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Pay for performance system in Turkey and the world; a global overview

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ABSTRACT

Objective: This study aimed to compare the pay for performance system applied nationally in Turkey and in other countries around the world and to reveal the effects of the system applied in our country on the general surgery.

Material and Methods: Current literature and countries' programs on the implementation of the pay for performance system were recorded. The results of the Turkish Surgical Association's performance and Healthcare Implementation Communique (HIC) commission studies were evaluated in light of the literature.

Results: Many countries have implemented performance systems on a limited scale to improve quality, speed up the diagnosis, treatment, and control of certain diseases, and they have generally applied it as a financial promotion by receiving the support of health insurance companies and non-governmental organizations. It turns out that surgeons in our country feel that they are being wronged because of the injustice in the current system because the property of their works is not appreciated and they cannot get the reward for the work they do. This is also the reason for the reluctance of medical school graduates to choose general surgery.

Conclusion: Authorities should pay attention to the opinions of associations and experts in the related field when creating lists of interventional procedures related to surgery. Equal pay should be given to equal work nationally, and surgeons should be encouraged by incentives to perform detailed, qualified surgeries. There is a possibility that the staff positions opened for general surgery, as well as, all surgical branches will remain empty in the near future.

Keywords: Pay for performance, healthcare implementation practices, P4P

INTRODUCTION

Pay for performance system can be defined as a change in the additional income of medical personnel according to their efforts and interventions in line with the financial incentive. The pay for performance system is, in essence, a quality-oriented system. The first of its main goals is to improve the quality of healthcare standards. Enabling the use of existing resources and demanding success to achieve these goals by setting measurable goals are seen as the secondary goals of the system. This system is not concerned with how the set goal was made, but with how much it was made. The advantage of the system is that it is easy to control and there are rewards or sanctions for achieving the goal.

In our country, the pay for performance with regard to interventions in health practices was adopted nationally to cover Ministry of Health Hospitals in 2004 and University Hospitals in 2010. Pay for performance (P4P) is not only applied in our country but is part of the health system in many countries of the world. Before the performance system, hospitals were operating on a volume basis, and, with this system, they started working on a performance basis.

Perhaps the most important of the differences in the application of this system in our country compared to the examples in the world is that the system is not applied to a special area, disease, screening program, region, or hospital, but is applied to all health units on a national scale.

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This study aimed to compare the pay for performance system applied nationally in our country and the systems applied in other countries of the world and to reveal the effects of the system applied in our country on the general surgery branch.

MATERIAL and METHODS

Current literature was reviewed using the keywords "pay for performance, P4P, fee for performance, performance for healthcare, performansa dayalı ödeme (which means performance-based pay in Turkish), and performans sistemi (which means pay for performance system in Turkish)" on PubMed, Web of Science, Scopus, Research Gate and Google Scholar data platforms (Access 15.04.2020), and countries' programs on performance system implementation were recorded.

The results of the Turkish Surgical Association performance and HIC commission studies were examined to evaluate the performance system implemented in hospitals of the Ministry of Health of our country since 2004 and in university hospitals since 2010 in terms of the general surgery branch. In conclusion, the results of the system applied to general surgeons were discussed by comparing the current situation in our country and examples in the world.

RESULTS

PubMed, Web of Science, Scopus, Research Gate, and Google Scholar data platforms were accessed on 15.04.2020. A total of 7542 articles were found when the terms 'pay for performance, P4P, fee for performance, performance for healthcare, performansa dayalı ödeme (Turkish), performans sistemi (Turkish)' were used as keywords. Articles not related to the pay for performance system were excluded from the review. A total of 118 articles were found to have expressed views on pay for performance. These 118 articles were examined and explored how the pay for performance system was applied around the world.

When the literature was examined, it was seen that the additional pay for performance system was implemented in many countries of the world. Countries implementing the system were found to have implemented the system across the state, region, hospital or center (1). In the reviewed literature, there was no other country except Turkey, where the entire health system nationally switched to the pay for performance (P4P) system.

One of the pioneers of the pay for performance (P4P) system was seen as the United States. The eight different programs implemented in the United States aimed to increase quality parameters in health, reduce hospital re-application rates and reduce ethnic challenges in hospital healthcare services (1). In the United States, the system was implemented locally, and, in some states, it was applied only in hospitals where it was necessary for solving a problem and improving quality. Pay for performance system was found to be made in relation to specific diseases or conditions such as diabetes control, vaccination in childhood, blood pressure control, and cancer screening. Insurance companies or charity organizations often provide these payments. The purpose of this practice is to provide diabetes education to patients and to reduce the costs of diabetes that will last for years and complications that will arise later (1-8). It is understood that insurance companies in the United States are a part of the P4P system in many programs that encourage them to reduce their expenses. As an example, for reducing the long-term costs of patients with chronic back pain, programs in which the adaptation of patients is controlled with regular doctor visits are heavily sponsored (9). In addition, the pay for performance system is partially implemented in many countries of The Organization for Economic Co-operation and Development (OECD), EU member countries, Asian and African countries (1).

A study of 34 different P4P systems applied in 14 OECD countries concluded that the system was applied differently and often on a regional-basis or centralized in many countries. According to this study, two P4P systems were implemented in Australia; the first was implemented in only 22 out of 111 medical centers in Queensland region in 2007 to improve quality practices in healthcare, and the second in 2012 in 244 out of 289 hospitals nationwide to reduce waiting times for emergency and elective surgery. It is emphasized that very little success has been achieved in this program, in which the cost of the system is supplied from the hospital budget and the total cost is less than 1% of the budget (1,10,11).

In Canada, the system was implemented in 2007, 2008, and 2011 to reduce waiting times for emergency department applications in 14 hospitals in British Columbia and 74 hospitals in Ontario. In emergency department applications, CAD 100 to CAD 600 were paid for each patient if the target waiting period is provided after the appropriate triage or if the patient is discharged or hospitalization procedures are performed within the target period (12). All of the implemented programs have been reported to provide little improvement far below the government's expectations, less than 1% of the overall hospital budget in terms of cost, while in private hospitals, it is equivalent to about 20% of the manager's profit (1,12-15).

In the southern region of Denmark, in 2009, it was carried out in four hospitals for sharing cases. In this system, where the cost of the system is less than 1% of the hospital budget, there has been concern that many of the patients are not 'examined' (1,16).

In the UK, some parts of the system were implemented only in northern England in 2008, 2009, 2010, and 2011, and some parts of the system were applied nationally and were used for special

headings such as reducing mortality, providing feedback on serious side effects and not being able to reapply to the emergency department for the first 30 days after discharge (1,17-23). The pay for performance system of the UK came into force in primary health care institutions in 2004 and in second-line health institutions in 2008. A program has been created to provide family physicians with an additional increase of up to 25% of their salary to improve quality in primary health care (24). In 2010, UK implemented the good practices guide to improve quality in the healthcare system. With this application, in 2010, it established the Commissioning for Quality and Innovation (CQUIN) and provided incentive additional payments to healthcare workers by introducing pay for performance practices in emergency services, community mental health services, and ambulance systems. In 2012, the program was revised and implemented in a limited number of centers in qualified services when enough financial resources were not allocated to carry out this program. These centers are tertiary healthcare service institutions and are designated as hospitals where very rare diseases are diagnosed and treated, genetic researches are carried out and diagnosis and treatment of rare cancers are done. In addition, 14.4% of the general health budget was transferred to these centers to be operated. In these centers, employees were rewarded with an extra payment of 25%-50% to increase productivity and encourage employees, and quality of health care was improved. However, it has been observed that the desired targets have not been achieved in all programs carried out (17).

In France, a nation-wide performance system was implemented in 2014 and 2016 to improve quality and documentation (1). No research that reveals the consequences of the system cost, which corresponds to 0.5% of the general hospital budget, has been found.

A program in Tel Aviv, Israel, which began in 2009 and was terminated in 2011, aimed to reduce the cost of complications in heart and thorax surgery. It has been reported that the program has positive contributions and has reduced costs. It has also been revealed that the cost of the program is less than 1% of the general hospital budget (1,25).

In Italy, the programs, which began to be implemented in Tuscany in 2006 and Lazio in 2009, aimed at reducing waiting times for hip prosthesis in patients aged 65 and older. It has been reported that the cost of this program is less than 1% of the overall hospital budget and reduces waiting times (1,26).

In 2008, a national program to improve the health quality of stroke patients was implemented in Japan. It has been found that the cost of this program is less than 1% of the overall hospital budget, providing an improvement in the management of stroke patients, as well as increasing potential risk-taking by doctors during the management of patients (1,27).

Programs were conducted to improve the quality of health in Luxembourg in 1998 and in four regions in Norway in 2014. While it has been reported that the program costs reached up to 2% of the hospital budget, no clear information has been given in relation to the results (1,28,29).

In Sweden in 2004 and 2005, four different programs were implemented regionally, aiming at improving the quality of health, with 2-18 participating hospitals from each region. Program costs have been reported to reach up to 4% of the hospital's budget, but no clear information has been given in relation to the results (1,30,31).

The pay for performance system has also been used to correct health parameters in underdeveloped or developing countries. In a P4P program in Rwanda in 2006, supported by the world bank, it was reported that great success was achieved in mother and infant mortality rates and disease treatment thanks to the financial promotions of the medics involved in prenatal diagnosis, childbirth, pediatric intensive care and postpartum vaccination (32). Additional payment to health workers in the pay for performance program in Kenya for malaria control has been reported to be successful (33).

When we reviewed the pay for performance system implemented in our country, it was seen that the system has come into force in all public health institutions with its implementation in all health units affiliated to the Ministry of Health since 2004 and in universities since 2010. Pay for performance system is carried out together with pricing list of Healthcare Implementation Communique (HIC) and invasive procedures list. Procedures and examinations are scored in accordance with these regulations. While it is aimed to calculate the progress payment of the health institution and the physicians working in it with the issued regulations as a result of establishing the service quality indicators and targets in the healthcare sector, the determination of the amount of money to be distributed depending on the quality standards covered by the general physical conditions of the hospital distorted the evaluation of the physician's performance. The quality factor that should be evaluated should be the clinical quality indicators of the physician. In this sense, the collection of the quality indicators of the hospital and the quality indicators that are the result of the physician's work under the same 'quality' caused the evaluation purpose of the system to be completely disrupted.

General surgery branch is one of the main branches negatively affected by the current pay for performance system. To identify the disadvantages caused by this system and to take measures for problems that may develop, the Turkish Surgical Association held a large workshop in 2010, before the P4P system was come into force nationally, and shared the results of the workshop and suggestions for solutions with the officials of the Ministry of Health (34).

Since no significant improvement has been made by health authorities despite many new problems that have emerged in the system over the past 10 years, members of the Turkish Surgical Association Performance-HIC working group held various meetings in 2019 and 2020 to determine the situation and create solutions. The feedbacks were received from 3930 general surgery specialists, who are members of the association and the sub-organizations and general surgery side branch associations related to the association. The conclusions emerging as a result of these meetings and feedbacks are as follows;

1. Many general surgeons are uncomfortable with the current performance system. They believe that they cannot get the reward for their work in terms of both points and financial terms.
2. Many operations performed in daily surgical practice have no equivalent in the list of interventional procedures or are insufficient to describe the performed operation.
3. The performance system is structured in such a way as to disrupt the working peace between clinics within the hospital, or even between physicians within the same clinic. Although many non-surgical clinics can benefit from ceiling payments, general surgery clinics in many centers experience a decrease in payments because the clinical average remains below the hospital average. In performance payment in hospitals with training clinics, 70% of the clinical average and 30% of individual performance are taken as influence value, so physicians who do not/cannot produce enough performance cause the peace of work in the clinic to be broken. As of January 2021, the Ministry of Health has started to make individual contracts with doctors, and within the contract period, it wants a certain percentage of the average clinical score and hospital overall score (which may be different for each physician and is determined by the chief physician) to be produced by physicians.
4. Since the quality of the work performed in the current performance system is not given importance, the procedure scores of the general surgery branch remain very low. For this reason, a large proportion of high-risk patients experience failures in follow-up and treatment due to the defensive medicine reflex of physicians. The surgeon prefers to operate the referral mechanism rather than dealing with a risky patient without a promotive score.
5. The performance system also prevents the proper implementation of educational training activities in educational research hospitals and university hospitals. Although the primary purpose of these institutions is education and training activities, the secondary purpose is service sharing for patient diagnosis and treatment, the time allocated to education is considered as a loss of performance, which prevents these activities from working healthily.
6. The fact that research assistants present for training are involved in the performance system is against the nature of life. It is suggestive that an assistant who is not authorized to produce performance is included in the denominator in the calculation of performance. As the number of assistants in clinics increases, the number of people in the denominator increases, and the performance of the surgeons decreases by division, so their income decreases significantly.

DISCUSSION

The pay for performance system (P4P) was established to increase quality standards in healthcare, to make the use of resources effectively, and to demand success by setting measurable goals. P4P includes encouraging or punitive financial sanctions in line with measurable goals in the performance of institutions and individuals. In the current system applied in our country, about 75% of the income received by the general surgery physician comes from the performance system. A surgeon has only a salary as a fixed income. There are two important differences between the situation in Turkey and examples of other countries. First, pay for performance, which is an item of income other than salary, is the work performance produced by the person. However, this performance income they earn depending on what is produced, unfortunately, is directly proportional to what the doctors working in the clinic produce, the number of employees in the clinic, whether they provide training, whether the clinic has trained assistants, the performance produced by other branch doctors working in the hospital, and the general quality indicators of the hospital. If an example is given, if all factors are assumed the same for surgeons working in two hospitals at the same standards, and only the number of doctors working in the clinic differs, the surgeon with a large number of doctors working in the clinic will receive less pay for performance. In other words, a person's work does not have a qualitative and quantitative value. From another point of view, from two surgeons with equal competencies working in two separate hospitals, the surgeon who has an assistant in the clinic or the surgeon with a high number of assistants in the clinic gets less performance pay. This system, which allows the punishment of a situation that should be encouraged from the point of view of training clinics, reduces the quality of training and the willingness of trainers.

The second important difference in the performance system in our country from other countries is that the additional income obtained in the countries that perform this practice is about 25% of the maximum salary of the doctor; while the ceiling pay for performance obtained in our country can be more than 4-5 times the salary of the doctor. Thus, a system initiated for the purpose of encouragement and stimulation eventually became the primary economic income of the physician, and the result remained far from the goal.

Physicians have a direct effect on the performance payment of the hospital where they work. A general surgery specialist working in a second-line hospital and a colleague working in a third-line hospital receive very different fees, even if all parameters are equal. The same surgery, the same labor, but different wages arise. The resulting difference can often reach astronomical levels. The economic value of a gallbladder or hernia operation performed at Ankara City Hospital in terms of pay for performance turns into a different performance value if the same operation is performed at Hitit University Medical Faculty Hospital.

Surgical branches, especially general surgery, make many invasive interventions in accordance with the definition of the working area. All interventions made by surgeons, pre-intervention preparations, and post-intervention follow-up directly or indirectly affect the performance of not only the relevant branch but also many units of the hospital. For a patient with suspected rectal cancer, preoperative blood tests are taken, colonoscopic examination, ultrasonography, computed tomography, magnetic resonance imaging are performed, and a biopsy is taken and examined by the pathology department. After the patient is diagnosed with rectal cancer, he/she is hospitalized, his/her nutritional status is evaluated before surgery, and support is started if necessary. Before the patients are admitted to surgery, they are consulted in the relevant branches such as anesthesia, pulmonology, cardiology, etc. After surgery, they are followed up in the intensive care unit and surgical service for about 5-7 days. In the presence of a developing complication, the patient can be re-evaluated by many clinics, such as interventional radiology, cardiology, anesthesia, and pulmonology. Although the general surgery branch, which works in coordination with many branches, works as a locomotive unit, it also has to cope with low patient cycle and high bed occupation rates as a result of continuous follow-up of the patient compared to other branches performing with a short-term contribution, so they are doomed to receive less points.

In the pay for performance system, the interventions and examinations performed by the physicians are evaluated through the point system of the interventional procedures specified in the Healthcare Implementation Communiqué (HIC). The doctor is entitled to additional payment at a certain rate from the circulating capital in exchange for points obtained during the month. The list of interventional procedures is determined and updated by the commissions of the Ministry of Health. It is a fact that the members of the commission have no comprehensive knowledge of the degree of difficulty, workload, and risk of the interventions as much as the physicians who carry out the relevant process. We believe that a fair and truth-reflecting assessment will occur by taking into account the recommendations of groups that have comprehensive knowledge about the issue in scoring for interventional operations, such as non-governmental organizations, professional associations, or commissioners from the relevant branch.

When examining the current list of HIC and interventional procedures, the operation value of an abdominal wall hernia corresponds to 400 points. Although abdominal wall hernias sometimes seem like a simple surgical procedure that can be repaired in 45 minutes, complex hernias sometimes last 4-5 hours and may contain difficulties that will require organ resections and anastomoses. However, in the list of interventions, the score of both is the same. Serious morbidity and complications are sometimes inevitable in complex hernias, and the risk faced by the doctor may exceed the risk that many branches face during their professional life.

If we give another example, the equivalent of laparoscopic cholecystectomy surgery is 650 points. In an uncomplicated operation, the procedure takes between 30-45 minutes, while in complicated cases, this procedure takes hours. Such cases, which are very open to the development of complications, carry risks that can lead to serious morbidity, which the patient will deal with for life, and even death. In the face of such an unfortunate situation, the doctor does not have any support, including compulsory professional insurance. In this case, the physician is faced with a fee policy that does not cover the risk he or she is taking.

In summary, how much the surgeon does not what he does or how he does, finds a monetary response in this system. After outpatient examination, admission to the service, preoperative preparation, further examination, and interventions, which are performed to prepare a patient with a periampullary tumor for the operation, the point you will get when you perform Whipple surgery is 3150, which involves mortality of about 10% and morbidity of up to 30-40% and lasts 3-4 hours and requires good experience even in the best medical centers. After surgery, the patient is followed up in intensive care and service for about a week. The management of such a patient requires a health army such as a nurse to follow up and care in the service and intensive care unit, anesthesiologist in the operating room, anesthesia technician, and surgery nurse. However, a plastic surgeon gets 150 processing points by excising cysts or nevus from a patient under local anesthesia and can admit approximately 40-50 patients in one day by performing the same procedure. Thus, he/she gets approximately twice the score and income without almost any risk of morbidity or mortality and without hospitalizing patients. Similarly, by performing cryotherapy on the dermatology clinic, a dermatologist can achieve the same process performance without even leaving the outpatient clinic.

The scores of the general surgery branch in the list of interventional procedures in the current HIC cause loss of rights, while the resulting score devalues the labor force, risk, and effort. Surgeons are very uncomfortable in this regard. Many interventional procedures performed in the general surgery branch

have no equivalent in points. This leads to a loss of motivation in the physician performing the procedure. In addition, it causes the performing of qualified surgeries to be performed only with personal attention and professional dedication. Many physicians, quite rightly, do not want to wear themselves off and begin to practice defensive medicine. Such applications give results in the future that are difficult to compensate for, sometimes even impossible. In other words, surgery is learned through the relationship of master-apprentices, unfortunately, it cannot be taught how to operate on the patient from books, unlike internal branches. When a general surgery assistant, who is raised in an institution where his/her trainer does not perform qualified surgeries, graduates, she/he may not be able to perform a full qualified surgery, and in this case, the patient's last chance to hold on to life is taken away.

Pay for performance system can provide success with additional incentive reward when fixed income is satisfactory. A survey study has been conducted in Germany on the involvement of family doctors in the P4P system for monitoring hypertension patients and controlling blood pressure, and it has been reported that when there was an additional payment of 2.5% (€5000) as a bonus payment in the program, the participation request was 28%, and if the payment rate was increased to 20% (€40.000), the participation rate reached 50%. In the same study, it has been determined that only 33% of the participants wanted to take part in the P4P system when it was reported that payment would be made if the target value for blood pressure regulation was achieved in 90% of patients and that 40% of the participants would like to take part in the P4P system if the same target value was achieved in 80% of patients (35).

A five year follow-up study has been conducted in a surgical center in Germany to investigate the effect of the P4P system on quality for cataract surgery, various quality parameters such as hospitalization time, patient satisfaction, complications were set, and reward and penalty came into force in the criteria for achieving the goal per case. As a result of the agreement with the insurance company, a standard payment of €1000 for each cataract operation was made, while each parameter was valued between €50 and €60 as a reward and penalty. As a result of the five year of follow-up, they have reported that the P4P system did not make a significant contribution to the parameters of the study, such as quality, patient satisfaction, hospitalization time. Also their outcomes of surgical procedures were similar to the outcomes of patients who did not participate in the study (36).

In the current performance system, the individual performance of a surgeon in third line training and research hospitals affects only 30%, while the remaining 70% is achieved from the clinical average. This condition, which is contrary to the peace of work within the clinic, often reveals the chore. Doctors who do not work equally in the clinic, or even sometimes do not put any effort, obtain income from doctors who work with great seriousness and dedication.

The concept of 'qualified intervention' has been created with the arrangements made recently. In this group, pancreaticoduodenectomy and transplantation procedures were accepted as a qualified intervention for the general surgery branch. It was not appropriate that trauma and cancer surgeries of the general surgery branch were not involved in this category on the grounds that trauma and cancer surgeries were "widely performed", but these surgeries really require special attention and experience. The fact that surgery is widely performed does not mean that it is unqualified. This has disrupted the peace of social work between general surgery and other branches.

Assistant physicians, who are involved in the denominator as a divisor in the performance system, reveal one of the most distorted aspects of the system. The specialization student, who is not authorized by law to intervene patients, is included in the divisor part as a denominator, which decreases incomes. Many clinics are uncomfortable with the presence of specialization students for this reason alone. However, the main purpose of the establishment of medical schools and educational research hospitals is to train doctors and specialized students first. Generating scores from caring for patients and interventional procedures are secondary, tertiary purposes. Nevertheless, the current system poses great obstacles to educating future physicians. Especially in affiliated hospitals, faculty members are punished by reducing the number of days worked because they do not generate points in the hospital during the time they teach the students lecture.

Difficulties in assistant training have had two negative consequences. First, assistants in educational institutions have begun to stand out as the cause of economic loss. The fact that the income in exchange for performance increased significantly above the salary of the doctor and became the main item of income increased the importance of the loss of the right to be exposed at this point. While this is the current situation for educators, as a result of malpractice law applications, the content of which is empty, and pay for performance practice, which becomes a source of income ahead of the salary with unfair distribution, medical school graduates do not prefer surgical branches anymore. When the results of the recent years' exams for specialization in our country are examined, surgical branches and general surgery have been seen to be preferred after the 30^{th} rank in 36 specialized areas.

The central physician appointment system (CPAS) is an approach established in good intention, aimed at reducing the patients' waiting time and giving them the chance to choose a physician. As classical information, a patient's examination is considered to last an average of 20 minutes with anamnesis and physical examination (37). This indicates that 24 patients can be

evaluated during 8-hour shifts. If the time is reduced to an average of 10 minutes, 48 patients will be evaluated. However, in the current practice, doctors admit not only 60-70 patients with CPAS appointment in the outpatient clinic, but 100 patients are examined in an outpatient day with the addition of urgencies such as control of operated patients, patients over 65 years of age, etc. (38). During the shift period, it is necessary to care for the patient, diagnose and manage their treatment for about five minutes. If the patient's examination is detailed and the duration is slightly extended, the doctor who is harassed by the waiting patients often experiences verbal and physical assault and the seeds of violence in healthcare are sowed. An increase in cases of malpractice and doctor violence is added to the extremely low expectations of the economic and social level, and interest in the general surgery branch decreases at even the research assistant level (39). In summary, the performance system in our country has shifted away from the international goal of 'increasing in quality' to the goal of 'increasing in quantity'.

CONCLUSION

Application of an international 'physician quality improvement' system, which has been put forward to improve the quality of the situations identified in certain hospitals, to all our country's hospitals with a single regulation without regard to local and social differences between them has brought together many problems, especially the deterioration of social work peace. When the monthly income of physicians is examined, it is seen that the fixed salary remains at a very low rate compared to the income obtained based on performance. As a result of the deterioration of this income balance, pay for performance ceased to be an additional income and began to take place as the main income of the physician. Coefficient applications made to correct the problem have made the situation more complicated. The addition of medical school graduate assistants who received training and could not contribute to the process score negatively affected the training. Regulations to support trainers have been a cause of negative discrimination for physicians without academic title participating in training in teaching hospitals, resulting in different fees for the same surgery. However, the same works are produced as a service. If the academic title contributes to salary, which is their main income, not performance income, then the full equivalent of the article of the constitution on equal pay for equal work is provided in this way, so the promotion of rising in academic titles will be encouraged in return for a salary. As a result, surgical branches have ceased to be popular branches by medical school graduates and started to take part in the last preferences, so they have only been preferred to have a specialization.

The pay for performance system, which aims at quality in healthcare service, must be overhauled before irreparable consequences. Quality is kept at the forefront in countries where pay for performance system is implemented, while quantity comes to the forefront in our country. Furthermore, with regional and purposeful regulations, as well as, reasonable prioritization and qualification configurations, the social work peace between branches should be ensured immediately.

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REFERENCES

1. *Milstein R, Schreyoegg J. Pay for performance in the inpatient sector: A review of 34 P4P programs in 14 OECD countries. 2016; 120(10): 1125-40. https://doi.org/10.1016/j.healthpol.2016.08.009*
2. *Ashby J, Juarez DT, Berthiaume J, Sibley P, Chung RS. The relationship of hospital quality and cost per case in Hawaii. Inquiry. 2012; 49(1): 65-74. https://doi.org/10.5034/inquiryjrnl_49.01.06*
3. *Zubair M, Ahmad J. Role of growth factors and cytokines in diabetic foot ulcer healing: A detailed review. Rev Endocr Metab Disord 2019; 20(2): 207-17. https://doi.org/10.1007/s11154-019-09492-1*
4. *Berthiaume JT, Tyler PA, Ng Osorio J, La Bresh KA. Aligning financial incentives with "Get With The Guidelines" to improve cardiovascular care. Am J Manag Care 2004; 10(7 Pt 2): 501-4.*
5. *Lee GM, Kleinman K, Soumerai SB, Tse A, Cole D, Fridkin SK, et al. Effect of nonpayment for preventable infections in U.S. hospitals. N Engl J Med 2012; 367(15): 1428-37. https://doi.org/10.1056/NEJMsa1202419*
6. *Lindenauer PK, Remus D, Roman S, Rothberg MB, Benjamin EM, Ma A, et al. Public reporting and pay for performance in hospital quality improvement. N Engl J Med 2007; 356(5): 486-96. https://doi.org/10.1056/NEJMsa064964*
7. *Ryan AM, Burgess JF Jr, Pesko MF, Borden WB, Dimick JB. The early effects of medicare's mandatory hospital pay-for-performance program. Health Serv Res 2015; 50(1): 81-97. https://doi.org/10.1111/1475-6773.12206*
8. *McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. Circulation 2015; 131(20): 1796-803. https://doi.org/10.1161/CIRCULATIONAHA.114.010270*
9. *Pursel KJ, Jacobson M, Stephenson K. Paying for quality not quantity: A wisconsin health maintenance organization proposes an incentive model for reimbursement of chiropractic services. J Manipulative Physiol Ther 2012; 35(6): 472-6. https://doi.org/10.1016/j.jmpt.2012.07.003*
10. *Duckett S, Daniels S, Kamp M, Stockwell A, Walker G, Ward M. Pay for performance in Australia: Queensland's new clinical practice improvement payment. J Health Serv Res Policy 2008; 13(3): 174-7. https://doi.org/10.1258/jhsrp.2008.007178*

11. *Australian Institute of Health and Welfare. Australian hospital statistics 2013-14: emergency department care. Health Services Series. 2014.*
12. *Cheng AHY, Sutherland JM. British Columbia's pay-for-performance experiment: Part of the solution to reduce emergency department crowding? Health Policy (New York). 2013; 113(1-2): 86-92. https://doi.org/10.1016/j.healthpol.2013.07.010*
13. *Cheng I, Lee J, Mittmann N, Tyberg J, Ramagnano S, Kiss A, et al. Implementing wait-time reductions under Ontario government benchmarks (Pay-for-Results): A cluster randomized trial of the effect of a physician-nurse supplementary triage assistance team (MDRNSTAT) on emergency department patient wait times. BMC Emerg Med 2013; 13: 17. https://doi.org/10.1186/1471-227X-13-17*
14. *Vermeulen MJ, Stukel TA, Boozary AS, Guttmann A, Schull MJ. The effect of pay for performance in the emergency department on patient waiting times and quality of care in Ontario, Canada: A difference-in-differences analysis. Ann Emerg Med 2016; 67(4): 496-505.e7. https://doi.org/10.1016/j.annemergmed.2015.06.028*
15. *Vermeulen MJ, Stukel TA, Guttmann A, Rowe BH, Zwarenstein M, Golden B, et al. Evaluation of an emergency department lean process improvement program to reduce length of stay. Ann Emerg Med 2014; 64(5): 427-38. https://doi.org/10.1016/j.annemergmed.2014.06.007*
16. *Kristensen SR, Bech M, Lauridsen JT. Who to pay for performance? The choice of organisational level for hospital performance incentives. Eur J Heal Econ 2016; 17(4): 435-42. https://doi.org/10.1007/s10198-015-0690-0*
17. *Feng Y, Kristensen SR, Lorgelly P, Meacock R, Sanchez MR, Siciliani L, et al. Pay for performance for specialised care in England: Strengths and weaknesses. Health Policy (New York). 2019; 123(11): 1036-41. https://doi.org/10.1016/j.healthpol.2019.07.007*
18. *Kristensen SR, McDonald R, Sutton M. Should pay-for-performance schemes be locally designed? Evidence from the commissioning for quality and innovation (CQUIN) framework. J Health Serv Res Policy 2013; 18(2 Suppl): 38-49. https://doi.org/10.1177/1355819613490148*
19. *Kamath P, Roy S, Dasgupta S, Bose Haider B, Gorman S, Tunstall Y, et al. Improving outcomes in asthma by Commissioning Quality and Innovation (CQUIN). Arch Dis Child 2012; 97: (Suppl 1) A27-A28. https://doi.org/10.1136/archdischild-2012-301885.70*
20. *Kristensen SR, Meacock R, Turner AJ, Boaden R, McDonald R, Roland M, et al. Long-term effect of hospital pay for performance on mortality in England. N Engl J Med. 2014; 371(6): 540-8. https://doi.org/10.1056/NEJMoa1400962*
21. *McDonald R, Boaden R, Roland M, Kristensen SR, Meacock R, Lau YS, et al. A qualitative and quantitative evaluation of the advancing quality pay-for-performance programme in the NHS North West. Heal Serv Deliv Res 2015. https://doi.org/10.3310/hsdr03230*
22. *Sutton M, Nikolova S, Boaden R, Lester H, McDonald R, Roland M. Reduced mortality with hospital pay for performance in England. N Engl J Med 2012; 367(19): 1821-8. https://doi.org/10.1056/NEJMsa1114951*
23. *Quentin W, Scheller-Kreinsen D, Blümel M, Geissler A, Busse R. Hospital payment based on diagnosis-related groups differs in Europe and holds lessons for the united states. Health Aff 2013; 32(4): 713-23. https://doi.org/10.1377/hlthaff.2012.0876*
24. *Roland M. Linking physicians' pay to the quality of care - A major experiment in the United Kingdom. New England Journal of Medicine. 2004; 351(14): 1448-54. https://doi.org/10.1056/NEJMhpr041294*
25. *Weiss Meilik A, Uretzky G. The effect of pay for performance (P4P) on quality of care in cardiac surgery. NIHP Publ 2012.*
26. *Colais P, Pinnarelli L, Fusco D, Davoli M, Braga M, Perucci CA. The impact of a pay-for-performance system on timing to hip fracture surgery: Experience from the Lazio Region (Italy). BMC Health Serv Res 2013; 13: 393. https://doi.org/10.1186/1472-6963-13-393*
27. *Jeong S, Katsunori K, Shiraishi N, Yusuke I. An evaluation of the quality of post-stroke rehabilitation in Japan. Clin Audit 2010; 2: 59-66. https://doi.org/10.2147/CA.S7970*
28. *FHL-CNS, C.D.E.. Module 2014-Incitant qualite. 2013: Bertrange.*
29. *Kiviluoto L, Beck Olsen C. Kvalitetsbasert finansiering 2015 Helsedirektoratet, Oslo (2014).*
30. *Högberg M, Lindvall S. Ersättningssystem inom hälso- och sjukvård. Erfarenheter, utvecklingslinjer och vägval för den mer specialiserade vården (Sjukhus, slutenvård och öppenvård) Forum för Health Policy, Stockholm (2012).*
31. *Västra Götalandsregionen Regiongemensamma ersättningsmodeller för sjukhusvård Uppföljning och förtydligande. Vänersborg; 2010.*
32. *Basinga P, Gertler PJ, Binagwaho A, Soucat AL, Sturdy J, Vermeersch CM. Effect on maternal and child health services in Rwanda of payment to primary health-care providers for performance: An impact evaluation. Lancet 2011; 377(9775): 1421-8. https://doi.org/10.1016/S0140-6736(11)60177-3*
33. *Menya D, Logedi J, Manji I, Armstrong J, Neelon B, O'Meara WP. An innovative pay-for-performance (P4P) strategy for improving malaria management in rural Kenya: Protocol for a cluster randomized controlled trial. Implement Sci 2013; 8: 48. https://doi.org/10.1186/1748-5908-8-48*
34. *Terzi C, Ağalar F. (eds) Genel Cerrahide Performans Sistemi Çalıştayı Ankara: BAYT Bilimsel Araştırmalar Basın Yayın ve Tanıtım Ltd Şti. Available from: https://www.turkcer.org.tr/files/publications/19/aba800531c2df1ae77264128480e2f61.pdf*
35. *Krauth C, Liersch S, Jensen S, Amelung VE. Would German physicians opt for pay-for-performance programs? A willingness-to-accept experiment in a large general practitioners' sample. Health Policy (New York) 2016; 120(2): 148-58. https://doi.org/10.1016/j.healthpol.2016.01.009*
36. *Herbst T, Foerster J, Emmert M. The impact of pay-for-performance on the quality of care in ophthalmology: Empirical evidence from Germany. Health Policy (New York) 2018. Available from: https://webarchive.nationalarchives.gov.uk/20180328130852tf_/http://content.digital.nhs.uk/catalogue/PUB01028/gp-work-serv-rep.pdf/)*
37. *Kamu Hastaneleri Genel Müdürlüğü 2017 Ocak-Ekim Hastane verileri, 2017, Tablo 12. Available from: https://dosyahastane.saglik.gov.tr/Eklenti/9300,2017-ocak-ekim-donemi-poliklinik-yatis-ve-yogunbakim-ve-acil-servis-verileri-baglaminda-her-bransta-ilk-100-hastanepdf.pdf?0*
38. *Yastı AÇ, Uçar AD, Kendirci M. General surgery specialism in Turkey: work power currently, continuity at quality and quantity. Turk J Surg 2020; 36: 82-95. https://doi.org/10.5578/turkjsurg.4643*

ORİJİNAL ÇALIŞMA-ÖZET
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Türkiye ve dünyada performansa dayalı ödeme sistemi; global bakış

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ÖZET

Giriş ve Amaç: Ülkemizde ulusal çapta uygulanmakta olan performansa dayalı ödeme sistemi ile dünyanın diğer ülkelerinde uygulanan performansa dayalı ödeme sistemlerinin karşılaştırılması ve ülkemizde uygulanan sistemin genel cerrahi branşı üzerindeki etkilerini ortaya koymaktır.

Gereç ve Yöntem: Performansa dayalı ödeme sistemi için güncel literatür gözden geçirildi ve ülkelerin performans sistemi uygulaması hakkındaki programları kayıt altına alındı. Türk Cerrahi Derneği Performans ve Sosyal Güvenlik Kurumu Sağlık Uygulama Tebliği (SUT) komisyonun yaptığı çalışmalarda çıkan sonuçlar literatür ışığında değerlendirildi.

Bulgular: Dünya üzerinde birçok ülkenin performans sistemini kalite artırmak, bazı hastalıkların tanı, tedavi ve kontrolünde hız kazanmak için kısıtlı çapta uyguladığı ve genelde sağlık sigorta şirketleri ve sivil toplum kuruluşlarının desteğini alarak finansal teşvik olarak uyguladığı görüldü. Ülkemizdeki cerrahların mevcut sistemdeki adaletsizlikten, yapılan işin niteliğinin değer görmemesinden, yaptıkları işin karşılığını alamadığından dolayı haksızlığa uğradıklarını düşündüğü ortaya çıkmaktadır. Bu durumun, tıp fakültesi mezunlarının genel cerrahi branşını tercihe olan isteksizliğin de nedeni olduğu düşünülmektedir.

Sonuç: Sağlık otoriteleri genel cerrahi branşını ilgilendiren girişimsel işlemler listelerini oluştururken derneklerin ve alanında yetkin sahadan kişilerin görüşlerine önem vermelidir. Ulusal çapta eşit işe eşit ücret verilmeli, cerrahların özellikli, nitelikli ameliyat ve tedavileri yapmaları teşvikler ile özendirilmelidir. Yakın zaman içerisinde genel cerrahi yanında cerrahi branşlar için açılan kadroların boş kalması ihtimali mevcuttur.

Anahtar Kelimeler: Performansa dayalı ödeme sistemi, sağlık uygulama tebliği, P4P

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