insufficicat	2	9.1			2	11.1			4	7.7			2	18.2	1	9.1			3	6.8	7	7.
Very bad					2	11.1	1	14.3	3	5.8	1	7.1	2	18.2					3	6.8	6	6.
No answer don't know	19	66.4	2	40	6	33.3			27	51.9	9	64.3	4	36.4	3	27.3	5	62.5	21	47.7	48	50
TOTAL %		100		100		100		100		100		100		100		100		100		100		100
TOTAL A		22		5		18		7		52		14		11		11		8		44		96
BASE		22		5		18		7		52		14		11		11		8		44		96

TABLE 59- EVALUATION OF SERVICES IN RELATION TO PAYMENT LEVEL (Tabulated by Hospitals)

Very good					3	16.7	5	71.4	8	15.4	1	7.1	1	9.1			1	12.5	3	6.8	11	11.
Good	3	13.6	2	40	5	27.3	2	28.6	12	23.1	3	21.4	4	36.4	3	27.3			10	22.7	22	22.
Medium			1	20	3	16.7			4	7.7	2	14.3	2	18.2	5	45.5			9	20.5	13	13.
Insufficient					1	5.6			1	1.9	1	7.1	1	9.1					2	4.6	3	3.
Very bad					1	5.6			1	1.9	1	7.1							1	2.3	2	2.
No answer/don't know	19	86.4	2	40	5	27.8			26	50	6	12.9	3	27.3	3	27.3	7	63.6	19	43.2	45	46.
TOTAL %		100		100		100		100		100		100		100		100		100		100		100
TOTAL A		22		5		18		7		52		14		11		11		8		44		96
BASE		22		5		18		7		52		14		11		11		8		44		96

price is insufficient, very bad or either very good (in two hospitals, insufficiency of services is mentioned by some individuals. In minor/very minor and medium category, the largest percentage of patients have stated the service/price comparison, as very good, while in serious-very serious-hopeless cases, more patients have stated that the comparison is very good or medium. Patients in A category of socio-economic class, stated that the service/price comparison is medium, this evaluation changes in B and C category from good, very good and medium, and increases in D+E class to good categorization. The difference in A and D+E classes can be associated with different expectations about hospital services (Table 61).

When satisfaction with the interest and quality of physicians was analyzed, it was observed (Table 62) that the highest percentage of patients found this service category as very good, and good (44.8 % and 40.6 % respectively). There were no patients who stated that service of physicians were very bad. In two of the foreign and minority hospitals, there were no patients who stated that the physician services were medium or insufficient. In proprietor-owned hospitals, the evaluation of physician services as medium or insufficient is higher than that in foreign and minority hospitals (Table 62).

In minor or very minor cases, 50 % of the patients stated that services of physicians were very good, while in medium and serious category, the percentage of patients who stated as very good and good are the same, showing that as seriousness of case category increases, patients become more critical of physician services (Table 63).

It can be seen in Table 64, which present the evaluation of the services of the nurses by patients, that patients are less satisfied with these services than they are with the services of physicians (Table 64).

The highest percentage of patients stated that services of nurses were "good" (43.75) followed by very good category (38.54). In fact, there were patients who stated that nurses services were insufficient and very bad. In the two upper socio-economic classes there were no patients who stated that nurses services were very bad, this can be due to the preferential service given by nurses

TABLE 60- EVALUATION OF THE REQUESTED PRICE LEVEL OF HOSPITALS BY PATIENTS - Tabulated by case severity and socio economic class

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good			1	2		1	1.0						1	6.3			1	1.0
Good	9	3.0	9	18	4	25	22	22.9	10	27.8	1	5	3	18.8	8	33.3	22	22.9
Medium	5	16.7	6	12	1	6.3	12	12.5	7	19.4	2	10	3	18.8			12	12.5
Insufficient	2	6.7	1	2	4	16.5	7	7.3			5	25	2	12.5			7	7.3
Very bad	1	3.3	4	4	1	6.3	6	6.3	3	8.3			2	12.5	1	4.2	6	6.3
No answer/don't know	13	43.3	29	58	6	24	48	50	16	44.4	12	60	5	31.3	15	62.5	48	50
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		35		96
BASE		30		50		16		96		36		20		16		24		96

TABLE 61- EVALUATION OF SERVICES IN RELATION TO PAYMENT LEVEL - Tabulated by case severity and socio-economic cases

Very good	3	10	4	8	3	18.8	11	11.4	2	5.6	3	7.5	4	25	2	8.3	11	11.5
Good	10	33.3	10	20	2	12.5	22	22.9	4	11.1	4	20	4	25	10	41.7	22	22.9
Medium	5	16.7	5	10	3	18.8	13	13.5	6	16.7	4	20	3	18.8			13	13.5
Insufficient			1	2	2	12.5	3	3.1			2	10			1	4.2	3	3.1
Very bad			2	4			2	2.1	1	2.8			1	6.3			2	2.1
No answer/don't know	12	40	28	56	6	33.3	45	46.9	23	63.9	7	35	4	25	11	45.8	45	46.9
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

TABLE 62- EVALUATION OF QUALITY AND INTEREST OF PHYSICIANS BY PATIENTS (Tabulated by Hospitals)

	A		B		C		D		Total		F		H		I		J		Total		Genera	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Very good	10	45.5	3	60	7	38.9	4	57.1	24	46.2	3	21.4	6	54.6	5	45.5	5	62.5	19	43.2	43	44.8
Good	12	54.6	1	20	8	44.4	3	42.9	24	46.2	8	57.1	3	27.3	3	27.3	1	12.5	15	34.1	39	40.6
Medium			1	20	2	11.1			3	5.8	2	14.3	2	18.2	1	9.1			5	11.4	8	8.3
Insufficient					1	5.6			1	1.9					1	9.1	2	25	3	6.8	4	4.2
No answer/don't know											1	7.1			1	9.1			2	4.6	2	2.1
TOTAL %		100		100		100		100		100		100		100		100		100		100		100
TOTAL A		22		5		18		7		52		14		11		11		8		44		96
BASE		22		5		18		7		52		14		11		11		8		44		96

TABLE 63- EVALUATION OF QUALITY AND INTEREST OF PHYSICIANS BY PATIENTS - tabulated by case severity and socio-economic class -

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	15	50	21	42	7	43.75	43	44.8	18	50	8	40	6	37.5	11	45.8	43	44.8
Good	11	36.67	21	42	7	43.75	39	40.6	15	41.67	7	35	7	43.8	10	41.7	39	40.6
Medium	4	13.33	3	6	1	6.25	8	8.9	1	2.78	4	20	3	18.8			8	8.9
Insufficient			3	6	1	6.25	4	4.2	1	2.78					3	12.5	4	4.2
Very bad																		
No answer																		
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

TABLE 64- EVALUATION OF SERVICES OF NURSES OF HOSPITALS BY PATIENTS - tabulated by case severity and socio-economic class -

Very good	14	46.67	18	36	5	31.25	37	38.54	17	47.22	7	35	6	30	7	29.1	37	38.54
Good	12	40	21	42	9	56.3	42	43.75	14	38.89	10	50	8	40	10	41.7	42	43.75
Medium	2	6.67	4	8	1	6.3	7	7.29	2	5.56	3	15	1	5	1	4.17	7	7.29
Insufficient	1	3.33	4	8	1	6.3	6	6.25	3	8.33					3	12.5	6	6.25
Very bad	1	33.33	3	6			4	4.17					1	5	3	12.5	4	4.17
No answer/don't know							1	1.04							1	4.17	1	1.04
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

to different group of patients as a result of the tipping mechanism in practise. In hospital A, where specialized nurses are functioning due to the presence of the nurses' college, there were no patients who stated that services of nurses were medium, insufficient or bad. These three categorizations were more apparent in proprietor-owned hospitals showing that dissatisfaction with nurses' services is greater in these hospitals (Table 65).

When satisfaction of patients with the services of other medical personnel (para medical personnel working in the X-ray departments, laboratory, surgery, pharmacy) was analyzed, it was found that the majority of patients evaluated these services as good, and none as very bad. Also, only a very small percentage of patients had no idea about the services of this paramedical group. No difference was observed in this category between the services of foreign-minority hospitals and proprietor-owned hospitals (Tablo 66).

A large percentage of patients (20.8 %) in D+E socio-economic class, stated that services of paramedical personnel were insufficien (larger percentage than in any other group) (Table 67).

Also, the D+E socio-economic group is critical about the services of non-medical personnel, although the majority of patients (45.8 %) have found the services of non-medical personnel as good. The major critical group of these services is the D+E category (25 %), stating these services as insufficient or very bad. Also, a large amount of criticism come from the serious case category (18.8 % as insufficient and very bad). It is possible to conclude that these two groups are more sensitive and dissatisfied with the services of non-medical personnel. In only one foreign hospital C, services of non-medical personnel were qualified as medium, insufficient and very bad. While in proprietor-owned hospitals, the percentage of patients in these categories are higher, with dissatisfaction of patients greater in this second group than foreign-minority hospitals (Table 68-69).

LE 65- EVALUATION OF SERVICES OF NURSES BY PATIENTS - tabulated by hospitals

	A		B		C		D		Total		F		H		I		J		Total		Gener	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	
y good	11	50	2	40	4	22.2	6	35.7	23	44.2	1	7.1	6	54.6	3	27.3	4	50	14	31.8	37	38
ood	11	50	2	40	10	55.6	1	14.3	24	46.2	9	64.3	4	36.4	4	36.4	1	12.5	18	40.9		
edium					2	11.1			2	3.9	2	14.3	1	9.1	2	18.2			5	11.4		
nsufficient			1	20	1	5.6			2	3.9	1	7.1			1	9.1	2	25	4	9.1		
ery bad					1	5.6			1	1.9	1	7.1			1	9.1	1	12.5	3	6.8		
answer/don't know																						
AL %		100		100		100		100		100		100		100		100		100		100		10
AL A		22		5		18		7		52		14		11		11		8		44		9
E		22		5		18		7		52		14		11		11		8		44		9

BLE 66- EVALUATION OF THE SERVICES OF THE PARAMEDICAL GROUP BY PATIENTS - by hospitals

y good	10	45.5			4	22.2	6	85.7	20	38.5	1	7.2	4	36.4	2	18.2	3	37.5	10	22.7	30	31
ood	12	54.6	5		8	44.4	1	14.3	26	50	9	64.3	5	45.5	4	36.4	1	12.5	19	43.2	45	46
edium					4	22.2			4	7.7	2	14.3	2	18.2	3	27.3			7	15.9	11	11
nsufficient					2	11.1			2	3.9	1	7.1			1	9.1	4	50	6	13.6	8	8
ery bad																						
answer/don't know											1	7.1			1	9.1			2	4.6	2	2
AL %		100.1		100		99.9		100		100.1		99.9		100.1		100		100		100		10
AL A		22		5		18		7		52		14		11		11		8		44		9
E		22		5		18		7		52		14		11		11		8		44		9

TABLE 67- EVALUATION OF SERVICES OF PARA-MEDICAL PERSONNEL BY PATIENTS - tabulated by case severity and socio-economic class

	Minor very minor		Medium		Serious very ser. hopeless		Total		A		B		C		D+E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	10	33.3	15	30	5	31.3	30	31.3	11	30.6	9	45	5	31.3	5	20.8	30	31.3
Good	16	53.3	20	40	9	56.3	45	46.9	20	55.6	5	25	6	37.5	13	54.2	45	46.9
Medium	2	6.6	8	16	1	6.3	11	11.5	4	11.1	5	25	1	6.25	1	4.2	11	11.5
Insufficient	2	6.6	5	10	1	6.3	8	8.3	1	2.7	1	5	2	8	5	20.8	8	8.3
Very bad			2	4			2	2.1					2	8.1			2	2.1
Don't know/no answer																		
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL C		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

TABLE 68- EVALUATION OF SERVICES OF NON-MEDICAL PERSONNEL BY PATIENTS - tabulated by case severity and socio-economic class

Very good	8	26.7	12	24	5	31.3	25	26.0	9	25	5	25	5	31.25	6	25	25	26.0
Good	12	40	24	48	8	50	44	45.8	19	52.8	12	60	7	43.75	6	25	44	45.8
Medium	3	10	6	12			9	9.4	2	56	2	10	4	25	1	4.2	9	9.4
Insufficient	2	6.7	5	10	1	6.3	8	8.3	3	8.3	1	5			4	16.7	8	8.3
Very bad					2	12.5	2	2.1							2	8.3	2	2.1
Don't know/no answer	5	16.7	3	6			8	8.33	3	8.3					5	20.8	8	8.33
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL C		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

LE 69- EVALUATION OF SERVICES OF NON-MEDICAL PERSONNEL BY PATIENTS - by hospitals

	A		B		C		D		Total		I		H		I		J		Total		General	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ry good	10	45.5			3	16.7	5	71.4	18	34.6	1	7.1	3	27.3			3	37.5	7	15.9	25	26.0
od	12	54.6	5	100	5	27.8	2	28.6	24	46.2	9	64.3	5	45.5	5	45.5	1	12.5	20	45.5	44	45.8
dium					3	16.7			3	5.8	1	7.1	2	18.2	3	27.3			6	13.6	9	9.4
sufficient					2	11.1			2	3.8	2	14.3					4	50	6	13.6	8	8.3
ry bad					2	11.1			2	3.8											2	2.1
answer/																						
n't now					3	16.7			3	5.8	1	7.1	1	9.1	3	27.3			5	11.4	8	8.3
PLAM %		100.1		100		100.1		100		100		99.9		100.1		100.1		100		100		99.9
PLAM A		22		5		18		7		52		14		11		11		8		44		96
SE		22		5		18		7		52		14		11		11		8		44		96

BLE 70- EVALUATION OF MEDICAL EQUIPMENT OF HOSPITALS BY PATIENTS - tabulated by hospitals

ry good	12	54.6	4	80			4	57.2	20	38.5			2	18.2					2	4.6	22	22.9
Good	6	27.3			6	33.3	2	28.6	14	27	7	50	3	27.3	6	54.6	1	12.5	17	38.6	31	32.3
Medium	1	4.6	1	20	4	22.2	1	14.3	7	13.5	2	14.3	2	18.2	2	18.2	1	12.5	7	15.9	14	14.6
sufficient	3	13.6			5	27.8			8	15.4	4	28.6			2	18.2	3	37.5	9	20.5	17	17.7
ry bad																						
answer/																						
n't know					3	16.7			3	5.8	1	7.1	4	36.4	1	9.1	3	37.5	9	20.5	12	12.5
IAL %		100		100		100		100		100		100		100		100		100		100		100
IAL A		22		5		18		7		52		14		11		11		8		44		96
SE		22		5		18		7		52		14		11		11		8		44		96

The medical equipment were evaluated as good by 32.3 % of the patients while 22.9 % of them evaluated them as very good. There were no patients who classified medical equipment as very bad (Table 70). In foreign - minorily hospitals the largest percentage (38.5 %) of patients stated that medical equipment was very good, while in proprietor owned hospitals, 38.6 % found medical equipment as good followed by 20.5 % considering them as insufficient. This is a basic difference between two groups because most foreign hospitals acquired modern medical equipment with the assistance provided by foreign governments, whereas proprietor-owned hospitals are restricted financially in acquizition of modern equipment. Dissatisfaction with equipment is most apparent in hospitals F and G which are general hospitals. An interesting point in Table 71 is that more than any other category, the D+E group have found the medical equipment of hospitals as insufficient. So, going from group A to E, dissatisfaction with medical equipment of hospitals increases (Table 70, 71).

When the hospitals are compared on the basis of services as room, bed, toilet, telephone, it was found (Table 72) that most patients 49 % found these services as good, followed by 32.3 % who found them very good. There was not much difference between hospitals on the qualification of these services except one foreign hospital C which was criticised on these services by most of the patients (33.4 % found these services as insufficient and very bad). Also, one proprietor owned hospital J was classified as insufficient on these services by 37.5 % of the patients (same percentage as those who evaluated the services of the same hospital as very good). Patients, in minor, and very minor categories became more critical of these services (showing that as case severity decreases, services other than medical care gain importance). The same pattern of criticism is apparent in D+E category, the criticism for these services increases as we move from A to D+E socio-economic class (Table 72, 73).

The general attention, upkeep and cleanliness of hospitals were found good by 41.7 % of the patients, while 31.3 % of patients, found these services very good. In foreign-minority hospitals these services were found very good by 42.3 % of patients while this percentage fell in proprietor-owned hospitals. In proprietor owned hospitals, the percentage of patients who found these services as medium, insufficient and very bad was

TABLE 71- EVALUATION OF MEDICAL EQUIPMENT OF HOSPITALS BY PATIENTS - tabulated by case severity and socio-economic clas

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	6	20	10	20	6	37.5	22	22.9	12	33.3	5	25	3	12	2	8.3	22	22.
Good	11	36.6	16	32	4	25	31	31.3	15	41.7	10	40	4	16	2	8.3	31	32.
Medium	4	13.3	8	16	2	12.5	14	14.6	5	13.9	3	12	2	8	4	16.6	14	14.
insufficient	4	13.3	11	22	3	18.75	17	17.7	1	2.8			4	16	12	50	17	17.
very bad																		
don't know/no answer	5	16.7	5	10	1	6	12	12.5	3	8.3	2	8	3	18.75	4	16.7	12	12.
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

ABLE 72- EVALUATION OF SERVICES OF HOSPITALS AS ROOM BED TOILET TELEPHONE tabulated by hospitals

	A		B		C		D		Total		J		H		I		J		Total		Genera	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ery good	12	54.5			2	11.1	5	71.4	19	36.5	1	7.1	5	45.5	3	27.3	3	37.5	12	27.3	31	32.
Good	10	45.5	4	80	8	44.4	1	14.3	23	44.2	12	85.7	6	54.6	4	36.4	2	25	24	54.6	47	49
ledium			1	20	2	11.1	1	14.3	4	7.7	1	7.1			3	27.3			4	11.4	8	8.
nsufficient					3	16.7			3	5.8							3	37.5	3	6.8	6	6.
ery bad					3	16.7			3	5.8											3	3.
o answer/																						
on't know															1	9.1					1	1
OTAL %		100		100		100		100		100		99.9		100.1		100.1		100		100.1		100
OTAL A		22		5		18		7		52		14		11		11		8		44		96
BASE		22		5		18		7		52		14		11		11		8		44		96

TABLE 73- EVALUATION OF SERVICES OF HOSPITALS LIKE ROOM, BED, TOILET, TELEPHONE - tabulated by case severity and socio-economic class -

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
very good	4	13.3	22	44	5	31.3	31	32.3	14	38.88	7	35	5	25	5	20.8	31	32.3
good	20	66.66	20	40	7	43.8	47	49	16	44.44	12	60	9	45	10	41.7	47	49
medium	1	3.33	5	10	2	4	8	8.3	6	16.7	1	5	1	5			8	8.3
insufficient	3	10	3	6			6	6.3							6	25	6	6.3
very bad	1	3.33			2	4	3	3.1					1	5	2	8.3	3	3.1
no answer/don't know	1	3.33					1	1							1	4.2	1	1
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

higher than that in foreign and minority owned hospitals (Table 74). The minor/very minor case category was more critical of these services than serious, very serious and hopeless categories, also as we move from A to D&E socio-economic class, criticism increase, showing that these two groups, (minor case category and lower socio-economic class) are more critical of services other than medical ones (Table 74, 75).

The location of the hospital was found to be good by 49 % of the patients, two hospitals (A and J) which are located on the same site, received the same kind of criticism as being insufficient and very bad. Also, the maternity hospital was found to be located on a somewhat unsuitable site by a large percentage of consumers (18.2 %). The D+F category did not have criticism on the site of the hospital, but A, B, C socio-economic classes appear to be more critical on this attribute (Table 76, 77).

When the patients were asked to compare the present hospital with the other hospitals that they were acquianted with, the results showed that in general the present hospitals were found to be good by 37.5 % while in foreign-minority hospitals an equal percentage of patients found present hospitals very good and good. None of the patients found the hospital as very bad compared with the other hospitals that he knows. An interesting factor is that the majority of patients in D E socio-economic class (37.5 %) have found the present hospitals as inferior compared to those hospitals that they know. The same criticism appears in the minor and very minor case category (Table 78, 79).

Patients, stated that private hospital services are in accordance with the recommendations of their acquiantances. Most of the patients stated that services of these hospitals can be evaluated as good in face of the recommendations. The percentage of patients who state that services are medium is second. For foreign, minority hospitals, services of these hospitals are stated as very good (30.8 %) by a larger percentage of patients than the proprietor-owned hospitals. So, it is possible to state that services of private hospitals (especially foreign-minority owned) are in accordance with the general expectations of the patients when compared with the recommendations of their acquiantances. The high percentage of serious, very serious and hopeless cases have stated that the hospital services are insufficient when compared

ABLE 74- EVALUATION OF THE GENERAL ATTENTION UP KEEP AND CLEANLINESS OF HOSPITALS BY PATIENTS - tabulated by hospitals

	A		B		C		D		Total		J		H		I		J		Total		Genera	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ery good	16	72.7	1	20	3	16.7	2	28.6	22	42.3	2	14.3	1	9.1	2	18.2	3	37.5	8	18.2	30	31.3
ood	5	22.7	3	60	7	38.9	2	28.6	17	32.7	10	71.4	7	63.6	5	45.5	1	12.5	23	52.3	40	41.7
edium	1	4.6	1	20	3	16.7	1	14.3	6	11.5	2	14.3			3	27.3			5	11.4	11	11.5
nsufficient					3	16.7	1	14.3	4	7.7			3	27.3			4	50	7	15.9	11	11.5
ery bad					2	11.1	1	14.3	3	5.8											3	3.1
o answer/ on't know															1	9.1			1	2.3	1	1.0
OTAL %		100		100		100.1		100.1		100		100		100.1		100		100		100		100
OTAL A		22		5		18		7		52		14		11		11		8		44		96
ASE		22		5		18		7		52		14		11		11		8		44		96

TABLE 75- EVALUATION OF THE GENERAL ATTENTION, UP KEEP AND CLEANLINESS OF HOSPITALS BY PATIENTS - Tabulated by case severi y and socio-economic class

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	6	20	22	44	2	12.5	30	31.3	16	44.4	9	45	4	25	1	4.2	30	31.3
Good	18	60	17	34	5	31.3	40	41.7	14	38.8	8	40	8	50	10	41.7	40	41.7
Medium	2	6.7	5	10	4	25	11	11.5	6	16.2	2	10	1	6.3	2	8.3	11	11.5
Insufficient	2	6.7	4	8	5	31.3	11	11.5					2	12.5	9	37.5	11	11.5
Very bad	1	3.3	2	4			3	3.1			1	5	1	6.3	1	4.2	3	3.1
No answer/don't know	1	3.3					1	1.0							1	4.2	1	1.0
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

TABLE 76- EVALUATION OF THE LOCATION OF THE HOSPITALS BY THE PATIENTS - tabulated by hospitals

	A		B		C		D		Total		I		H		I		J		Total		Gener	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	
Very good	10	45.5			5	27.8	4	57.1	19	36.5			4	36.4	3	27.3	3	37.5	10	22.7	29	30
Good	8	36.4	4	80	9	50	1	14.3	22	42.3	14	100	6	54.6	5	45.5			25	56.8	47	49
Medium	2	9.1	1	20	4	22.2			7	13.5			1	9.1	1	9.1	3	37.5	5	11.4	12	12
Insufficient	1	4.6					2	28.6	3	5.8					2	18.2	1	12.5	3	6.8	6	6
Very bad	1	4.6							1	1.9							1	12.5	1	2.3	2	2
No answer/ don't know																						
TOTAL %		100		100		100		100		100		100		100		100		100		100		10
TOTAL A		22		5		18		7		52		14		11		11		8		44		9
BASE		22		5		18		7		52		14		11		11		8		44		9

TABLE 77- EVALUATION OF THE LOCATION OF THE HOSPITAL BY THE PATIENTS - Tabulated by case severity and socio-economic cl

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	12	40	11	22	6	37.5	29	30.2	11	30.6	7	35	3	18.8	8	33.3	29	30.
Good	15	50	25	50	7	43.8	47	49	19	52.8	3	15	11	68.8	14	58.3	47	49
Medium	2	6.7	8	16	2	12.5	12	12.5	3	8.3	6	30	1	6.3	2	8.3	12	12.
Very bad	1	3.3			1	12.5	2	2.1			2	10					2	2.
Insufficient			6	12			6	6.3	3	8.3	2	10	1	6.3			6	6.
No answer/don't know																		
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

ABLE 78- COMPARISON OF THE SERVICES OF THE PRESENT HOSPITAL WITH OTHER HOSPITALS - tabulated by hospitals

	A		B		C		D		Total		I		H		I		J		Total		Gener	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	
'ery good	10	45.5	1	20	4	22.2	4	57.1	19	36.5	1	7.1	1	9.1	1	9.1	2	25	5	11.4	24	25
Good	10	45.5	3	60	3	16.7	3	42.9	19	36.5	7	50	5	45.5	5	45.5			17	38	36	37.
Medium			1	20	4	22.2			5	9.6	2	14.3	2	18.2	3	27.3	6	75	13	29.5	18	18.
Insufficient	2	9.1			4	22.2			6	11.5	1	7.1	2	18.2	2	18.2			5	11.4	11	11.
Very bad																						
No answer/ don't know					3	16.7			3	5.8	3	21.4	1	9.1					4	9.1	7	7.
TOTAL %		100		100		100		100		100		100		100		100		100		100		100
TOTAI A		22		5		18		7		52		14		11		11		8		44		96
BASE		22		5		18		7		52		14		11		11		8		44		96

TABLE 79- COMPARISON OF THE SERVICES OF THE PRESENT HOSPITAL WITH OTHER HOSPITALS - Tabulated by case severity and socio economic class

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D + E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	8	26.7	13	26	3	18.8	24	25	10	27.8	5	25	3	18.8	6	25	24	25
Good	14	46.7	16	32	6	37.5	36	37.5	16	44.4	13	65	6	37.5	1	4.2	36	37.5
Medium	4	13.3	8	16	6	37.5	18	18.8	4	11.1	1	5	7	43.8	6	25	18	18.8
Insufficient	4	13.3	6	12	1	6.3	11	11.5	1	2.8	1	5			9	37.5	11	11.5
Very bad																		
No answer/don't know			7	14			7	7.4	5	13.9					2	8.3	7	7.4
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

E 80- EVALUATION OF HOSPITALS SERVICES IN RELATION TO THE RECOMMENDATIONS OF ACQUIANTANCES. - tabulated by hospitals

	A		B		C		D		Total		I		H		I		J		Total		General	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
good	9	40.9			1	5.6	6	85.7	16	30.8	1	7.14	1	9.1	1	9.1	2	25	5	11.36	21	21.9
od	8	36.4	4	80	4	22.2	1	14.3	17	32.7	8	57.1	6	54.5	6	54.6			20	45.5	37	38.5
dium	5	22.7	1	20	9	50			15	28.8	2	14.3	4	36.4	3	27.3	5	62.5	14	31.8	29	30.2
fficient					4	22.2			4	7.7	2	14.3							2	4.5	6	6.25
bad																						
nswer/ t know											1	7.14			1	9.1	1	12.5	3	6.8	3	3.1
L %		100		100		100		100		100		100		100		100		100		100		100
L A		22		5		18		7		52		14		11		11		8		44		96
		22		5		18		7		52		14		11		11		8		44		96

TABLE 81- EVALUATION OF HOSPITAL SERVICES IN RELATION TO THE RECOMMENDATIONS OF ACQUIANTANCES - Tabulated by case severity and socio-economic class

	minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
Very good	7	23.3	10	20	4	25	21	21.9	9	25	7	35	4	25	1	4.2	21	21.9
Good	13	43.3	17	34	7	49.8	37	38.5	17	47.2	10	50	6	37.5	4	25	37	38.5
Medium	6	20	20	40	3	18.8	29	30.2	6	16.6	3	15	2	12.5	18	75	29	30.2
Insufficient	2	6.7	4	8	2	12.5	6	6.3	4	11.1			2	12.5			6	6.3
Very bad																		
No answer/don't know	2	6.7	1	2			3	31					2	12.5	1	4.2	3	3.1
TOTAL %		100		100		100		100		100		100		100		100		100
TOTAL A		30		50		16		96		36		20		16		24		96
BASE		30		50		16		96		36		20		16		24		96

with the recommendations of their acquiantances (Table 80, 81).

TABLE 82- SERVICES WHICH HAVE THE HIGHEST PERCENTAGE OF THE SAMPLE IN EACH EVALUATIVE CATEGORY

44.8 %	Quality of physician services	(very good)
48.9 %	Room-bed, toilet, telephone services the location of the hospital	(good)
12.5 %	The quality of medical equipment services of the hospital when compared with other hospitals	(medium)
6.3 %	The quality of medical equipment services of the hospital when compared with other hospitals	(insufficient)
3.1 %	The requested price level of hospital services	(very bad)
44.8 %	The requested price level of hospital services	(do not know)

* Table 82 is summarization of Tables 83-88 which show the percentages of the sample that place hospital services in each evaluative category.

The above table is given to show which service categories have the highest percentage in six evaluative category. As can be seen, the "very good" evaluation is earned by the highest percentage only in the case of physicians services.

Patients are satisfied with room, bed, toilet, and telephone services of the hospital together with the site of the hospital. The quality of medical equipment and services of the hospital when compared with other hospitals are stated as insufficient or medium. The major criticism is on the price level of the hospitals. So requested price level of hospital services is the major factor that leads to complaints of the patients (it is important to note that services compared with payment level is not a major critical factor:

The below table shows the satisfaction level of patients associated with each individual hospital (Table 89).

TABLE 83- THE PERCENTAGE OF THE SAMPLE THAT PLACE HOSPITAL SERVICES IN VERY GOOD CATEGORY - Tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		General	
	K19	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Services in relation to payment level	y					3	16.7	5	71.4	8	15.4	1	7.1	1	9.1			1	12.5	3	6.8	11	11.5
The requested price level	x							1	14.3	1	1.9											1	1.0
The interest and quality of physicians	0	10	45.5	3	60	7	38.9	4	57.1	24	46.2	3	21.4	6	54.6	5	45.5	5	62.5	19	43.2	43	44.8
The interest and quality of nurses	1	11	50	2	40	4	22.2	6	42.9	24	46.2	1	7.1	6	54.6	3	27.3	4	50	14	2.3	38	39.6
The interest and quality of medical personnel	2	10	45.5			4	22.2	6	42.9	20	38.5	1	7.1	4	36.4	2	18.2	3	37.5	10	22.7	30	31.3
The interest and quality of other personnel	3	10	45.5			3	16.7	5	71.4	18	34.6	1	7.1	3	27.3			3	37.5	7	15.9	25	26.0
Medical capacity equipment	4	12	54.6	4	80			4	57.1	20	38.5			2	18.2					2	4.6	22	22.9
Room, bed, toilet telephone and like services	5	12	54.6			2	11.1	5	71.4	19	36.5	1	7.1	5	45.5	3	27.3	3	37.5	12	27.3	31	32.3
General care and cleanliness	6	16	72.7	1	20	3	16.7	5	71.4	25	48.1	2	14.3	1	9.1	2	18.2	3	37.5	8	18.2	33	34.4
The site of the hospital	7	10	45.5			5	27.8	4	57.1	19	36.5			4	36.4	3	27.3	3	37.5	10	22.7	29	30.2
This hospital compared with others that you know	8	10	45.5	1	20	4	22.2	4	57.1	19	36.5	1	7.1	1	9.1	1	9.1	2	25	5	11.4	24	25
This hospital compared to the recommendation of acquiantances	9	9	40.9			1	5.6	6	42.9	16	30.8	1	7.1	1	9.1	1	9.1	2	25	5	11.4	21	21.1

BLE 84- THE PERCENTAGE OF THE SAMPLE THAT PLACE HOSPITAL SERVICES IN "GOOD" CATEGORY. - tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		General	
	K20	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ervices in relation to payment level	y	2	9.1	2	40	4	22.2	2	28.6	10	19.2	3	21.4	4	36.4	3	27.3			10	22.7	20	20.8
he requested price level	x	1	4.6	2	40	5	27.8	4	57.1	12	23.1	2	14.3	1	9.1	3	27.3	2	25	8	18.2	20	20.8
he interest and quality of physicians	0	13	59.1	1	20	8	44.4	3	42.9	25	48.1	9	64.3	3	27.3	3	27.3	1	12.5	16	36.4	41	42.7
he interest and quality of nurses	1	11	50	2	40	10	55.6	1	14.3	24	46.2	9	64.3	4	36.4	4	36.4	1	12.5	18	40.9	42	43.8
he interest and quality of medical personnel	2	12	54.6	5	100	8	44.4	1	14.3	26	50	9	64.3	5	45.5	4	36.4	1	12.5	19	43.2	45	46.9
he interest and quality of other personnel	3	12	54.6	5	100	5	27.8	2	28.8	24	46.2	9	64.3	5	45.5	5	45.5	1	12.5	20	45.5	44	45.8
edical capacity, equipment	4	6	27.3			6	33.3	2	28.8	14	26.9	7	50	3	27.3	6	54.6	1	12.5	17	38.6	31	32.3
oom, bed, toilet telefone and like services	5	10	45.5	4	80	8	44.4	1	14.3	23	44.2	12	85.7	6	54.6	4	36.4	2	25	24	54.6	47	48.9
eneral care and cleanliness	6	5	22.7	3	60	7	38.9	2	28.6	17	32.7	10	71.4	7	63.6	5	45.5	1	12.5	23	52.3	40	41.7
he site of the hospital	7	8	36.4	4	80	9	50	1	14.3	22	42.3	14	100	6	54.6	5	45.5			25	56.8	47	48.9
his hospital compared with others that you know	8	10	45.5	3	60	3	16.7	3	42.9	19	36.5	7	50	5	45.5	5	45.5			17	38.6	36	37.5
his hospital compared to the recommendations of acqiantances	9	8	36.4	4	80	4	22.2	1	14.3	17	32.7	8	57.1	6	54.6	6	54.6			20	45.5	37	38.6

TABLE 85- THE PERCENTAGE OF THE SAMPLE THAT PLACE HOSPITAL SERVICES IN "MEDIUM" CATEGORY

		A		B		C		D		Total		F		H		I		J		Total		General	
	K21	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Services in relation to payment level	y			1	20	2	11.1			3	5.8	1	9.1	5	45.5			8	18.2	14	31.8	17	17.8
The requested price level	x			1	20	1	5.6	1	14.3	3	5.8	1	9.1	4	36.4			7	15.9	12	27.3	15	15.6
The interest and quality of physicians	0			1	20					1	1.9	2	18.2	1	9.1			5	11.4	8	18.2	9	9.1
The interest and quality of nurses	1											1	9.1	2	18.2			5	11	8	18.2	8	8.3
The interest and quality of medical personnel	2	1	4.6			2	11.1			3	5.8	2	18.2	3	27.3					5	11.4	8	8.3
The interest and quality of other personnel	3	1	4.6			3	16.7			4	7.7	2	18.2	1	9.1					3	6.8	7	7.3
Medical capacity equipment	4	1	4.6	1	20	4	22.2	1	14.3	6	11.5			2	18.2	1	12.5			3	6.8	9	9.2
Room, bed, toilet, telephone and like services	5	1	4.6	1	20	2	11.1	1	14.3	4	7.7			3	27.3					3	6.8	7	7.3
General care and cleanliness	6	2	9.1	1	20	1	5.6			3	5.8			3	27.3					3	6.8	6	6.3
The site of the hospital	7	1	4.6	1	20					2	3.9	3	27.3	1	9.1					4	9.1	6	6.1
This hospital compared with others that you know	8			1	20	4	22.2			5	9.6	2	18.2	3	27.3					5	11.4	10	10.1
This hospital compared to the recommendations of acquiantances	9			1	20	1	5.6			2	3.9			3	27.3					3	6.8	5	5.

TABLE 86- THE PERCENTAGE OF THE SAMPLE THAT PLACE HOSPITAL SERVICES IN "INSUFFICIENT" CATEGORY - tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.22	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Services in relation to payment level	y					1	5.6			1	1.9			1	9.1					1	2.3	2	2.1
The requested price level	x					1	5.6			1	1.9			1	9.1	1	9.1			2	4.6	3	3.1
The interest and quality of physicians	0					1	5.6			1	1.9					1	9.1			1	2.3	2	2.1
The interest and quality of nurses	1					1	5.6			1	1.9	1	7.1			1	9.1			2	4.6	3	3.1
The interest and quality of medical personnel	2					2	11.1			2	3.9	1	7.1							1	2.3	3	3.1
The interest and quality of other personnel	3					2	11.1			2	3.9	2	14.3							2	4.6	4	4.2
Medical capacity equipment	4					2	11.1			2	3.9	2	14.3			2	18.2			4	9.1	6	6.3
Room, bed, toilet, telephone and like services	5					3	16.7			3	5.8											3	3.1
General care and cleanliness	6					3	16.7			3	5.8											3	3.1
The site of the hospital	7	1	4.6					2	28.6	3	5.8							1	12.5	1	2.3	4	4.2
This hospital compared with others that you know	8					2	11.1			2	3.9	1	7.1	2	18.2	1	9.1			4	9.1	6	6.3
This hospital compared to the recommendations of acquiantances	9					4	22.2			4	7.7	1	7.1							1	2.3	5	5.2

LE 87- THE PERCENTAGE OF THE SAMPLE THAT PLACE HOSPITAL SERVICES IN "VERY BAD" CATEGORY - tabulated by hospitals.

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.23	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
rvices in relation																							
payment level	y					1	5.6			1	1.9	1	7.1							1	2.3	2	2.1
e requested price																							
vel	x					1	5.6			1	1.9			2	18.2					2	4.6	3	3.1
e interest and quality																							
physicians	0					1	5.6			1	1.9											1	1.0
e interest and																							
ality of nurses	1																						
e interest and quality																							
paramedical personnel	2																						
e interest and quality																							
other personnel	3																						
dical capacity																							
uipment	4																						
om, bed, toilet																							
lephone and like																							
rvices	5					1	5.6			1	1.9											1	1.0
neral care and																							
eanliness	6					2	11.1			2	3.9											2	2.1
e site of the																							
spital	7	1	4.6							1	1.9			1	9.1					1	2.3	2	2.1
is hospital compared																							
th others that you																							
ow	8																						
is hospital compared																							
the recommendations																							
acquiantances	9																						

TABLE 88- THE PERCENTAGE OF THE SAMPLE THAT PLACE HOSPITAL SERVICES IN "DO NOT KNOW" CATEGORY - tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		Genera	
	K.22	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
Services in relation to payment level	y	19	86.4	2	40	5	27.8			26	50	6	42.9	3	27.3	3	27.3			12	27.3	38	39.6
The requested price level	x	19	86.4	2	40	6	33.3			27	51.9	9	64.3	4	36.4	3	27.3			16	13.6	43	44.8
The interest and quality of physicians	0	1	4.6							1	1.9	1	7.1			1	9.1			2	4.6	3	3.1
The interest and quality of nurses	1											1	7.1			1	9.1			1	2.3	1	1.0
The interest and quality of paramedical personnel	2											1	7.1			1	9.1			2	4.6	2	2.1
The interest and quality of other personnel	3					2	11.1			2	3.9	1	7.1	1	9.1	4	36.4			6	13.6	8	8.3
Medical capacity equipment	4	4	18.2			3	16.7			7	23.1	1	7.1	4	36.4	3	27.3			8	18.2	15	15.6
Room, bed, toilet telephone and like serv.	5															1	9.1			1	2.3	1	1.0
General care and cleanliness	6															1	9.1			1	2.3	1	1.0
The site of the hospital	7	2	9.1							2	13.5											2	2.1
This hospital compared with others that you know	8	2	9.1			3	16.7			5	9.6	3	21.4	1	9.1	1	9.1			5	11.4	10	10.4
This hospital compared to the recommendations of acquintances	9					1	5.6			1	1.9	1	7.1	1	9.1	1	9.1			3	6.8	4	4.2

LE 89- SATISFACTION LEVEL OF PATIENTS ASSOCIATED WITH EACH INDIVIDUAL HOSPITAL

	Hospital A	Hospital B	Hospital C	Hospital D	Hospital F	Hospital H	Hospital I	Hospital J
y good	general attention, upkeep and cleanliness	quality of medical equipment	quality of physicians	-services/price level -quality of non medical personnel	quality of physicians —	-quality of physicians -quality of nurses	quality of physicians	quality of physicians
d	quality and interest of the physicians	quality of paramedical staff, quality and interest of nonmedical personnel	quality of nurses	-bed, room and other services -care and upkeep of hospitals -demanded payment pattern.	-site of the hospital	-care and general attention	-quality of medical equipment -service level compared with the recommendations of relatives -other services	demanded payment pattern -room, bed, toilet and telephone services
ium	general care and cleanliness	other services	other services	other services	other services	other services	other services	other services
uf- ient	the cite on which the hospital is situated, the cite on which the hospital is situated	-	service level compared with the recommendations of relatives	the site of the hospital	-interest of non-medical personnel -quality of medical equipment	-services compared with the services of other hospitals	quality of medical equipment	site of the hospital building
y bad	"		quality of care and cleanliness	-	services/ price level	demanded payment pattern	-	-
t know	-price of services -services compared with price structure	price of services, services compared with price struct.	price of services	-	price of services	price of services, quality of medical equipment	interest of other non-medical personnel	-

It was thought that same correlation might exist between the evaluation of services by patients and their previous experiences with hospital services. So we segmented those who had previously stayed in a hospital and those that had not. The results are tabulated in TABLE 90. Those that had stayed in the hospital found the services compared with payment level of hospitals as good; compared with a smaller percentage of the patients in the first category. Also, price structure of hospital services were found to be good by 25 % of patients with prior experience compared with those patients who had stayed in the hospital for the first time. A larger percentage of patients (50 %) with first experience with hospitals found the services of physicians as very good, also quality of nurses staff was defined to be very good, by the same group, whereas those with prior experience criticised the nurses staff more than the other group.

The patients with prior experience with hospital services stated the quality of paramedical personnel and non-medical personnel as better than those with no experience but still insufficiency of service by this personnel is more predominant in the first group. The same pattern of evaluation can be found in relation to other services in the list, so it can be stated that patients with prior experience in hospital services, act more critically in the evaluation of the hospitals in question.

Table 91, shows the intention of patients to recommend the hospital to their relatives and relations. A large majority 51 % stated "yes" when asked about their intention of recommending the hospital to their relatives and relations. Only 13.6 % stated definitely that they will recommend the hospital to their acquiantances, 23 % of the patients stated that this would depend on a number of conditions, as the income of the acquiantance, the physician who diagnoses the case. 9.4 % of the patients, answered in the negative. In foreign-minority hospitals, 11.5 % of the patients refused to refer their acquiantances to the particular hospital, while 6.9 % of patients of proprietor hospitals were negative, showing more satisfaction of present patients with the services of the second group of hospitals. A larger percentage of serious, very serious and hopeless cases refused to have any infention of referring their patients to the particular hospital. The same negative intention is seen in D+E socio-economic group. In the analysis of satisfaction with hospital services, it was

90- EVALUATION OF SERVICES OF HOSPITALS BY PATIENTS, WITH FIRST Stay in hospital and prior stay in the hospital

	SERVICES COMPARED TO PRICE LEVEL						REQUESTED PRICE LEVEL						SERVICES OF PHYSICIANS						SERVICES OF NURSES					
	First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		Gene	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	
good	3	7.5	8	14.3	11	11.5	1	2.5			1	1.04	20	50	23	41.1	43	44.8	21	52.5	16	28.6	37	3
	11	27.5	11	19.6	22	22.9	8	20	14	25	22	22.9	14	35	25	44.6	39	40.6	12	30	30	53.6	42	
ium	5	12.5	8	14.3	13	13.5	4	10	8	14.3	12	2.08	2	5	6	10.7	8	8.33	2	5	5	8.9	7	
fficient	2	5	1	1.8	3	3.1	2	5	5	8.9	7	7.3	2	5	2	3.6	4	4.2	3	7.5	3	5.4	6	
bad			2	3.6	2	2.1	2	5	4	7.1	6	6.3	2	5			2	2.1	2	5	1	1.8	1	
nswer	19	47.5	26	46.4	45	46.9	23	57.5	25	44.6	48	50									1	1.8	1	
%		100		100		100		100		100		100		100		100		100		100		100		10
A		40		56		96		40		56		96		40		56		96		40		56		9
		40		56		96		40		56		96		40		56		96		40		56		9

E 90- (Cont.)

	SERVICES COMPARED TO PRICE LEVEL						REQUESTED PRICE LEVEL						SERVICES OF PHYSICIANS						SERVICES OF NURSES					
	First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		Gene	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	
good	17	42.5	13	23.2	30	31.3	13	32.5	12	21.4	25	26.04	11	27.5	11	19.6	22	22.9	15	37.5	16	28.6	31	3
	14	35	31	55.4	45	46.8	14	35	30	53.6	44	45.8	14	35	17	30.4	31	32.3	16	40	31	55.4	47	4
um	5	12.5	6	10,7	11	11.5	3	7.5	6	10.7	9	9.4	5	12.5	9	16.1	14	14.6	3	7.5	5	8.9	8	
fficient	1	2.5	7	12.5	8	8.33	4	10	4	7.1	8	8.33	7	17.5	10	17.8	17	17.7	4	10	2	3.6	6	
bad									2	3.6	2	2.1									3	5.4	3	
swer	1	2.5	1	1.8	2	2.08	6	15	2	3.6	8	8.33	3	7.5	9	16.1	12	2.1	2	25			2	
%		100		100		100		100		100		100		100		100		100		100		100		1
A		40		56		96		40		56		96		40		56		96		40		56		
		40		56		96		40		56		96		40		56		96		40		56		

LE 90- (Cont.)

	SERVICES COMPARED TO PRICE LEVEL						REQUESTED PRICE LEVEL						SERVICES OF PHYSICIANS						SERVICES OF NURSES					
	First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		General		First stay in the hosp.		Prior stay in the hosp.		Gene	
	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	
y good	13	32.5	16	28.6	30	31.3	12	30	17	30.4	29	30.2	12	30	12	21.4	24	25	5	12.5	16	28.6	21	
od	15	37.5	25	44.6	40	41.6	15	37.5	32	57.24	47	48.9	11	27.5	24	42.9	36	37.5	16	40	21	37.5	37	
dium	2	5	9	16.1	11	11.5	6	15	6	10.7	12	12.5	8	20	10	17.9	18	18.8	7	17.5	22	39.3	29	
sufficient	9	22.5	2	3.6	11	11.5	6	15	10	17.8	16	16.7	4	10	7	12.5	11	11.5	2	5	4	7.14	6	
ry bad	1	2.5	2	3.6	3	3.12	4	10	2	3.6	6	6.3												
answer			1	1.8	1	1.04	1	2.5	1	1.8	2	2.1	5	12.5	2	3.6	7	7.3	7	7.3	3	5.4	3	
AL %		100		100		100		100		100		100		100		100		100		100		100		
AL A		40		56		96		40		56		96		40		56		96		40		56		
		40		56		96		40		56		96		40		56		96		40		56		

BLE 91- THE INTENTION OF PATIENTS IN RECOMMENDATION OF THE HOSPITAL TO ACQUIANTANCES - tabulated by hospitals

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.34	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
st probably	y			1	20	4	22.2	1	14.3	6	11.5			2	18.2	1	9.1	4	50	7	15.9	13	13.6
s	x	16	72.7	3	60	7	38.9	5	71.4	31	59.6	9	64.3	3	27.3	3	27.3	3	37.5	18	40.9	49	51
ssible	0	5	22.7	1	20	3	16.7			9	17.3	2	14.3	6	54.6	5	45.5	1	12.5	14	31.8	23	24
	1	1	4.6			3	16.7	1	14.3	5	9.6	1	7.14			1	9.1			2	4.6	7	7.3
ever	2					1	5.6			1	1.9					1	9.1			1	2.3	2	2.1
answer/don't know	3											2	14.3							2	4.6	2	2.1
TAL %			100		100		100		100		100		100.1		100.1		100.1		100		100.1		100.1
TAL A			22		5		18		7		52		14		11		11		8		44		96
ASE			22		5		18		7		52		14		11		11		8		44		96

TABLE 92- THE INTENTION OF PATIENTS IN RECOMMENDATION OF THE HOSPITAL TO ACQUIANTANCES - tabulated by case severity and socio-economic class

		minor very minor		medium		serious very ser. hopeless		Total		A		B		C		D+E		Total	
	K.34	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%	C	%
most probably	y	3	10	4	8	6	37.5	13	13.1	1	2.77	4	20	3	18.75	5	20.8	13	13.6
yes	x	16	53.3	26	52	7	43.8	49	51	20	55.55	7	35	10	62.5	12	50	49	57
possible	0	9	30	14	28			23	24	10	27.77	8	40	1	6.25	4	16.7	23	24
no	1	1	3.3	3	6	3	18.75	7	73	4	11.11	1	5	2	12.5			7	7.3
never	2	1	3.3	1	2			2	2.1	1	2.77					1	4.2	2	2.1
no answer/don't know	3			2	4			2	2.1							2	8.4	2	2.1
TOTAL %			100		100		100		100		100		100		100		100		100
TOTAL A			30		50		16		96		36		20		16		24		96
BASE			30		50		16		96		36		20		16		24		96

seen that this socio-economic group was the major one in criticism of hospital services. So, it is appropriate that this group should be the one holding negative intention for referral to particular hospital (Table 91, 92).

The major reasons for the referral of relatives and acquiantances to the particular hospital are careful service, cleanliness and order of the hospital, interest and understanding of physicians. Among the choice criteria cited by the current patients, the major one was the quality of physician service while this loses its importance in the referral pattern. The major reason may be the personal character of the physician services related to the individual patient. Every patient feels trust in a particular physician, this changes according to psychological factors of the individual (level of anxiety and fear) and the diagnosis. So, in the choice of a particular hospital for himself, physicians' services are of major importance, while recommending it to another person, it depends on the diagnosis of the individual and this criteria loses its importance. Other factors cited for the referral of the hospital are home like comfort, satisfaction with everything in the hospital and the quality of nurses' services. Others can be observed in Table 93.

The reasons for the non-referral of patients, are tabulated in Table 94. The major ones are that the hospital services got worse when compared with past conditions of the same hospital. The insufficiency of cleanliness, of service, and of the personnel are the other reasons influencing the patients in rejecting the hospital in the referral process to other individuals. The lack of a garden is an interesting reason for influencing the evaluation of hospital services. Also the inadequacy of equipment for maternity services and also lack of personnel and equipment for important surgical processes are some of the other reasons. Also, a majority of the patients prefer to leave the choice to the individual because of the importance of the decisions pertaining to problems of life and death (Table 94).

ABLO 93- REASONS FOR THE REFERRAL TO ACQUAINTANCES BY PATIENTS TO THE PARTICULAR HOSPITAL - tabulated by hospitals -

		A		B		C		D		Total		F		H		I		J		Total		General	
	K.25	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ood medical service	y	12	48 75	1	16.7	6	31.6 54.6	1	12.8 14.3	20	35.8 54.1	3	23.1 33.3	2	25 40	2	33.3 50	2	28.6	9	26.5 36	29	32.6 46.8
leanliness and orderly	x	2	8 12.5	3	50	2	10.5 18.2			7	12.5 18.9	4	30.8 44.4			2	33.3 50			6	17.6 24	13	14.6 20.9
hysicians are dependable and interested	0					4	21.1 36.4			4	7.14 10.8			2	25 40			1	14.3	3	8.8 12	7	7.9 11.3
urses are interested	1													2	25 40			1	14.3	3	8.8 12	3	3.3 4.8
ualified physicians	2	4	16 25	1	16.7	1	5.26 9.1			6	10.7 6.2					1	16.6 25			1	2.9 4	7	7.9 11.2
ome-like comfort	3					1	5.26 9.1	1	12.8 14.3	2	3.6 5.41							1	14.3	1	2.9 4	3	3.3 4.84
atisfied with everything	4	2	8 12.5					2	29.8 33.3	4	7.14 10.8	1	7.6 11.1							1	2.9 4	5	5.61 8.06
rivate nurse service	5	1	4 6.25							1	0.66 2.7											1	1.1 1.6
ot noisy	6					1	5.26 9.1			1	0.66 2.7											1	1.1 1.6
omfortable room	7					1	5.26 9.1			1	0.66 2.7											1	1.1 1.6
eautiful	8					1	5.26 9.1			1	0.66 2.7											1	1.1 1.6
eneral service-good	9	1	4 6.25							1	0.66 2.7											1	1.1 1.6
	K.24																						
ersonnel is close to patients	4	2	8 12.5			1	5.26 9.1	3	44.7 50	6	10.7 16.2	3	23.1 33.3	2	25 40			1	14.3	6	17.6 24	11	12.4 17.74
he visiting hours are well regulated	5											1	7.6 11.1							1	2.9 4	1	1.1 1.6
etter hospital	6						5.26				0.66										2.9		2.3
no answer	7	1	4			1	9.1			1	2.7							1	14.3	1	4	2	3.23
odern equipment	8		6.25							1	0.66 2.7	1	7.6 11.1			1	16.6 25			2	1.5 8	3	3.3 4.84
ull-service and ully equipped	9			1	16.7					1	0.66 2.7											1	1.1 1.6
OTAL %			100 156		100		100 172.9		100 111.9		100 151.31		100 144.3		100 160		100 160		100		136		100 143.5
OTAL A			25		6		19		9		56		13		8		6		7		32		90

ABLE 94- REASONS FOR THE NON-REPEAL OF HOSPITALS TO ACQUIANTANCES BY PATIENTS - tabulated by hospitals -

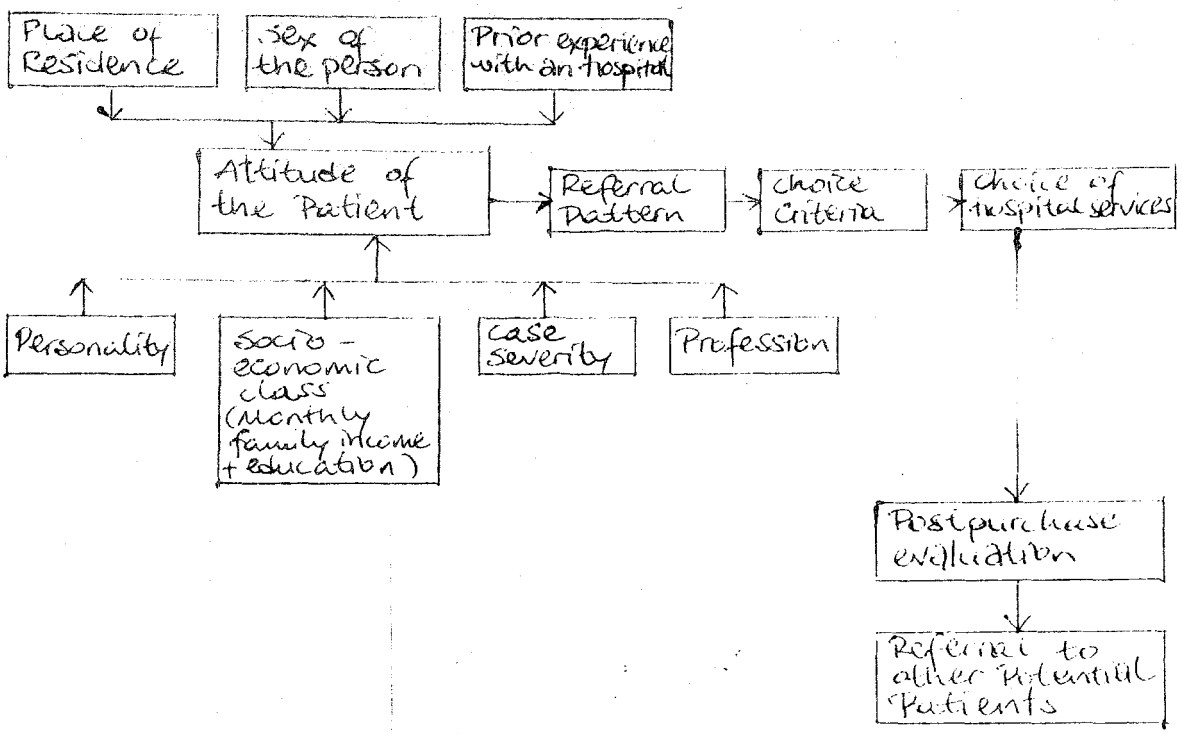
		A		B		C		D		Total		F		H		I		J		Total		General	
	K.26	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%	A	%
ot worse	y						16.6				11.1						3.3				16.7		13.3
						1	25			1	16.6					1	50			1	20	2	18.2
nadequacy of clean-liness	x						33.3				22.2												13.3
						2	50			2	33.3											2	18.2
ervice inadequate	0						16.6				11.1												6.6
						1	25			1	16.6											1	9.1
ublic hospitals are also adequate	1		50				16.6				11.1												6.6
		1	100			1	25			1	16.6											1	9.1
quipment for birth inadequate	2										11.1												6.6
								1	100	1	16.6											1	9.1
ew personnel	3						16.6				22.2												13.3
						1	25			2	33.3											2	18.2
o garden	4																						
et him decide for himself	5		50								11.1										16.7		13.3
		1	100							1	16.6	1	33.3							1	20	2	18.2
ude personnel	6																						
nadequacy of nurses staff	7																3.3				16.7		6.6
																1	50			1	20	1	9.1
nadequacy of equipment for important oper.	8																3.3				16.7		6.6
																1	50			1	20	1	9.1
dministration too loose	9																						
	K.27																						
nterested personnel	4																						
o answer	5											2	66.7								33.4		13.3
																				2	40	2	18.2
OTAL %			100 200				150		100		100 149.6		100				100 150				100 120		100 136.5
OTAL A			2				6		1		9		3				3				6		15
ASE			1				4		1		6		2				1				5		9

7.6.1. Conclusions of the Survey of the Patients

It may be thought that people, as patients, are more likely to be concerned with their painful and incapacitating symptoms related to underlying organic disease, rather than with the social and psychological elements related to their choice of medical care process. So, the consumption of medical care services, physician and hospital services are mainly concerned with physiological needs of the individual, which can be called the physical experience, by which we mean the pain, discomfort, change of appearance or disability actually felt. Also, the consumption process includes a cognitive aspect and emotional aspects. Cognitive aspect can be defined as the interpretation and derived meaning for the individual experiencing the symptoms, and emotional aspect as the fear and anxiety that accompanies both the physical experience and the cognitive interpretation. So, attitude of consumers towards consumption of medical care consists of three components: a) physical experience b) cognitive aspect, c) emotional aspect. These symptoms or aspects of illness attitude, will be recognized and defined not in medically diagnostic categories but in terms of their inference with normal functioning. As a result of this awareness of attitudes, the potential patient begins to seek symptom alleviation, information, and advice and seeks professional medical care. In this stage, the referral structure of patients gain importance. In our analysis, we tried to find out what factors influence the choice process of patients regarding the use of private hospital services.

The decision process for medical care service consumption of a patient can be summarized as follows:

FIGURE 7- DECISION PROCESS FOR MEDICAL CARE SERVICE CONSUMPTION



The factors that influence the attitude of the patient can be summarized as personality, socioeconomic class (A,B,C,D+E), Case Severity, Profession, Place of Residence, Sex of the Person, Prior Experience with an hospital. We have not considered the personality factor in our analysis, but it is important to note that personality is a major factor in influencing the attitude of the patient. Among the demographic characteristics we have considered, we have tabulated the results according to socioeconomic class and case severity. It was found that a majority of patients had prior experience with the same private hospital or another private hospital. It can be concluded that satisfaction with the services of previous hospitals lead to positive attitudes about the same hospital or all private hospitals. (Generalization due to the same experience in the consumption process). Among the reasons given for the satisfaction with previous hospital services are quality and attention of physicians and nurses, and the general quality of medical services by the hospitals. It is interesting to note that while minor cases are more interested with cleanliness and noise aspects of the hospitals, services/hopeless cases regard medical services as the major category of services that influence

their level of satisfaction with hospital services. This discrepancy between individuals of different case severity show that the level of case severity is an important factor that shapes the attitude of individuals. The factors that lead to dissatisfaction of patients with previous hospital services are inefficiency of medical care and uncleanliness.

Also, it was observed that individuals with higher socio-economic status (A and B) state "Permission for visitors" as an important factor in satisfaction with previous hospital services. It is concluded that in some cases, (especially minor cases as maternity) consumption of hospital services can be defined as conspicious consumption, feeling proud due to the perceived quality of the product in the eyes of other people. As higher monetary value is associated with private hospital services, the consumption of these services does give a status value to the consumer in some socio-economic classes. This is an important element that influences the price decisions of some hospitals, as maternity homes.

With the above mentioned enviromental and personal factors (case severity and previous experiecne) the potential patient forms an attitude towards the services of private hospitals. In our analysis it was found that the respondents have formed positive attitudes towards the private hospitals because a majority of them have chosen the private hospitals in their second hospitalization.

The second stage of medical decision process is the one during which the patient decides to seek the services of hospitals. The findings of the research indicate that a large majority of patients leave the choice to their physicians, which shows the centrality of the physician in the medical decision process. So it can be stated that in most cases physicians are the central actors in this decision process, the choice of hospital services depends on their decision. The second important factor in the choice process is the lay referral system of the patient, namely potential consultation with relatives, friends and family. This lay referral system is especially important in lower socio-economic classes. It can be summarized that lower socio-economic groups prefer lay referral systems while higher socio-economic classes prefer professional opinions. It was found that in lower socio-economic class; (D+E), some patients with severe cases stated

that they would not have chosen the private hospital if it were not for the choice of the physician. So severity of certain cases, brings the centrality of the physician as the important referral channel for all the patients in different socioeconomic classes. The third important referral pattern is the family physician, who both chooses the physician specialized on a specific diagnosis and the hospital. The patients do not employ active search, as visiting hospitals to analyze their services pattern or price structure. In only maternity cases, some young patients have stated that they were involved in active search.

In addition to the referral pattern to private hospitals, there are some factors (choice criteria) that influence the choice of hospitals by the patient compared with the alternative of free service by public hospitals. The criteria are summarized in the order of importance given by the patients.

- Careful service and care patterns
- Physician and personnel characteristics
- Service contract of firms (enabling free service to the personnel).

In order to determine the level of satisfaction with hospital services, we tried to determine the post purchase evaluation of services of current patients. In most of the service categories, the patients were pleased with the services given. The highest satisfaction was derived from the services of physicians and secondly from nurses' services. The lower socio-economic group and serious case category, are critical of the services of paramedical personnel and also of non-medical personnel. The same socio-economic group and minor case category are dissatisfied with the general attention, upkeep and cleanliness. It can be stated that the lower socio-economic group are more critical of the services offered by the private hospitals. In most cases, it can be stated that the product of private hospitals does not appeal to the lower-socio-economic class, they consume it due to emergency condition or due to the choice of the physician.

The current patients are more critical of the medical equipment of proprietor owned hospitals, than foreign and minority hospitals. Quality of bed, room, toilet, telephone services are considered to be satisfactory. It is interesting to note that a

structure of the hospitals or that they cannot make evaluations about the services compared to price structure. So we can state that in most cases (except in plastic surgery), the individual consumes the product without knowing its price, so he has to pay any price that the hospital charges. Most of the patients are aware of this fact, and feel dissatisfied and discouraged in using private hospital services. In higher-socio economic class, the site of the hospital gains importance. When patients' have previous experience with hospital services, they are more accostomed to price structures and know what to expect of the end of the diagnosis process. Among the group that know or have a fairly good idea of the price structure there is not much criticism on price of hospital services. Also, the group with prior experience are more critical of services than the group with the first trial.

So we can conclude that the majority of respondents are satisfied with the services of private hospitals. A large majority of the respondents state that they would recommend the particular hospitals to their relatives, friends while most of the lower socio-economic closs stated that they would not. The major factors given for the referral were those other than the quality of physicians as most respondents think that the performance of the physician would depend on the particular individual patient and the diagnosis. Some of the patients thought that it would be best for the potential patient to decide for himself in such an important decision involving life and death.

8. CONCLUSION

We have stated at the beginning of the thesis that with the use of the concepts of "social marketing", the activities of private hospitals can be better understood and placed in an analytical framework. From the research conducted on the activities and operations of these hospitals, it is apparent that the use of marketing concepts does not represent a complete departure from what well managed and progressive hospitals have been doing all along, although these activities are not coordinated in a well-defined and integrated marketing program. If a hospital commits itself to a full-fledged marketing program, it is going to have to conduct systematic research on the needs of the constituencies it serves and respond in an organized fashion to those needs. If a hospital wants to keep up with rapid changes in an expanding market, he must be an active participant in the health care process, rather than as just a passive link between the physician and his patient. And to be an active participant, the hospitals must know the needs of their markets - their patients, physicians, donors and the society at large - as medical service is a societal issue which influences the whole health care sector if certain changes take place.

Hospitals should view marketing as an investment, rather than as an expense, that will help optimize the capacity and ability of the hospital to effectively respond to the needs of its market segments.

We have tried to draw a step-by step approach which would help guide the marketing effort of the hospitals.

First, hospitals should set up a marketing task force under the leadership of someone who is thoroughly knowledgeable and experienced in marketing.

Second, a situation analysis must be conducted to answer the question "Where are we now?" The analysis should include a definition of the nature of the hospital's purpose and organization, an analysis of the hospital's enviroment and competition, a market audit of the hospital's capabilities and possible opportunities, a historical andit of records to determine utilization and trends and an interview survey of key individuals in the hospital.

Third, research priorities and objectives must be developed to determine the nature of the organization's markets and image.

Fourth, research studies must be conducted as follows: an audit of patient load and physician staffing over the past three or four years; an attitude and needs survey of a sample of former patients, physicians and staff; positioning studies to determine where the hospital stands in relation to existing medical/health care facilities and the health care needs of the community.

Fifth, research results must be analyzed and market potentials must be outlined. Possible objectives that state where the organization should be heading must be drawn up.

Sixth, the marketing team should assign priorities to markets, and formulate a marketing plan with policies, objectives, strategies, marketing programs, priorities and schedules, organization and assignments, budgets and resource allocations, and feedback and review procedures.

The above schedule can be helpful in formulation of a coordinated, ongoing program to answer the needs of the hospital's markets. Marketing, helps to keep the hospital on target in a changing world and changing demands. So, we can conclude that private hospitals should be aware that "marketing concepts and techniques" help to reach their objectives, "increasing the health level of the community".

This thesis tried to analyze the operations of private hospital sector from a marketing perspective. Another analysis that would consider the public medical care sector would bring important insights to some of the problems in the medical care sector.

APPENDIX I

QUESTIONNAIRE

Hospital	K.4
A	y
B	x
C	0
D	1
F	3
H	5
I	6
J	7

Dear Mr. - Mrs:

We are conducting a research related to the services of private hospitals. We request you to answer the following questions.

Thank you:

1- Can you state the reason for your stay within the hospital?

	K.5
Surgery	y
Internal Diseases	x
Genecological	0
Physiotheraphy	1
Psychological	2
Orthopedical	3
Opthalmic	4
Other (state)	

2- Did you stay within a hospital previously?

	K.6
It's my first stay within the hospital	y (Q.7)
I had stayed within a hospital previously	x (Q.3)

3- Which is the hospital that you had stayed previously?

	K.7
Hospitals belonging to SSK	y
Military Hospitals (M.S.B. and Navy)	x
University Hospitals (Çapa, Tıp)	0
Hospitals belonging to state enterprises (Railroads, etc.)	1
Others _____	

4- Were there services with which you're dissatisfied with in the previous hospitals?

	K.8
I was satisfied with everything	y (Q.5)
There were services that I was dissatisfied with	x (Q.6)

5- What are the reasons for your satisfaction with previous hospitals ? (Mark K.9).

6- What are the reasons for the dissatisfaction with previous hospitals? (Mark K.11)

	K.9( )	K.11(-)
The physicians are very interested	y	y
The nurses are very interested	x	x
The number of physicians, nurses, personnel is sufficient	0	0
Very clean	1	1
The medical service is sufficient	2	2
Visitors are allowed	3	3
The number of visitors are limited	4	4
Not noisy	5	5
Meals are clean and tasty	6	6
Accompaignment is allowed	7	7
Number of patients/room is small	8	8
Distribution of drugs-is orderly	9	9
	K.10	K.12
Everything is sterile	y	y
The technical equipment is modern and sufficient	x	x
Sufficient service in X-ray department and laboratory	0	0
Others _____		

7- Can you define the reasons for your choice of the present hospital? (Attention: more than one answer)

	K.13	
The frequency of visits by physicians	y	
Nurses are helpful, smiling (interested)	x	
The number of physicians on duty-sufficient	0	
The number of nurses on duty-sufficient	1	
Quiteness.	2	
My physician wanted this hospital	3	
Better service	4	
There was no place in another hospital	5	
My family and acquiantances recommended it	6	
Paid by the company	7	
Cleanliness (general)	8	
Meals and kitchen-clean	9	K.14
Accompaignement is present and comfortable	y	
Exceptious medical service	x	
X-ray depart and lab. function well	0	
Visiting hours are well scheduled	1	
Heating is sufficient	2	
A relative stayed and was pleased	3	
The comfort of the lifts	4	
Sterility of equipment	5	
Brought in an emergency	6	
Others _____		

8- Did you conduct a research before coming to this hospital? If you have done, can you state which kind of research you have conducted?

	K.15
No research	y
Visited several hospitals	x
I asked my physician	0
I asked my acquiantances	1
I learned from the media	2
Other _____	

9- Hospital services, are provided cheaper in public hospitals relative to private ones? Still, you have preferred a private one. Can you define your reasons for this preference? (Attention - three reasons required)

A- K.16 y x 0 1 2 3 4 5 6 7 8 9

B- K.17 y x 0 1 2 3 4 5 6 7 8 9

C- K.18 y x 0 1 2 3 4 5 6 7 8 9

10- We would like you to evaluate the services offered by hospitals? Show the card)

	K.19 very good	K.20 good	K.21 medi- um	K.22 insuff- icient	K.23 very bad
A. Services related to payment level	y	y	y	y	y
B. Demanded price structure	x	x	x	x	x
C. Interest and Quality of physicians	0	0	0	0	0
D. Interest and Quality of nurses	1	1	1	1	1
E. Interest and Quality of medical personnel	2	2	2	2	2
F. Interest and Quality of other personnel	3	3	3	3	3
G. Medical Equipment	4	4	4	4	4
H. Room, beds, toilet, telephone etc. and like services	5	5	5	5	5
İ. Service and cleanliness	6	6	6	6	6
J. The site of the hospital	7	7	7	7	7
K. Services of the hospital in comparison with other hospitals that you know	8	8	8	8	8
L. Services of the hospital compared with the recommendations of your acquiantances	9	9	9	9	9

11- If one of your relatives were in need of hospital services, would you recommend this hospital?

	K.24	
Certainly Yes	y x	pass to Q.12
Perhaps	0	pass on to statistics
No Certainly not	1 2	pass on to Q.13

12- (Asked to those with certainly and Yes answers). Would you state the most important reason for your recommendation?

_____ K.25 y x 0 1 2 3 4 5 6 7 8 9

13- (Asked to those with No and Certainly Not answers) Would you state the most important reason for your non-recommendation of this hospital?

_____ K.26 y x 0 1 2 3 4 5 6 7 8 9

14- (Attention: Asked to the Physician)

Case severity	K.27
Very minor	y
Minor	x
medium	0
severe	1
very severe	2
hopeless	3

The Respondent's:

15- Name: Surname:

AGE	K.28
10-19	y
20-29	x
30-39	0
40-49	1
50-59	2
60-69	3
70-79	4
80-+	

16- SEX K.32

Male	y
Female	x

17- Level of Education K.33

primary school	y
highschool	x
college	0
technical	1
university	2

18- Profession K.29

housewife	y
employee (public)	x
Manager	0
Tradesmen	1
Businessmen	2
employee (private)	3
Private business	4
Worker	5
No profession	6
Others _____	

19- Montly Family Income K.34

20.000- 30.000	y
31.000- 40.000	x
41.000- 50.000	0
51.000- 60.000	1
61.000- 70.000	2
71.000- 80.000	3
81.000- 90.000	4
91.000-100.000	5
101.000-120.00	6
121.000-140.000	7
141.000-160.000	8
161.000-180.000	9

20- Socio-Economic Group K.30

A	y
B	x
C	0
D	1
E	2

21- Permanent Residence K.31

Istanbul	y
Others _____	

10 - Aşağıda belirtilen personelimizin genel davranışları

	Çok iyiydi	Yeter derecede iyiydi	Hiç iyi değildi
a - Laboratuar teknisyenleri	( )	( )	( )
b - Röntgen teknisyenleri	( )	( )	( )
c - Fizikoterapistler	( )	( )	( )
d - EKG ve EEG teknisyen.	( )	( )	( )
e - Hastabakıcılar	( )	( )	( )
f - Diet personeli	( )	( )	( )
g - Temizlik personeli	( )	( )	( )

11 - Hergün 12.30 - 20.30 arası olan ziyaret saatleri sizce	Yeterlidir ( )	Süresi uzatılmalıdır ( )	Süresi kısaltılmalıdır ( )
12 - Ziyaretçilerin kalabalıklığı ve uzun süre yanımızda kalmaları	Sizi hiç yormuyor ve sıkmıyor ( )	Ancak tahammül edebiliyorsunuz ( )	Çok kez tahammül zor oluyor ( )
13 - Pratisyen Doktorlarımızın davranış ve tutumları	Çok kere iyiydi ( )	Bazan iyiydi ( )	Hiç iyi değildi ( )

14 - Hastahanemizde en çok neleri beğendiniz? (Tercih sırasına göre numaralayınız.)

( ) Tıbbi bakımı
( ) Personelin hasta ve ziyaretçilere karşı tutumu
( ) Fiziki çevre
( ) Tedavi olanakları
( ) Başka

15 - Tekrar hastalanma halinde Hastanesinde tedavi görmeyi istermiydiniz	Evet ( )	Hayır ( )

Neden evet veya neden hayır

Kişisel görüş ve düşünceleriniz :

Teşekkür ederiz.

ünlük Oda Ücretleri :

ek yataklı oda ücreti	2200.-- TL.
efakat ücreti	1100.— TL.
'ek yataklı refakatli oda ücreti	3300.— TL.
ki yataklı oda ücreti, beher yatak	1600.-- TL.
Dört-Beş yataklı oda ücreti, beher yatak	1.00.— TL.

Not : Yukardaki ücretlerden aşağıdaki masraflar hariçtir

Ameliyathane ve ameliyathanede kullanılacak hususi malzeme, nestezi, doğumhane, röntgen, laboratuvar, kan tranfüzyonu, natomo-patolojik tetkikler, hususi test ve tedaviler, ilaçlar, Koroner İntensif Bakım, klinik, konsültasyon ve hastane rak'alarından alınacak ameliyat ve doğum ücretleri.

Yemek Servisi : Hastanemize bağlı yemekhanede üç öğün yemek verilir ve günlük yemek ücreti hergün alınır.

Refakatli oda için günlük yemek ücreti ..... 500.— TL.

Tıbbî Koordinasyon Ücreti : ..... Günde 375.— TL.

Günde 24 saat, haftada 7 gün nöbetçi mütehassıs doktor, sağlık teknisyeni ve röntgen, laboratuvar, E.K.G., respirasör, defibrilatör gibi tıbbî cihazları devamlı hizmet etmeye hazır şekilde koordine ederek çalışan hastanemiz sadece yatan hastalardan tıbbî koordinasyon ücreti alır.

Taburcu Saati : Taburcu olacak hastaların kesinlikle 11.00 e kadar odalarını terk etmeleri icap etmektedir. Bu süreyi geçenlerden ilâve bir günlük oda ücreti alınır. Cumartesi, pazar ve bayram günleri taburcu işlemleri engeç 13.00 e kadar yapılır.

Telefon Kirası : ..... Günde 400.— TL.
(Şehirler arası % 20 servis ücreti eklenir.)

İdare Servis Ücreti : Hastanın faturasına % 10 servis ücreti ilâve edilir. Alınacak servis ücreti 10.000 TL. yı geçmez.

Ameliyathane Ücreti : Ameliyatın cinsine göre tesbit edilmiş ana ücrete ilâve olarak ilk yarım saatten sonraki her 15 dakika için ..... 1600.— TL.

8) **Doğumhane Ücreti :** ..... 10.000.— TL.

9) **Bebek Bakımı :** Günde 1000.— TL.

10) **Ziyaret Saatleri :** Her gün 12.30 — 20.30 arasındadır Her hastanın yanında aynı anda kesinlikle iki kişiden fazla ziyaretçi kalamaz.

Hastanemizde yatan hasta herşeyden evvel tıbbî bakıma ve istirahate muhtaçtır. Yukardaki saatler hastalarımıza en iyi hizmeti verebilmek gayesiyle saptanmıştır. Ziyaretçilerin bu hususta kendi hastalarının yararına bize yardımcı olacaklarına inanıyoruz. Ayrıca refakatlar yalnız tek yataklı odalarda kabul edildiğinden 20.30 dan sonra sadece kayıtlı refekatlar kendi hastalarının odalarında kalabilirler.

11) **Çocuk Ziyaretçiler :** 12 yaşından küçük çocuklar kendi sıhhatleri bakımından kesinlikle ziyaretçi olarak kabul edilmiyeceklerdir.

12) **Telefon :** Her gün saat 9.00 - 12.00 arası ve 22.00 den sonra dışardan gelen telefonlar hasta bakımı ve Doktor vizitesini aksatmamak amacıyla hastaya veya refakatlara bağlanmıyacaktır. Ancak kritik listede olan hastaların telefonları katlara bağlanabilir.

13) **Emanet :** Para ve kıymetli eşyalarınızı kasamıza emanet edebilirsiniz. Teslim edilmiyen eşyalardan hastanemiz sorumlu değildir.

14) **Televizyon :** Arzu edenler tek yataklı odalarda televizyon kiralayabilirler. Kat hemşeremiz bu konuda size yardımcı olacaktır.

15) **Kantin :** Gönüllü hanımların çalıştırdığı kantinimizdeki çay - kahve servisinden 9.00 - 13.00 arasında yararlanabilirsiniz.

Hastanemize yatan hastalarımız veya hasta sahipleri yukarda belirtilen hususları okumuş ve kabul etmiş sayılırlar.

Nisan 1981

Teşekkür ederiz.
HASTANE İDARESİ

APPENDIX IV

TENZİLAT MURACAAT FORMU

HASTANIN ADI SOYADI : Prot. No.

Hastayı Tavsiye Eden :

Yatacağı Tarih : Kaç Gün Yatacağı

Yaşı : Adresi :

İşi : Eşinin İşi :

Mali Durumu :

Tenzilat için neden müracaat ettigi :

TEŞHİS :

Yapılacak Tedavi :

Yapılacak Ameliyat :

Tedavi Edecek Doktor : İmzası

TENZİLAT

%

Oda, kreş, ref.

Ameliyathane

Anestezi

Doğumevi

Röntgen

Laboratuar

Diger

ÖZEL ŞARTLAR :

İdare tarafından kabul edilmiştir :

Tarih :

İmza :

NOT : Tenzilattan istifade edebilmek için aşağıdaki şartların yerine getirilmesi lâzımdır.

a) Hasta yatmadan önce bu formun kabul edilmesi
b) Hastanın üçüncü sınıfta yatması
c) Hastane vakası olması

APPENDIX V

OPERATIONS OF PRIVATE MENTAL HOSPITAL

The private mental hospital is related to a foreign religious order and was established during the late years of the Ottoman Empire. The hospital is based on a foundation related to Catholic Church. The site and the buildings on which the hospital is situated, belong to the foundation. The Board of Trustées is the link between the hospital and the religious organization. The Board of Trustées consist of the representatives of the religious order and the medical administrator of the hospital together with the surveillance (head-nun). An investigator who is responsible for the coordination of activities of the Middle East Section of the religious order, acts as the head of the Board of Trustées. The medical-director is a Turkish physician, due to legal requirements, and acts as the coordinator of medical activities of the hospital. The surveillance fulfills the role of the head-nurse (as all the nurse staff consist of nuns) and also acts as a deputy to the medical director. She is the representative of the religious order in the hospital, and has the supervisory role in all activities of the hospital, as financing, recruitment of personnel, supervision of patients, house-keeping activities, purchasing of material and such. The medical-director functions in collab ration with the surveillance in administrative, financial and operational activities of the hospital. The house physicians consist of the medical director (neorologist), the bacteriologist, and an internist. Two physicians function as active staff, working alternatively performing electro-shock activities required in medical diagnosis. The nurses staff consist entirely of nuns, ranging from 17-20. The medical director stated that most of the nuns have been in the hospital for almost fifteen years, and no replacement is possible due to the insufficiency of nuns in the religious order.

The hospital consists of two sections: active service (28 males and 22 women) and chronic service (100 females and 100 males). Severe cases are taken to the hospital, which require close surveillance and constant service for the patients. The price of rooms are given by the Ministry of Health and Social Security, ranging from 1st class 1800, 2nd class 1300 and 3rd class (wards) 800. The hospital has been facing a budget deficit in the last ten

years and this deficit is met by the foundation of the religious order. Also, the foundation is giving donations in the form of equipment and medical supplies. The medical director states that if it were not for the donations of the foundation, both financially and in the form of supplies, the hospital would have been closed down years ago. The hospital has faced a serious conflict with the union two years ago, and was saved from this financial crisis by the financial support of the foundation.

This mental hospital is the only private one left in Istanbul, two others have been closed down in recent years. The hospital continues its operations due to the striving of the medical director, her powerful professional contracts are the only supports to hold the hospital intact. Due to the character of illnesses which require long periods of medical care, and convalescence, and lack of surgical processes which bring profit to the private hospitals, this hospital will continually face financial problems. The medical director states "How long the religious order will support our loses, depends on their good will, because there is no way one can run a mental hospital profitably". This is due to the fact that most of the activities of the hospital consist of chronic services, which consist of service to the aged with no illnesses, or those patients which require very little medical help or those to whom very little medical help can be given. In these cases, only payment for hotel services are taken. Another phenomena is that all the patients are brought to the hospital by others as they are unable to make rational decisions. The payment is taken from the "guardian" of the patients, and in some cases, the guardian forgets altogether about the patient. The patient is kept within the hospital on a charity basis. It is interesting to note that nearly 40 % of the patients in chronic service are charity cases.

The mental hospital will face certain problems in the near future. The medical administrator states that they have to have a promotional strategy which brings the hospital in contact with the society, to increase the awareness that the hospital is not a foreign institution but situated to serve the needs of the society at large. With this awareness, the hospital can face the financial crisis and will be able to survive and continue its operations.

BIBLIOGRAPHY

BOOKS

Baker,Timothy D., and Perlman,Mark. Health Manpower in a Developing Economy-Taiwan, A Case Study in Planning. Baltimore: Johns Hopkins Press, 1967.

Berki,Sylvester E. Hospital Economics. Studies in Social and Economic Process, Lexington Books, D.C.Health and Company, 1972.

Culyer,A.J. Need and the National Health Service-Economics and Social Choice. York Studies in Economics. Martin Robertson, 1967.

Culyer,A.J. The Political Economy of Social Policy. Oxford: Martin Robertson, 1980.

Davies,Llewelyn R. and Macaulay,H.M.C.: Hospital Planning and Administration. Geneva: World Health Organization, 1966.

Demirel,Nedim, Gözenman,Faik, Yiğit, İlhan, and Tuncay,Lütfü. Sağlık Mevzuatımız. Istanbul: Filiz Kitapevi, 1969.

Dublin,Richard L. and Springgall,Herbert W.: Organization and Administration of Health Care-Theory, Practise, Environment. Second Edition, 1974.

Eren,Nevzat (ed.) Ankara Kentinde Yaşıyan Halkın Saptanan Sorunlarına Göre Sağlık Hizmetleri İçin Örgütlenme Önerileri. T.C. Başbakanlık Devlet Planlama Teşkilatı Yayınları, No: DPT 1687, SPD. 314, Planlama Şubesi, 1979.

Feldstein,M.S., Econometric Studies of Health Economics. Discussion Paper, No: 291. Cambridge: Harvard Institute of Economic Research, 1973.

Griffith,John R., Quantitative Techniques for Hospital Planning and Control. Lexington Books, D.C. Health and Company, 1972.

Halloway,R.J. and Hancock,R.S. Marketing in a Changing Environment. New York: John Wiley and SOns, Inc., 1973.

Intriligator,M.D., Issues in the Economics of Health, New York: MacMillan Co., 1958.

Kaitz,E.M., Pricing Policy and Cost Behaviour in the Hospital Industry. New York: Praeger Publishers, 1968.

Leftwidth,Richard M., Health System and Resource Allocation. New York: MacMillan Co., 1953 (2nd Edition).

Marshall,Alfred. Principles of Economics. (London: MacMillan and Co., 1929).

Rathmell,John. Marketing and The Service Sector. Cambridge. Mass: Winthrop Publishers, 1974.

Reinhardt,V.E., An Economic Analysis of Physicians' Services. Yale University, 1968.

Salort,Marie M. La Santé. Paris: Hatiér, 1977.

Saunders Carr,A.M. and Wilson,P.A. The Professionals. Oxford: Clarendon Press, 1933.

ARTICLES AND PERIODICALS

Akdur,Recep. "Sağlık Düzenimiz ve Politikasında Kargaşa", Toplum ve Hekim, XII (December, 1978), 39-54.

Anderson,C.E. "Hospital Production: Can Cost be Contained?", American Economic Review, (May, 1979), 293-397.

Arndt,Johan. "How Broad Should the Marketing Concept be". Journal of Marketing, (January, 1978), 101-103.

Arrow,Kenneth,J. "The Welfare Economics of Medical Care", American Economic Review. LIII (January 1967), 941-973.

Battisti,Paul O. "Manpower Management in a Hospital Setting", Cento Seminar on Hospital Administration. Seminar on the Training of Hospital Administrators and the Review of Modern Advances in Hospital Administration, Karatchi, Pakistan 1972, p.169.

Banhakker,Henri L. "Multiple Correlation. A Technique for the Prediction of Hospital Beds", Operations Research, (1963), 824-839.

Berger,Stephen. "The Interplay of State and Local Government in Health Care", Health Services, The Local Perspective. ed. Arthur Levin (New York, Academy of Political Science, 1977), 63-75.

Berry,Leonard L., and Maricle,Kenneth E. "Consumption without Ownership: Marketing Opportunity for Today and Tomorrow", MSW Business Topics, (1973), pp.33-41.

Bess,Dana. "Consumer Health Education", Health Services, The Local Perspective, ed. Arthur Levin, (New York, Academy of Political Science, 1977), pp.184-194.

Bessom,Richard M., and Jackson,Donald W. "Service Retailing: A Strategic Marketing Approach", Journal of Retailing, LI, No 2 (Summer 1975), 75-84.

Bloom,Paul N. "Advertising in the Professions: The Critical Issues", Journal of Marketing, (July, 1977), 103-110.

Bloom,Paul N. and Novelli,William D. "Problems and Challenges in Social Marketing", Journal of Marketing. XLV. (Spring, 1981), 79-88.

Cairns,J.A. and Snell,M.C. "Prices and the Demand for Care", Economic Aspects of Health Services, ed. A.J.Culyer and K. G.Wright (Martin Robertson Co.Ltd., 1978), 95-118.

Chester,T.E. "Market Forces and Health Economics. A Case Study of Switzerland", National Westminster Bank Quarterly Review, ed. David F.Lomax (November, 1981), 2-16.

Culyer,A.J. "The Quality of Life and the Limits of Cost-Benefit Analysis", Institute of Social and Economic Research-Department of Economics and Related Studies, York Studies in Economics, University of York, Number 246, (Martin Robertson and Co.Ltd., 1977), 141-152.

Culyer,A.J. "Is Medical Care Different?" Extract from A.J.Culyer 'The Nature of the Commodity "health care" and its Efficient Allocation', Oxford Economics Papers, XXIII, 1971, 189-211.

Davis,Karen. "Relationship of Hospital Prices to Costs", Applied Economics, IV (1971), 115-125.

Dirican,M.R. "Türkiye'de Sağlık Hizmetlerinin Örgütlenmesinin Kısa Tarihçesi", Atatürk Üniversitesi Tıp Bülteni, II, No: 7 (Erzurum; 1970), 12-21.

Dumbaugh,Karin, Bentkover,Judith, and Neuhauser,Duncan. "Public Hospitals-An Evaluation", Health Services, The Local Perspective, ed. Arthur Levin, (New York: Academy of Political Science, 1977), 149-184.

Editorial: "Should We Market Health Care", Hospitals, Journal of the American Hospital Association, LI, (June, 1977), 51.

Enthoven,Alain C. "How Interested Groups Have Responded to a Proposal for Economic Competition in Health Services", American Economic Journal, LXX, No: 2, 149-149

Enthoven,Alain C. "Consumer-centered, v.s. Job Centered Health Insurance", Harvard Business Review, (January-February, 1979), 141-152.

Eren,Nevzat. "Kentlerde Sağlık Sorunları", Toplum ve Hekim, No: 19 (Nisan, 1977), 2-12.

Falberg,Warren O. and Bannem,Shirley. "Good Marketing Helps a Hospital", Hospitals-Journal of American Hospital Association, LI, (June, 1977), 70-72.

Feingold,Eugene. "Who Controls the Medical Care System?", Health Services. The Local Perspective, ed. Arthur Lewin, (New York: Academy of Political Science, 1977), p.194.

Feldstein,M.S. "On Aggregate Planning Model of the Health Care Sector", Medical Care, V, 1967, 369-381.

Feldstein,M.S. "Rising Price of Physicians' Services", Review of Economica, XXXVII (May, 1970), 139-162.

Field,Mark G. "The Doctor-Patient Relationship in the Perspective of 'the Fee-for Service' and 'the Third Party Medicine", Patients, Physicians and Illness. A Source book in Behavioral Science and Health, ed. E.Gartly Jaco, 2nd Edition (New York: Collier, Macmillan Lmd: 1972), 155-171.

Fişek,Nusret. "Sağlık Yönünden İnsan ve Çevresi", Hacettepe Üniversitesi Yayınları, Ankara, 1972.

Fox,Peter D. "Access to Medical Care for the Poor: The Federal Perspective", Health Services, The Local Perspective, ed. Arthur Levin (New York: Academy of Political Science, 1977).

Freidson,Eliot. "Client Control and Medical Practise", Patients, Physicians and Illness. A Sourcebook in Behavioural Science and Health, ed. E.Gartly Jaco, 2nd Edition, (New York: Collier, Macmillan Lmt. 1972), 214-221.

Fuchs,Victor R. "The Contribution of Health Services to the American Economy", Millbank Memorial Fund Quarterly, XLIV, 1966. 65-101.

Fuchs,Victor R. "The Output of the Health Industry", Milbank Memorial Fund Quarterly, XLIV, 1966, 36.

George,William R. "The Retailing of Services. A Challenging Future", Journal of Retailing, LIII, No: 3, (Fall, 1977), 85-97.

George,William R. and Barksdale,Hiram C. "Marketing Activities in the Service Industries", Journal of Marketing, Marketing Notes and Communications. (October, 1971), 65-70.

Georgopoulus,Basil S. and Mann,Floyd C. "The Hospital as An Organization", Patients, Physicians and Illness. A Source-book in Behavioral Science and Health, E Gartly Jaco, 2nd Edition (New York: Collier, Macmillan Lmt. London, 1972), 155-171.

Gitlow,Howard S. "Abortion Services: Time For a Discussion of Marketing Policies", Journal of Marketing, (April, 1978), 71-81.

Goode,W.J. "Community Within a Community; The Professionals", American Sociological Review, XXII, (April, 1957), 194-200.

Hall,O. "The Informal Organization of the Medical Profession", Canadien Journal of Economics and Political Science, XII, (February, 1946), 30-41.

Herzlinger,Regina. "Can We Control Health Care Costs?", Harvard Business Review, (March-April 1978), 102-109.

Hunt,Shelby,D. "The Nature and Scope of Marketing", Journal of Marketing, XL, (July, 1976), 17-28.

Ireland,Richard C. "Using Marketing Strategies To Put Hospitals on Target", Hospitals, Journal of American Hospital Association, LI, (June, 1977), 54-58.

Jonsson,B. "Application of Cost-Benefit Analysis To Health Problems", Economie Publique et Ressources Humaines, Proceeding of the 31st Congress of the International Institute of Public Finance, ed. Victor Halberstadt and Antony J.Culyer, (Nice: Editions Cujas, 1977), 177-192.

Judd,Robert C. "The Case for Redefining Services", Journal of Marketing, XXVIII (January, 1964), 58-59.

Judd,Robert C. "Similarities or Differences in Product and Service Retailing", Journal of Retailing, XLIII, No: 4 (Winter, 1968), 1-9.

Karr,David D. "Increasing A Hospital's Market Share", Hospitals. Journal of American Hospital Association, LI, (June, 1977), 64-66.

Kadushin,C. "Individual Decisions to Undertake Psychotherapy", Administrative Science Quarterly, III (December, 1958), 379 - 411.

Kotler,Philip and Levy,Sidney J. "Broadening the Concept of Marketing", Journal of Marketing, XXXIII, (January, 1969), 10-15.

Kotler,Philip and Levy,Sidney J. "A New Form of Marketing Myopia: Rejoinder to Professor Luck", Journal of Marketing, XXXIII, (July, 1969), 55-57.

Kotler,Philip. "Strategies for Introducing Marketing Into Non - Profit Organizations", Journal of Marketing, XLIII, (January, 1979), 37-44.

Kotler,Philip and Connor,Richard A. Jr. "Marketing Professional Services", Journal of Marketing, (January, 1977), 71-76.

Kotler,Philip and Zaltman,G. "Social Marketing: An Approach to Planned Social Change", Journal of Marketing, XXXV, (July, 1971), 5.

Kutner,B. and Gordon,G. "Seeking Care for Cancer", Journal of Health and Human Behaviour, (Fall, 1961), 174.

Laczniak,Gene R., Lusch,Robert F. and Murphy,Patrick,E. "Social Marketing Its Ethical Dimensions", Journal of Marketing, XLIII, (Spring, 1979), 29-36.

Levine,Sol and White,Paul E. "Exchange as a Conceptual Framework for the Study of Interorganizational Relationships", Patients, Physicians and Illness-A Sourcebook in Behavioral Science and Health, ed. E.Gartly Jaco, 2nd Edition, (New York: MacMillan Lmt. 1972), 354-363.

Levitt,Theodore. "Production-line Approach to Service", Harvard Business Review, (September-October, 1972), 41-51.

Levitt,Theodore. "The Industralization of Service", Harvard Business Review, (September-October, 1976), 63-74.

Lin,Lee Maw, "A Conspicuous Production Theory of Hospital Behaviour", Paper Presented at the Conference of the Western Economic Association (August, 1970), 4-16.

Linden,Fabian. "The Consumer Market in 1980-Services", The Conference Board Record, (May, 1972), 50-54.

Luck,David. "Broadening the Concept of Marketing Too Far", Journal of Marketing, XXXIII, (July, 1969), 53-63.

Mann,J.K. and Yett,D.E. "The Analysis of Hospital Costs: A Review Article", Journal of Business, XLI, 1968, 191-202.

Maynard,A.K. "An Economic Analysis of Medical Care in Western Europe", Economie Publique et Resources Humaines; Proceedings of the 31st Congress of the International Institute of Public Finance, ed. Victor Halberstadt and Antony J.Culyer (Editions Cujas, 1977), 177-192.

Mc Laren, John A. "Marketing Assures A Satellite Facility. A Safe Send-off", Hospitals. Journal of American Hospital Association, LI, (June, 1977), 67-69.

Mechanic,D. and Volkart,E.H. "Stress and Behaviour and the Sick Role", American Sociological Review, (February, 1961), 27 - 32.

Merton,R.K. "Some Preliminaries to a Sociology of Medical Education", The Student-Physician, ed. R.K.Merton, G.G.Reader and P.L.Kendal (Cambridge, Mass: Harvard University Press, 1957), 73-79.

Moody,Philip M. and Gray,Robert M. "Social Class, Social Integration and the Use of Preventive Health Services", Patients, Physicians and Illness-A Sourcebook in Behavioral Science and Health, ed. E.Gartly Jaco. 2nd Edition (New York: Collier, MacMillan Lmt. 1972), 250-261.

Moriarty,Mark and Venkatesan,M. "Concept Evaluation and Market Segmentation", Journal of Marketing, (July, 1978), 82-86.

Mott,Basil J.F. "Health Planning", Health Services, The Local Perspective, ed. Arthur Levin, (New York, Academy of Political Science, 1977), p.241 .

Myers,James H., Stanton,Roger R. and Haug,Arne F. "Correlates of Buying Behaviour: Social Class v.s. Income", Journal of Marketing, XXXV, (October, 1971), 8-15.

Newhouse,J.P. "Toward a Theory of Non-Profit Institutions: An Economic Model of a Hospital", American Economic Review, LX, 1970, 64-74.

Newhouse,J.P. "Forecasting Demand and the Planning of Health Services", Systems Aspects of Health Planning. Proceedings of the II. ASA. Conference. Baden, Austria, August 20-22 1974. (North Holland Publishing Company, 1975), 19-30.

Newhouse,J.P. "Toward a Theory of Non-Profit Institutions: An Economic Model of A Hospital", American Economic Review, LX, 1970, 64-74.

Oliver,Richard L. and Berger,Philip K. "A Path-Analysis of Preventive Health Care Decision Models", Journal of Consumer Research, VI, (September, 1979), 113-121.

Padilla,Elena. "Community Participation", Health SErvices-The Local Perspective, ed. Arthur Lewin (New York: Academy of Political Science, 1977), 241-2.

Parsons,T. "The Professions and the Social Structure", Essays in Sociological Theory, (New York: Free Press, 1949), 186.

Perchansky,R. and Rosenthal G. "Productivity, Price and Income in the Physicians' Services Market-A Tentative Hypothesis", Medical Care, (October, December, 1965).

Peterson,O.L. "An Analytical Study of North Caroline General Practise", Journal of Medical Education, XXXI, (December, 1950), 1-165.

Platou,Carl N. and Rice,James A. "Multihospital Holding Companies", Harvard Business Review, 1, No: 3, (May-June 1972).

Rathmell,John M. "What is Meant by Services?", Journal of Marketing, XXX, (October, 1968), 32-36.

Reder,M.W. "Some Problems in the Measurement of Productivity in the Medical Care Industry?", Production and Productivity in the Service Industries, ed. Victor R.Fuchs, National Bureau of Economic Research, the Conference on Research in Income and Wealth, XXXIV, (Columbia University Press, 1969), 95-153.

Reder,M.W. "Some Problems in the Economics of Hospitals", American Economic Review, (May, 1965).

Reinhardt,Uwe,E. "Health Insurance and Cost Containment Policies: The Experience Abroad", American Economic Review, (May, 1980), 149-156.

Robins,Leonard. "Controlling Health Care Costs", Health Services. The Local Perspective", Ed. by Arthur Levin (New York: Academy of Political Science, 1977), 273-241.

Rothschild,Michael L. "Marketing Communications in Non-Business Situations or Why Its So Hard to Sell Brotherhood Like Soap", Journal of Marketing: XLIII, (Spring, 1979), 11-20.

Seaver,Douglas J. "Hospital Revises Role, Reaches Out to Cultivate and Capture Markets", Hospitals. Journal of American Hospital Association, LI, (June, 1977), 59-63.

Shapiro, Benson P. "Marketing for Non-Profit Organizations", Harvard Business Review, (September-October, 1973), 123-132.

Shostack, Lynn G. "Breaking Free from Product Marketing", Journal of Marketing, XLI (April, 1977), 73-80.

Stevens, C.N. "Hospital Market Efficiency: The Anatomy of the Supply Response", Empirical Studies in Health Economics, Proceedings of the 2nd Conference on the Economics of Health. ed. Herbert E.Klarmann and Helen H.Jaszi, (Baltimore: Md. John Hopkins Press, 1970), 7-14.

Stoeckle, John D. "After Everyone Can pay for Medical Care: Some Perspective on Future Treatment and Practise", Patients, Physicians and Illness-A Sourcebook in Behavioral Science and Health, ed. E.Gartly Jaco, 2nd ed. (New York: Collier, Macmillan Lmt., 1972), 389-397.

Suchman, Edward A. "Stages of Illness and Medical Care. Patients, Physicians and Illness. A Sourcebook in Behavioral Science and Health, ed. E.Gartly Jaco. 2nd Edition, (New York: Collier. Macmillan Lmt. London, 1972), 155-171.

Suchman, Edward A. "Social Patterns of Illness and Medical Care", Journal of Health and Human Behaviour, VI, 1965, 2-16.

Taylor, Thayer C. "Selling the Services Society", Sales Management, The Marketing Magazine, Features, (March C., 1972), 23-38.

Venediktov, D.D. "Systems Analysis of Health Services", Systems Aspects of Health Planning, ed. N.T.J. Bailey and M.Thompson, Proceedings of the II. ASA Conference, Baden, Austria, August 20-22, 1974) (North Holland Publishing Company, 1975), 19-30.

Wexler, Nat N. "What is Marketing", Hospitals. Journal of American Hospital Association, LI (June, 1977), 52-53.

Wittreich, Warren J. "How to buy/sell professional Services", Harvard Business Review, (March-April, 1966), 127-138.

Yamak, Kamil Oygur. "Sağlık Hizmetlerinde Bilgisayar", Haydarpaşa Numune Hastanesi-Tıp Dergisi, Sayı: 3 (Temmuz-Ağustos-Eylül, 1979), 683-693.

Zaltman, S. and Ilan Vertinsky. "Health Service Marketing, A Suggested Model", Journal of Marketing. July 1971, 17-25.

OTHER SOURCES

Alpagun, Oktay. "Genel Hastanelerin Kullanımı, Türkiye'de Uygulamada Karşılaşılan Kimi Sorunlar ve Bu Sorunların Çözümlenmesi", T.C. Ege Üniversitesi İşletme Fakültesi, Doçentlik Tezi, Mart 1981.

World Health Organization, Modern Management Methods and the Organization of Health Services, Public Health Papers, No: 55, Geneva, 1974.

World Health Organization, Technical Report Series, Geneva, 1974.

World Health Organization, Health Economics, Public Health Papers, No: 64, Geneva, 1975.

Cento Seminar on Hospital Administration, "Seminar on the Training of Hospital Administrators and the Review of Modern Advances in Hospital Administration", (Karatchi, Pakistan, March 19-24, 1973).

Cento Conference On Hospital Administration (Tehran, Iran, April 28-May 8, 1964).

T.C. Başbakanlık Devlet Planlama Teşkilatı, Dördüncü Beş Yıllık Kalkınma Planı, 1979-1983, Başbakanlık Devlet Matbaası, 1978.

Sağlık ve Sosyal Yardım Bakanlığı; Türkiye Sağlık İstatistik Yıllığı, 1975-1978, Başbakanlık Basımevi, Ankara, 1977.

Sağlık ve Sosyal Yardım Bakanlığı; Türkiye Sağlık İstatistik Yıllığı, 1980, Başbakanlık Basımevi, Ankara, 1977.

T.C.Büyük Millet Meclisi, "Law for Socialization of Health Services", 224, (Ankara, 1961).

UNPUBLISHED MATERIAL

Bodur,Muzaffer. "Marketing of Services", Unpublished Paper.

Culyer,A.J., Maynard,Alan and Williams,Alan. "Alternative Systems of Health Care Provision. An Essay on Motes and Beams", University of York.

Yamak,Oygur. "Hastane Servis Sistemlerine Bir Yaklaşım -Hasta ve Yatak İstatistiklerinin Kantitatif Açıdan Değerlendirilmesi ve Tıbbi Arşiv Alt-Sistemi En İyi Düzenlenmesi Üzerine", Yöneylem Araştırması 6. Ulusal Kongresi 23-25 Haziran 1980. Ankara, Unpublished Paper.