



Türkiye'de Üniversite Hastanelerinde Performansa Dayalı Ek Ödeme Sistemi

Performance Based Supplementary Payment System at University Hospitals in Turkey

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OZ

Amaç: Bu araştırma Türkiye'de üniversite hastanelerinin en önemli ödeme sistemlerinden biri olan performansa dayalı ek ödeme (PDEÖ) sisteminin avantajları ve dezavantajlarını değerlendirmeyi amaçlamaktadır.

Yöntem: Bu çalışmada 2011 yılından beri kullanılmakta olan PDEÖ sisteminin avantaj ve dezavantajlarını hakkında hekim algılarını açıklamak için nitel araştırma yöntemi kullanılmıştır. Veriler, yarı yapılandırılmış nitel görüşmeler ile deneyimli hekimlerden toplanmıştır. Araştırma bir üniversite hastanesinde yürütülmüştür.

Bulgular: Analiz sonucunda PDEÖ sistemlerinin finansal teşvik alacak hekimler açısından motive edici olduğu tespit edilmiştir. PDEÖ sistemi bireysel performansı desteklemek, bekleme sürelerini azaltmakta, gelirleri artırmakta, giderleri azaltmakta, iş doyumunu, hasta tatminini ve verimliliği artırmaktadır. Ancak bu ödeme sistemi uygulama sayısını, iş yükünü artırmakta ve personel arasında çatışmayı zemin hazırlamaktadır.

Sonuç: Üniversite hastaneleri araştırma, tıp eğitimi ve sağlık hizmetleri sunumu gibi önemli misyonları icra eden akademik kurumlardır. Üniversite hastanesinde bu misyonu teşvik edecek şekilde yürütebilmek için, PDEÖ sisteminin revize edilmesi gerekmektedir. Ayrıca üniversite hastanelerinde finansal kaynak sıkıntısı bulunmaktadır. Bu durum hekimlere daha az ek ödeme yapılmasına neden olmaktadır.

Anahtar Kelimeler: Hekim Ödeme Modeli, Performans, Motivasyon, Üniversite Hastanesi

ABSTRACT

Objective: This study aims to evaluate the advantages and disadvantages of the performance-based supplementary payment (PBSP) system which is one of the foremost payment systems of university hospitals in Turkey.

Method: In this study it is used qualitative analysis methods to explore experienced physicians' perceptions about the advantages and the disadvantages of PBSP payment system which has been implemented at university hospitals since 2011. The study was carried out by using qualitative research method. Data were collected from semi-structured qualitative interviews with experienced. The study was conducted at a university hospital.

Results: The result of the analysis has revealed that PBSP system encourage physicians who would like to receive financial incentives. PBSP system supports the individual performance, reduces waiting times in patients, increases revenues and decreases expenditures and increases in efficiency of department. However, this payment system increases work load, number of examinations and provokes the conflict among personals.

Conclusions: University hospitals are academic institutions that perform important missions such as research, medical education and health services provision. Therefore, PBSP system should be revised so as to encourage performing these missions at university hospitals. There is also shortage of financial resources at the university hospitals. This situation leads to less additional payments to physicians.

Key Words: Physicians Payment Model, Performance, Motivation, University Hospitals.

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INTRODUCTION

One of the most concerning issues in today's hospital organizations is to enhance the performance of health professionals at hospital. Because of technological improvements, it is a must to know about how to encourage the physicians to contribute to the hospital in accordance with their maximum capabilities and skills and to increase quality based output of health care services (1). For this goal, health policy makers and hospital managers have proposed changes to physician rational payment system. This payment system improves the quality of health care and reduces hospital costs (3).

The design of remuneration methods is a priority in health care policy (4). There are three commonly used main methods of remunerating at health care professionals: pay for performance or fee-for-service (payment is made for every item of care provided, capitation (payment is made for every patient for whom care is provided) and salary (5-6-7). Different countries use one or another of these three payment models of compensation for health care professionals(8). Perhaps the most common system of physician remuneration is salaries (9). However a major problem with salary-based remuneration systems is that there are no incentives for physicians. Capitation, which is a lump-sum payment per patient managed for a given period of time (8). One increasingly popular mechanism for stimulating quality improvements is pay-for- performance(10).

Pay-for-performance has been widely adopted by health care providers as an incentive to improve health care quality improvement and safety (11-12-13). This basic concept of this payment systems I is simple: rather than paying for care by the piecemeal method (fee for service), reimbursement should be linked at least in part to adherence to safety and quality

measures(14). In contrast, most physician payment systems simply use a fee-for-service approach, paying providers based on the volume, frequency. Performance based payment system adjusts the fee-for-service model to include higher payments for higher-quality care(11) and it might crowd out the intrinsic motivation to care for patients (15). For this reason, performance based payment system is that the quality of care will improve if physicians can earn bonuses for providing high-quality care (16).

Traditionally, physicians are paid for each service that they perform for health care provision(2). Payment methods of physicians effect healthcare service providing positively or negatively in different forms (17). Because of physicians own contributions they receive rewards compared to other physicians in terms of payment (18). In the world many countries have linked the remuneration problem with concerns about health care quality and performance, focusing new attention on payment for performance payment systems (19). Also to accelerate quality improvement, many private and public health care organizations have begun to offer financial incentives to physicians and hospitals based on their performance on clinical and service quality measures(20).

There is a growing interest in using performance based payment mechanisms in developing and developed countries in order to improve the performance of hospital organizations(21). For example, physicians in the United States have been affected by significant changes in the payment modeling. These changes include new measures to a) curb increasing costs, b) increase access to patient care, c) improve quality of healthcare, and d) pay for prescription drugs (22). Although performance payment systems may provide a tool policy-makers and hospital administrators to encourage high-quality and appropriate care, it is unlikely that it can be

sufficiently powerful to encourage an efficient level and quality of care without challenges(23).

The Turkish health care system has been undergoing a significant transformation with the Health Transformation Program (HTP) since 2003 (24-25). Turkey has implemented major health care reforms to develop easily accessible, high-quality, efficient, and effective healthcare services for the population(26-27). This program has been made according to the ultimate performance goals of a health care system, such as improvement in health status, long-term fiscal sustainability of the health care system and provider satisfaction with health care (28). However, major structural changes in the health care PBSP system(29) has been done at all Turkish university hospital since 2011. This payment system is taken into consideration which staff title, its role, working conditions and the time period, the training and education and research activities, professional applications, medical performance and contribution to health care. In this system, there are five categories about scores of remunerating health care professionals: score of enterprise contribution (A), score of physicians individual income generating activity (B), score of training and education activity (C), score of scientific activity (D), score of other activities (E). University hospital organizations conduct performance of monthly appraisals. At university hospitals, PBSP is performed according to the following formula(30);

Individual Net Contribution Score (INCC) = $A + [(B1+B2+C+D) \times CK] + E$,

Period Additional Payment Coefficient: (Money that can be distribution/Unit Individual Net Contribution Score)

The Additional Payment Amount= Period Additional Payment Coefficient x Individual Net Contribution Score

Calibration Factor (CK): (0.2-0,9)

MATERIALS AND METHODS

In this study it is used qualitative analysis methods to explore experienced physicians' perceptions about the advantages and the disadvantages of PBSP payment system which has been implemented at university hospitals since 2011. The study was carried out at the university hospitals from 20 December 2015 to 15 January 2016. Data were collected from semi-structured qualitative interviews with experienced physicians. The interview questions have been prepared following a thorough literature survey and based on the experiences of the researcher as a hospital manager. The interview questions were tested on two healthcare professionals. The interviews lasted almost half hour and were recorded. Afterwards major themes and relations among performance based payment were refined by using selective coding.

RESULTS AND DISCUSSION

Pay for performance has become a popular approach to performance improvement in health care (31). Performance payment system for physicians may affect the efficiency and effectiveness of health care service provision(32). For this reason, health policy makers and hospital managers in many countries have used performance based payment systems to influence the clinical, scientific, training and medical education activity of behavior of specialist physicians.

This study analyses the perceptions of physicians about the PBSP system at the university hospitals in Turkey. The demographic profile of the physicians is presented in Table 1. With regard to the specialty of the physicians, 56 per cent of the respondents are from surgical medical sciences specialty, in other hand 44 per cent of them are internal medical sciences physicians. The highest response rates at 92.0

% were at the experience of 5-9 years and above with males (60%).

Table 1. Demographic Profile of the Physicians

Variable	N	Percentage
Gender		
Female	10	40,00
Male	15	60,00
Specialty		
Surgical medical sciences	14	56,00
Internal medical sciences	11	44,00
Experience		
0-4	2	8,00
5-9	8	32,00
10-14	6	24,00
15-19	6	24,00
20+	3	12,00

Understanding how health care professionals respond to incentives from payment models is a central concern in health economics research(7). Physician payment systems contain different financial incentives that could influence both patient and physicians' decisions (33). Performance based payment systems are intended to accelerate improvements in health care, yet little is known about the benefits of these methods of providing incentives for improving care (34). Health care is essential for the effective and efficient functioning of health care delivery systems, yet there is an impending crisis in the field due to in part a dysfunctional payment system(35). Each method generates a number of favorable and a number of adverse incentives for physicians, high or low administrative costs for the payers and favorable or adverse effects for the patients(9). An effective payment system has to align financial incentives with the best medical practice(36). Performance-based payment is increasingly advocated as a way to improve the performance of health systems in low-income countries (37). Pay for performance has become a central strategy in the drive to improve health care (38). But pay for performance is no panacea and has a lot of

challenges in implementation so pay for performance is the best worst choice (14)

Table 2: Advantages of Performance-Based Supplementary Payment System

No	Themes	Frequency Occurrence	Percentage
1	PBSP encourages physicians to be more eager to work and increases earning	22	88,00
2	PBSP supports the individual performance, scientific, training and education activity (B,C, D, E Scores)	16	64,00
3	PBSP reduces waiting times in patients (inpatient, outpatient)	15	60,00
4	PBSP provides high performance of healthcare provision	14	56,00
5	PBSP increases revenues and decreases expenditures	13	52,00
6	PBSP improves job satisfaction, increases work motivation and patient satisfaction	12	48,00
7	PBSP increases in efficiency of department	10	40,00
8	PBSP reinforces a sense of ownership	6	24,00
9	PBSP improves organizational culture	4	16,00

The physicians were asked about the advantages of PBP systems. The responses in this study related to the advantages of PBPS are summarized in Table 2. The great majority of physicians expressed PBSP that encourages physicians to be more eager to work and increases earning (88%), supports the individual performance, scientific, training and education activity (B,C, D, E Scores) (64 %), reduces waiting times in patient (60%), provides high performance of healthcare provision (56%), increases revenues and decreases expenditures (52%), PBSP improves job satisfaction, increases work motivation and patient satisfaction (48%), increases in efficiency of department (40%), PBSP reinforces a sense of ownership (24%), improves organizational culture (16%) .

Table 3: Disadvantages of Performance-Based Supplementary Payment System

No	Themes	Frequency Occurrence	Percentage
1	PBSP increases the number of examinations, test, visit, interventions due to more earning	23	92,00
2	PBSP increases conflicts among the physicians	22	88,00
3	PBSB increases using of drugs and medical material	20	80,00
4	PBSB increases work load	18	72,00
5	PBSB affects health workers' holiday activities	15	60,00
6	PBSB' B score application does not support teamwork.	14	56,00
8	PBSB is a preference of low risk case and earning easily points services	13	52,00
9	PBSB is avoidance of the necessary diagnostic tests for the services that are within the scope of the package.	10	40,00
10	PBSB reduces co-operation among physicians	9	36,00
11	PBSB reduces the importance of preventive services.	7	28,00
12	PBSB is difficult to measure in each medical practice. Thus, this system cannot measure performance precisely.	6	24,00

The main objective of performance-based payment systems, the staff is to promote work motivation and productivity. However there are disadvantages in this system. To determine the disadvantages of this system, physicians were asked about the PBP systems. The responses in this study related to the advantage of PBPS are summarized in Table 3. The great majority of physicians expressed PBSP that increases the number of examinations, test, visit, interventions due to more earning (92%), increases conflicts among the physicians (88%), increases using of drugs and medical material (80%), increases work load (72%), affects health workers' holiday activities (60%), B score application does not support teamwork (56%), is a preference of low risk case and earning easily points services(%52), is avoidance of the necessary diagnostic tests for the services that are within the scope of the package (40%), reduces co-operation among physicians (36%), reduces the importance of preventive services (28%), is difficult to measure in each medical practice. Thus, this system cannot measure performance precisely (24%).

CONCLUSION

University hospitals are academic institutions that perform important missions such as research, medical education and health services provision. Therefore, PBSP system should be revised so as to encourage performing these missions at university hospitals. Physicians have proposed changes for PBSB system because of the disadvantages as a way to improve the quality of health care and reduce costs. There is shortage of financial resources at the university hospitals. This situation leads to less additional payments to physicians. To improve quality and efficiency, physician payment systems should be improved and financial difficulties should be eliminated at university hospitals. To encourage physicians, if health policy makers and hospital managers improve PBSB system, physicians may affect the efficiency and effectiveness of health care service provision.

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