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Healthcare Organizations' Readiness for Potential System Transformation to Value-Based Care

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Abstract

Aim: This study aimed to determine the readiness of healthcare organizations for a potential systemic shift to value-based healthcare. Meanwhile, it also sought to understand healthcare professionals' awareness and attitudes toward value-based healthcare, their views on the need for system change, and on what is needed to achieve system change.

Methods: The basic qualitative analysis design was used in the study. Interviews using a semi-structured questionnaire were conducted with 14 clinical and non-clinical health professionals. The data obtained were evaluated by content analysis and MAXQDA 2024 program was used in the analysis.

Results: It's stated that there are deficiencies and failures in the current health system (n=14) and that value-based system can be realized in the long term, provided that some changes are made (n=9). Care delivery and human resources aspects of the current health system are the most problematic and these are the priority areas that will ensure the harmonization of organizations

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with the value-based system through regulation. Evaluations in terms of care delivery process, financial strength, clinical and operational informatics, and provider network comprehensiveness were particularly positive about technology and informatics (n=27). The areas with the most negative evaluations were provider network comprehensiveness (n=23) and financial strength (n=26).

Conclusion: Healthcare professionals' demands on the system are aligned with the promises of value-based healthcare. Many processes, especially in private and city hospitals, are running parallel to value-based healthcare, even if they are not labeled as “value-based”. Private hospitals are better prepared than public hospitals for the potential transition to value. If implemented with the necessary changes, value-based healthcare can be a suitable reform for the Turkish health system and an ideal method to meet the needs.

Keywords: Value, value-based care, value-based care readiness.

INTRODUCTION

Today, rising prosperity and advancing technology have led to a substantial increase in healthcare expenditures worldwide. Despite this increase in healthcare expenditure, there is no visible improvement in the health status of individuals and populations. Healthcare is one of the basic needs of any society, and healthcare providers are committed to providing quality services that meet the needs and expectations of individuals. However, the complexity of healthcare services and the presence of cost and quality issues have made it difficult for healthcare providers to fulfill these obligations. In the literature, the inadequacy of current implementation models in the health system is attributed to three reasons: inability to measure outcomes that really matter to patients, low transparency in financial and clinical outcomes, and lack of integration between providers in the care cycle (Aakash Keswani et al., 2016). Due to the aforementioned shortcomings in the system and healthcare delivery models, healthcare reform is no longer a hypothetical concept, but a necessity for systemic change toward value-based healthcare. This need has ushered in a fundamental shift in payment models and incentive structures - the era of value - where economic rewards are increasingly based on quality, cost and access to care (Bhatt, Forster and Welter, 2015).

Porter (2009) suggests the need for a comprehensive vision for health system change and a clear national strategy to achieve it, with a focus on improving value for patients. The "value" referred to here refers to the health outcomes achieved per dollar spent (Porter, 2006). National

health systems planning to deliver value-based health services by adopting an interrelated six-component model for restructuring health care systems with the goal of inclusive value for patients should build enabling collaborations across their systems to avoid fragmentation in the value chain (Porter and Teisberg, 2006; Porter, 2008; 2010; Porter and Lee, 2013; Kaplan and Porter, 2011). The components of the strategic framework that incorporate the principles described earlier, include (i) organizing care around medical conditions rather than skills and facilities (integrated practice units), (ii) systematically measuring outcomes and costs at the patient level, (iii) developing bundled prices for the full cycle of care, (iv) integrating service delivery across different institutions, (v) extending best practice geographically, and (vi) creating an enabling information technology platform. It is seen that this strategic framework is adopted in the literature as the steps that should be implemented while transitioning to a value-based healthcare system (Wilson et al., 2016). There is an overlap between the key deficiencies that are seen as the cause of dysfunction in the current healthcare system and the ways in which the transition to value-based systems can be implemented.

While moving to value-based care may be a solution to address the failings of existing healthcare systems, it would be wrong to characterize this as something which can be suddenly and easily implemented. Many healthcare providers are facing the fact that making the transition to a value-based healthcare system while ensuring financial sustainability is one of the biggest challenges they face. The first step in the value journey is to understand the characteristics of value-based healthcare organizations and assess their readiness for the process. Only those healthcare providers who are able to proactively design the necessary strategies and develop core competencies with the intention of transforming into value-based organizations will be successful on their value journey (Bhatt et al., 2015). To prepare for this change, healthcare providers should understand the principles and concepts of value-based healthcare and take steps to align their practices with these principles. This involves focusing primarily on organizational readiness and creating a culture of continuous improvement and innovation (Varela-Rodriguez et al., 2022; Nilsonn et al., 2017). Aligning with a value-based system may require changes in workflows, care delivery and the use of technology (Meinert et al., 2018). It is also important for providers to involve their employees in the transition process and ensure that they understand the goals and principles of value-based healthcare and have the necessary skills and knowledge (Nilsson et al., 2017).

In order to become a value-based healthcare organization, there are a number of factors that need to be implemented and considered. A full picture of the strategic, financial, operational, and technological aspects of organizations should be revealed through a value-based readiness assessment. A comprehensive measure of an organization's readiness to deliver value-based healthcare can be revealed by assessing areas such as the service delivery process, the cost of care, payment models and financial strength of the organization, the scope of the provider network, and clinical and operational informatics (Salvatore et al., 2020; Adelson et al., 2016; Bhatt et al., 2015).

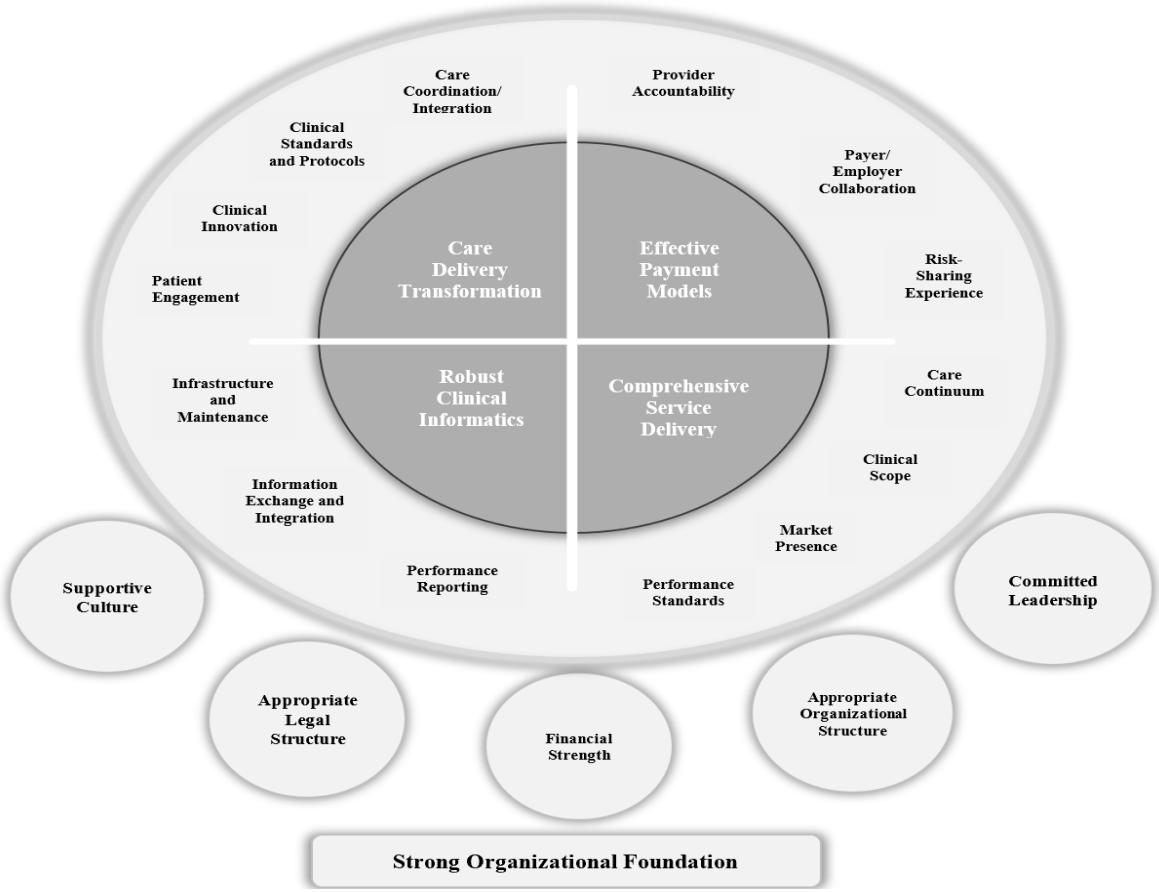


Figure 1. Value-based Healthcare Readiness Assessment Tool (Bhatt et al., 2015, pp.64)

1. RESEARCH METHODOLOGY

Purpose, Model and Design: The aim of the study was to assess the readiness of healthcare organizations for a possible system change towards value-based healthcare. The study was conducted using qualitative research methods and a basic qualitative research design. Revealing

how people make sense of their lives and experiences is the general aim of the basic qualitative research design (Merriam and Tisdell, 2015).

Data were collected from clinical and non-clinical professionals working in healthcare institutions affiliated with the Ministry of Health in a major urban area in Turkey, referred to as "X province" to protect the confidentiality of the participants. This selection was made to provide an in-depth understanding of the readiness of healthcare organizations within a specific urban context. It is important to note, however, that the findings of this study are specific to the healthcare institutions in "X province" and may not be generalizable to the entire healthcare system in Turkey.

Participants: Convenience sampling and criterion sampling, which are purposive sampling methods, were used to determine the participants of the study according to the content and purpose of the study. Convenience sampling method is the sampling of individuals from whom data can be obtained in the easiest way for the research to be conducted (Kurtuluş, 2010). The basic idea in the criterion sampling method is to investigate the situations that meet the specified criteria. The criteria to be established in the study to be conducted using this method can be pre-defined criteria lists or criteria created by the researcher (Yıldırım and Şimşek, 2016). In this context, the criteria determined by the researcher and used in the study are as follows.

- To be working in healthcare organizations affiliated to the Ministry of Health in X province, Turkey,

-To be working as a health professional in a clinical or non-clinical role,

- Worked for at least one year in the current healthcare organization,

-To be over 18 years of age.

When determining the sample criteria, a wide range of different healthcare organizations and positions were considered to enhance the inclusivity and representativeness of the research. This approach aims to obtain perspectives from individuals with diverse experiences, viewpoints, and working conditions, thereby achieving more generalizable and reliable results. To ensure that participants have a comprehensive understanding of the organization's structure, operations, and processes, one of the sample criteria was that participants must have been employed at the organization for at least one year. It is anticipated that this requirement will enable participants to provide more in-depth and informed opinions based on their experiences within the organization, thus enhancing the reliability of the research and the validity of the findings. Additionally, a random sampling method was adopted in the selection process to eliminate the risk of focusing on

a specific group or individual. During the data collection phase, the anonymity and confidentiality of the participants were maintained, which encouraged them to provide sincere and honest responses. All these measures aim to minimize bias in the sample and to enhance the reliability and validity of the study.

The sample size was not calculated within the scope of the study as it is difficult to determine the sample size in qualitative research compared to quantitative research (Büyüköztürk et al., 2016) and cannot be determined by statistical calculations based on factors such as the target confidence interval, margin of error and population size as in quantitative research. Sample size in qualitative research may vary depending on the nature and objectives of the research. Depending on the nature of the research questions, the research design and the complexity of the targeted phenomenon, researchers assess how much data should be collected. An adequate sample size is assumed to be the number of data that will be sufficient to meet the objectives and quality of the research. It is stated that instead of determining a sample size at the beginning, it may be more appropriate to determine the sample size at the point where the data obtained provides sufficient saturation in terms of research (Creswell, 2017). In this context, "theoretical sampling" method was used to determine the sample size of the study.

The study population consists of clinical and non-clinical health professionals from health care organizations operating under the Ministry of Health in Turkey. In qualitative research, sample size is generally not characterized as a goal to reach a certain number of participants in advance. However, a sample size can be predicted by the researchers in order to carry out the data collection process in a detailed and satisfactory manner. In this context, in line with the purpose of the study, the sample size was determined as 20 clinical and non-clinical professionals. However, in the following process, it was decided that the research had reached saturation before reaching the determined sample size and the data of the research were obtained as a result of interviews with 14 healthcare professionals. Information about the participants is presented in Table 1.

Table 1. Participants' Information

Num.	Code	Participant Information
1	CP 1	Physician -Has been in the profession for 9 years. Current workplace is a public hospital and has been working here for 2 years.
2	CP 2	Physician -Has been in the profession for 10 years. Current workplace is a public hospital and has been working here for 3 years.

3	CP 3	Physician -Has been working in the profession for 9 years. Current workplace is a public hospital. Has been working here as a specialist physician for 1,5 years.
4	CP 4	Nurse -Has been working in the profession for 5 years. Current workplace is a public hospital. Has been working here for 5 years.
5	CP 5	Nurse -He has been working in the profession for 7 years. Current workplace is a city hospital. Has been working here for 4 years.
6	CP 6	Home Health Care Nurse -Has been working in the profession for 10 years. Has been working current workplace – a public hospital- for 5 years. For 2 years as a home health nurse in charge.
7	CP 7	Midwife, baby nurse -Has been working in profession for 7 years. Current workplace is a public hospital and has been working here for 2 years.
8	NCP 1	IT Vice Director/ IT Infrastructure Lead and Architect -Has been working in the profession for 24 years. Current workplace is a private hospital. Has been working here for 23 years.
9	NCP 2	Business Services Assistant Business Manager -Had serviced administrative, financial and support service units in various public and private organizations in the sector for 19 years. Current workplace is a city hospital. Has been working here for 2 years.
10	NCP 3	Health Care & Patient Services and Quality Coordinator -Has worked in the sector for 35 years in various public and private organizations. For 7 years has been working in current organization which is a private hospital.
11	NCP 4	Administrative and Financial Personnel -For 13 years, has worked in different units for public hospitals in the sector. Current workplace is a public hospital that has been in for 4 years and is currently working in the accounting department.
12	NCP 5	Administrative and Financial Personnel -For 17 years, has worked in public organizations in the sector and has been working in the purchasing department in the current workplace.
13	NCP 6	Quality Coordinator and Consultant -For 25 years, has been working in the sector and during this period, has worked and managed in various areas of public and private hospitals, especially performance and quality. Currently working as a consultant and coordinator in city hospital.
14	NCP 7	Housekeeping and Administration Manager -Has been working in the sector for 13 years. Current workplace is a private hospital and working as housekeeping and administration manager in here.

Data Collection: Data collection for the study used a semi-structured questionnaire to assess the readiness of health care organizations and professionals to manage the transition to value-based care. The questionnaire assessed the demographic characteristics of clinical and non-clinical professionals, their perspectives on value-based healthcare services and models, organizational readiness, the current status of treatment and care in their organizations, and their views on the barriers they believe exist to the transition to value-based healthcare. It is planned that the data obtained from the healthcare professionals will help us to understand whether the existing resources, processes and employees of the organizations are suitable for the delivery of value-based health services.

The questionnaire used for data collection was developed by the researchers by examining the studies in the literature (Adelson et al., 2016; Bhatt et al, 2015; Ergin, 2019; Salvatore et al,

2020; Wilson et al, 2016) on how organizations should prepare for the transition to value-based healthcare.

The questionnaire, which was created as a result of the literature review, consists of three sections and a total of 10 questions prepared in a way that prevents one-word answers such as yes or no to the research questions. The first section contains questions on the demographic characteristics of the participants, such as age, gender, occupation, length of service in the profession, whether the organization they work for is public or private, and length of service in the organization. The second section includes questions about their views on the current health care system, value-based health care, and change towards value-based health care. In the third section, there are questions to determine the clinical and operational problems they face in their organizations and the care delivery process, financial status, clinical and operational informatics, and the comprehensiveness of provider network.

In order to evaluate the validity and reliability of the questionnaire, expert opinion (3) was consulted in addition to the literature review. The experts were asked to give their opinion on factors such as the content of the questionnaire, the appropriateness and comprehensibility of the questions and whether they accurately reflected the variable being measured. After considering the missing or misunderstood points, the questions that were considered unnecessary or complex, and the differences of opinion among the experts, the necessary revisions were made to the questionnaire and, as a result of these revisions, a consensus was reached among the experts.

The questionnaire was administered by the researcher to those who agreed to participate in the study after explaining the purpose of the study, informing them about the study and obtaining their verbal consent, and interviewing them through online communication tools based on self-report. Considering the principle of confidentiality of participants' personal information, a blackout method was applied on private information about participants and institutions. Before starting the interview, the participants were informed that voice recordings would be created, and voice recordings were created after their consent was obtained. The voice recordings were anonymized by assigning codes to individuals and kept only by the researcher.

Ethical Dimension of the Research: The research was approved by Duzce University Graduate Education Institute Scientific Research and Publication Ethics Committee on 23.11.2023 with decision number 2023/384.

Analyze: The data obtained in the study were evaluated by content analysis, one of the qualitative

data analysis methods, and the findings were presented in a descriptive narrative with direct quotations.

In the first step of the analysis process, a database containing the interview records and transcripts of these records was created. The transcripts were examined by the researcher and a general understanding of the database was obtained and the data coding process began. The coding and analysis of the data was carried out with the MAXQDA 2024 program.

2. ANALYSIS

Demographic Characteristics of Participants: Within the scope of the research, participants were asked to briefly introduce themselves in order to create a participant profile. Descriptive findings regarding the demographic characteristics of the participants based on their responses are presented in Table 2.

Table 2. Descriptive Findings on Demographic Characteristics of Participants

Features	Categories	N	%	Features	Categories	N	%
Gender	Male	5	35,71	Workspace	Clinical	7	50,00
	Female	9	64,29		Non-Clinical	7	50,00
Education	Undergraduate	7	50,00	Type of Organization	Public	8	57,14
	Postgraduate	4	28,57		Private	3	21,43
	Specialization in Medicine	3	21,43		City Hospital	3	21,43
Length of Employment with Current Organization	1-3	5	35,71	Length of Service in the Profession	1-8	4	28,57
	4-7	5	35,71		9-14	5	35,71
	8 and above	4	28,57				
Management obligation	Yes	7	50,00		15 and above	5	35,71
	No	7	50,00				
Total		14	100	**Total**		14	100

Of the participants, 64.29% (n=9) were female, 50% (n=7) had an undergraduate degree, and 50% (n=7) were clinical professionals. 57.14% of the participants work in public hospitals, 21.7% (n=3) in private hospitals and 21.43% (n=3) in city hospitals. 35.5% of the participants have been working in the health sector for more than 15 years and 28.57% (n=4) for less than 8 years. 71.43% of the participants have been working in their organization for less than 8 years and 50% of them have management responsibilities.

Views on the Current Healthcare System: Within the scope of the research, it was tried to reveal the opinions of healthcare professional about the current healthcare system. For this purpose, questions were asked to participants about whether the current system has deficiencies, what these deficiencies are,

if any, and whether the system should be changed. All of the participants stated that there are deficiencies and defects in the current system, 85.7% (n=12) stated that the system should be completely changed and 14.3% (n=2) stated that the system should be upgrade. None of the participants stated that the current system is sufficient and that there is no need for change. The themes and sub-themes that characterize the deficiencies of the current health system, which were formed according to participants' responses, are presented in Table 3. Some of the statements made by healthcare professionals on this topic are also presented In Table 3.

Table 3. Views on Deficiencies of the Current Healthcare System

Main Theme	Sub Themes	n*	%
Deficiencies of the Current Healthcare System	Deficiencies in the Care Delivery Process	19	27,54
	Insufficient Resources	17	24,64
	Access Problems	9	13,04
	Medical Education, Qualified Health Professionals	5	7,25
	Quality and Safety Issues	5	7,25
	Healthcare System Culture and Human Resources Management	4	5,80
	Wrong, Incompatible Policies	4	5,80
	Financial Challenges	3	4,35
	Lack of Health Awareness, Distrust in Care Providers and Treatment	3	4,35
TOTAL		69	100,00

Statement	**Participant**
There is currently a system in where healthcare professionals are unhappy, patients receive poor quality health care, patients are only considered in terms of the the quantity of care they receive, and the service provided is only considered in terms of quantity. The quality of the service provided is not important at all. It is only important that the patient applies to the hospital, not whether they are satisfied with the service they receive. There is a system where only the fact that the patient has received this service is important. There is a system where the number of hospital admissions is billions per year, which leads to poor quality services. First of all, these need to be changed from the beginning. It needs to be changed completely, there is a wrong system, full of wrong practices.	CP 1
Midwifery or nursing is not limited to administering medication and providing treatment. It involves addressing a multitude of patient needs, which may include psychological support and various other aspects of care. In many places and at many times, though not always, we are unable to provide quality care to patients.	CP 7
In terms of numbers, it is not only necessary to have buildings, but also to have qualified human resources in them. I think if we think about the public hospitals now, they were very elegant buildings with very good hotel services, so if I evaluate 35 years of my professional life, physically we worked under very difficult conditions in terms of buildings, and now they are relatively qualified. But in terms of the number of employees, unfortunately, it is not enough to meet the current demand, both quantitatively and qualitatively. But if we come to the private sector,	NCP 3

	of course, in the private sector, for the economic reasons I just mentioned, it is easy for patients to access services, but the number of people who can financially compensate for this is gradually decreasing

*****n indicates the frequency of participant mentions related to the sub-themes.

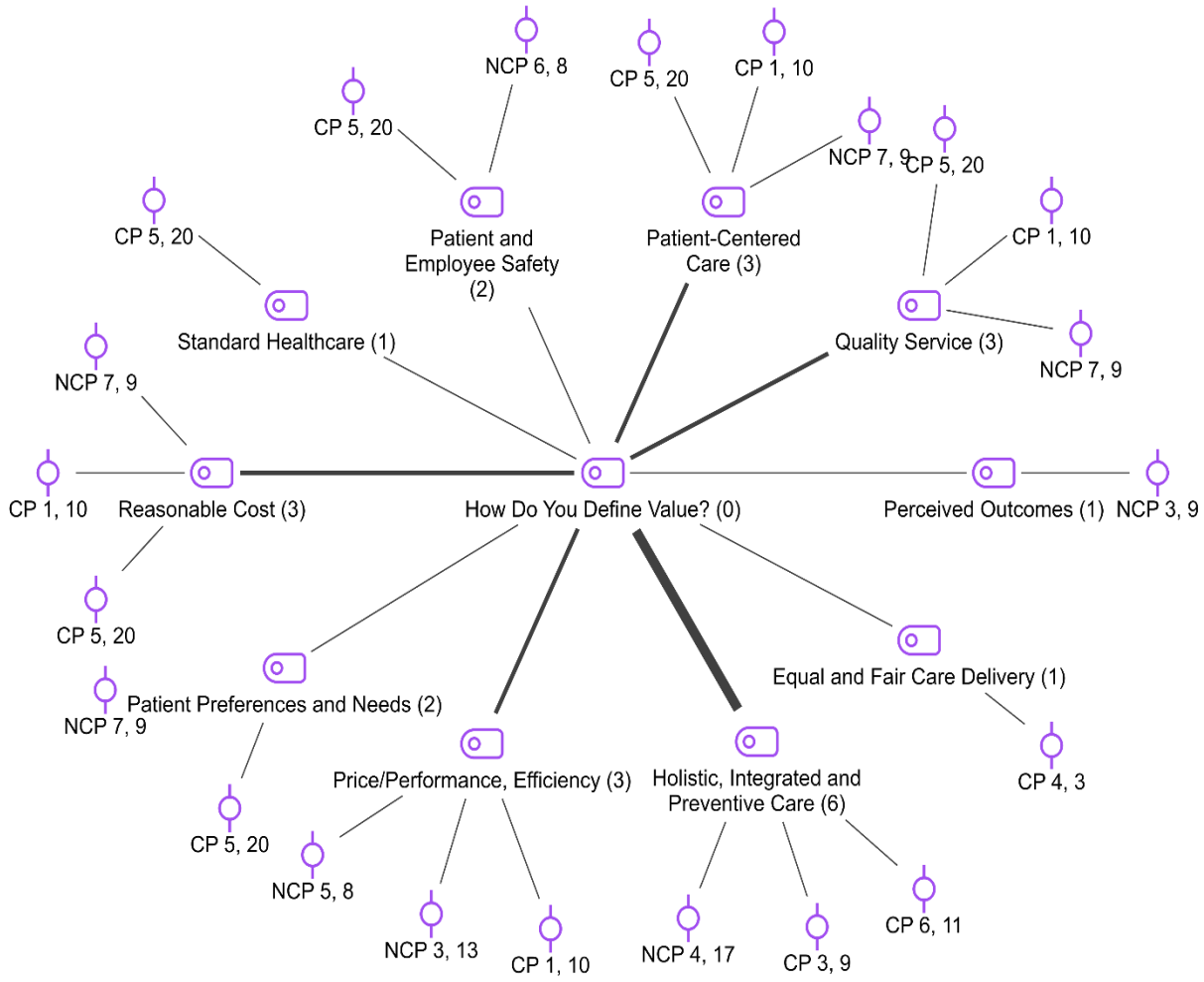
The most frequently mentioned system deficiencies by the participants are the sub-themes of "Deficiencies in the Care Delivery Process" (n=19), "Insufficient Resources"(n=17) and "Access Problems" (n=9). The most emphasized issues related to the service delivery process were the inability to provide holistic care to patients, the fact that qualitative outcomes related to and important to patients are not as important as quantitative outcomes, and insufficient time allocated to the patient. In terms of resources, the most frequently evaluated issue by participants was the inadequacy of human resources in terms of quantity.

When participants' statements are analyzed, an important point stands out. Clinical and non-clinical professionals agree that the most important resource issue is the lack of human resources. However, clinical professionals emphasize the quantitative deficit in human resources, while non-clinical professionals emphasize both the qualitative and quantitative deficit. Clinicians attribute many of the system's failures to inadequate levels and distribution of resources, especially human resources. Non-clinical health professionals, on the other hand, associate the current problems, especially in the service delivery process, with the qualitative as well as the quantitative aspect of the lack of human resources, and believe that radical steps should be taken to change the quality of health professionals and the service delivery process, starting with the medical education curriculum. In the study, none of the interviewees possessed specific expertise in medical education. The statements regarding the need for changes in the medical education curriculum, starting with the curriculum itself, were based on the perspectives of non-clinical health professionals.

Views on the Value-Based Healthcare: After determining participants' views on the current healthcare system, the research sought to determine their views on the value-based healthcare system. The participants in the study had varying levels of knowledge regarding value-based healthcare services. The first step in ensuring that healthcare institutions are prepared for value-based service delivery is the identification and understanding of value. Therefore, in order to assess the readiness of institutions, the initial focus was on determining the participants' levels of knowledge about value. To determine the level of knowledge healthcare professionals had about value-based care, they were asked if they had any knowledge about the value-based care topic

before the interview. 78.6% (n=11) of the participants indicated that they had not heard of value-based care, while 21.4% (n=3) indicated that they had limited knowledge of the topic. All the participants who had heard of value-based healthcare were postgraduate educated and held management roles at their organizations. To determine how employees define value, participants were asked what "value" means to them. The code-subcode model for participants' definitions of value is shown in Figure 2.

Figure 2. Code-Subcode Model for Value Definitions



*The thickness of the arrows indicates the frequency of use of the code.

Figure 2 shows that value in healthcare is most commonly associated with holistic, integrated care and preventive healthcare services. These statements are followed by patient-centered care, quality service delivery, reasonable cost and price performance, and efficiency. According to the

participants, to create value, patient-centered, high-quality care should be provided in a holistic and integrated manner at a reasonable cost. These statements are quite consistent with definitions in the literature on value-based health care. Some of the participants' statements are presented in Table 4.

Table 4. Example Statement on Value Definitions

Statement	Participant
I would like to answer this as a healthcare professional and healthcare manager. We can consider providing a service based on trust to the other party as a value-based approach. In other words, I think that all of the work we do within the scope of patient safety and employee safety can be handled within the value-based approach. So, to explain further, what we mean by value-based is the elements of a safe system that we have created for patients and employees, and I interpret this as the activities we do without expecting any financial return. We are talking about a 360-degree structure. In fact, this is exactly the structure that quality in healthcare aims for. What I mean by patient safety is, for example, when a patient is discharged, when they go home, when they have orthopedic surgery, if there is something that restricts their movement, we question whether they can get home upstairs, or if they have no one to take care of them afterwards, and if they are dependent patients, we question whether they have social services support. Or after discharge, we include the patient in a program by calling and checking the patient at home at a certain frequency to see if the patient has developed a hospital-acquired infection, and if there are symptoms, we detect it beforehand... In fact, in structures and companies that are entirely based on patient safety, services are provided by fulfilling the concept of value you mentioned in this way	NCP 6
When talking about value-based healthcare, I understand it as a healthcare concept where the focus is on the value given to the patient and efforts to increase this value. I perceived it as a healthcare service that is based on price-performance, aiming to deliver quality at a lower cost.	CP 1
As far as I can tell, there is an understanding of coming from the one and going to the whole, that is, looking holistically. Integrating different parts rather than dividing them into parts and generally providing improvement. I believe that value can be created by starting to deal with the disease before it occurs and by changing the treatment and lifestyle of society. This should be approached holistically, not only in terms of healthcare services, but also in collaboration with the food sector, the agricultural sector and all related sectors. By addressing the root causes of disease, value can be created and value-based health care services can be provided.	NCP 4
To create value, care must be patient-centered. This means responding to patient preferences. We must be able to provide quality service for every patient, doing so safely and at a reasonable cost. Currently, with the widespread establishment of city hospitals, it can be said that there is an effort to prefer this type of service delivery that focuses on high-quality, patient-centered care, ensuring patient confidence without creating any additional costs compared to other public hospitals. Indeed, there is an effort to transition to this new system, which, although it yields positive	CP 5

results for patients, we must be cautious of the burden it may impose on healthcare workers and the potential feelings of undervaluation they may experience.	
There is this in private hospitals, of course there is a different process in public hospitals, but when evaluating private hospitals, it is like this: "Yes, I paid a good price, but I got a service that was worth it." Yes, we can think that in the end there is value in comparing quality, fee and service received. Especially from a financial point of view. Both the service recipient and the service provider need to make this comparison.	NCP 3

Views on Potential Transitions to a Value-Based System: After determining healthcare professionals' perspectives on the current system and their thoughts about value-based healthcare, the research sought to determine their views on possible changes to value-based healthcare. Participants were briefly informed about value-based healthcare and then asked if this system could be considered as an alternative to the current healthcare system. All participants (n=14) agreed that a value-based system could be considered instead of the current healthcare system. In response to the question of whether it would be possible to transition to a value-based health care system in Turkey, 69.2% (n=9) of the participants stated that it would be possible. It was stated that the existing regulations in the system are qualified and well prepared to support the value-based system, that there is a will to support it, and that the technological infrastructure is robust.

30.8% (n=4) of the participants stated that the transition to a value-based healthcare system is not possible under the current circumstances. The reason for the impossibility of the transition was attributed to the socio-cultural differences of the society, and it was emphasized that this change is not possible due to deficiencies such as infrastructure deficiencies, lack of resources, and the functioning of management processes, especially in public hospitals rather than private hospitals. Some of the statements on this subject are given in Table 5.

Table 5. Example Statements on Value Based System and Transition to "Value"

Statement	**Participant**
Well, to be honest, if we think about it like that, in our country, for example, some infrastructures are incredibly successful. Here is 'e-Nabız'. I don't think there are many examples in the world, I don't know, to be honest. It is not available in most of the developed countries. E-Nabız is a system that has been developed over a period of maybe 15, 20 years, and since 2005 we have been slowly developing it, and the current telemedicine infrastructure, our sending data... For example, people have also learned, they check the reports on e-pulse, something happens, you share it with the doctor on e-Nabız.. Look, this has been done in our country. With this logic, I say that the system you are proposing can also be done. I mean, of course, the legal supports are regulations, so there is a will to do it. If we were still in the same system that we were in 20 years ago, we could say that there is no way we can do it, but I think it can be done.	NCP 1

In fact, I think the first steps of the structures that need to be built have been taken. In other words, services such as the family medicine system and then the cascade of health institutions are among the building blocks of this. In other words, if the system works properly, it will actually take us there. .... In fact, the standards, regulations, guidelines, whatever you call them, the legal conditions are very well established. Everything is written and described step by step... We have a lot of valuable scientists, professors... They are not people who do not know this work, they are people who come and give conferences all over the world and explain their subjects, so they cannot not know. Therefore, it is necessary to support them and provide them with resources so that the work pays off.	NCP 6
It might be a bit difficult in Turkey. Patients should be ready for this system. They should want holistic care, they should have holistic care and aftercare. They should not consider it as 'I have a disease, let me get well'. For example, family practitioners were established to provide a lot of prophylactic services, to provide early diagnosis, to reduce the burden on hospitals, but as a country we could not implement it. So I think our society is not very suitable for this system. I mean, they do not have the mindset of, "Let the physicians deal with my situation as a whole; let me recover mentally, psychologically, and socially". At least a certain part of it is not.	CP 2
The most important of these aspects is that the infrastructure required for the transition to the system is not ready. The criteria for this infrastructure are the lack of a sufficient number of physicians, the low number of health workers per patient, the accumulation in some health institutions due to the unequal distribution of equipment such as tools and devices in health institutions to all health institutions, and therefore delays in accessing services. Valuable physicians leaving the country, physicians from other cultures and geographies who are deficient in terms of education and qualifications filling the vacancies left by them, the fact that a generation that does not receive proper education in medical faculties is being trained as doctors due to the corruption in the education system, and in parallel to this, the existence of unnecessary universities that are increasing due to the wrong political policies in the country, and the opening of universities - faculties of medicine - that do not even have hospitals... It goes on and on, but for all these reasons, I think that transition to a value-based system will not be possible in Turkey in the near future.	NCP 7

The majority of participants who stated that the transition to value-based health care is possible also indicated that there are some prerequisite changes that must be implemented in order for this transition to be possible and for the transition to be achieved in the long term. The themes and subthemes created from the participants' responses regarding the changes needed to make the transition possible are presented in Table 6. Some of the statements made by healthcare professionals on this topic are also presented In Table 6.

Table 6. Changes Needed to Enable a Transition to a Value-based System in Turkey

Theme	**Sub-Themes**	**n**	**%**
Changes to be made in the system to enable the transition to a value-based system	Education and Awareness Raising	8	28,57
	Management and Managers	6	21,43
	Resources	5	17,86
	Providing Suitable Conditions and Infrastructure	4	14,29
	Changes to Service Delivery	3	10,71

	Changes to Financial Regulations and Payment Methods	2	7,14
TOTAL		28	100,00

Statement	**Participant**
Because it's not just the thing, mind sets need to change as a culture in employees... I mean, such a value-based management is not just about building a hospital and doing it well. That equals city hospitals... The mind-set of the employees also needs to change. Maybe even the mindsets of the people who use these services need to change.	NCP 1
At this point, most managers listen to and take into account what the political authority has to say and are in contact with them. The system is full of managers with no merit and no understanding of health management. These managers do not think about the patient or the healthcare professionals, they only act in a way that makes the political authority happy. Therefore, the biggest obstacle to this system is the current managers and the political authority. The same is true for the organization I work for. There are problems in managerial processes. In other words, we are talking about a system where a person can be appointed because of his/her closeness to someone, regardless of merit, regardless of competence	CP 1

When Table 6 is examined, it is seen that the most emphasized sub-themes by the participants are "Education and Awareness Raising", "Management and Administrators", and "Resources". Participants indicated that comprehensive change is needed, including raising the health awareness of society, supporting the education and development of healthcare professionals, ensuring a change in culture and mindset, and redesigning the medical education curriculum to ensure patient-centered care. They believe that a change in management approach and perspective is needed at all levels of management, from top to bottom. In order to make the transition to a value-based system possible, there should be experienced and competent, merit-based independent managers who are willing to do this work, and the will of political authority and decision-makers is important. In terms of resources, the lack of human resources was particularly emphasized. It was stated that it is essential to increase the quantity of human resources through proper resource planning and allocation. In regards to care delivery and treatment approach, they stated that patient participation should be ensured, a quality-based rather than a quantity-based approach to care should be adopted, and standardization of care delivery, materials used, and physician approach should be ensured. Participants believe that financial arrangements and changes in payment methods can encourage patient participation in care and reduce waste by discouraging unnecessary utilization of services, thus paving the way for an environment conducive to value-based care.

It was tried to determine the opinions of healthcare professionals about the aspects that would challenge organizations and employees in a potential system change. The code-subcode

model created according to the responses of the participants is presented in Figure 3.

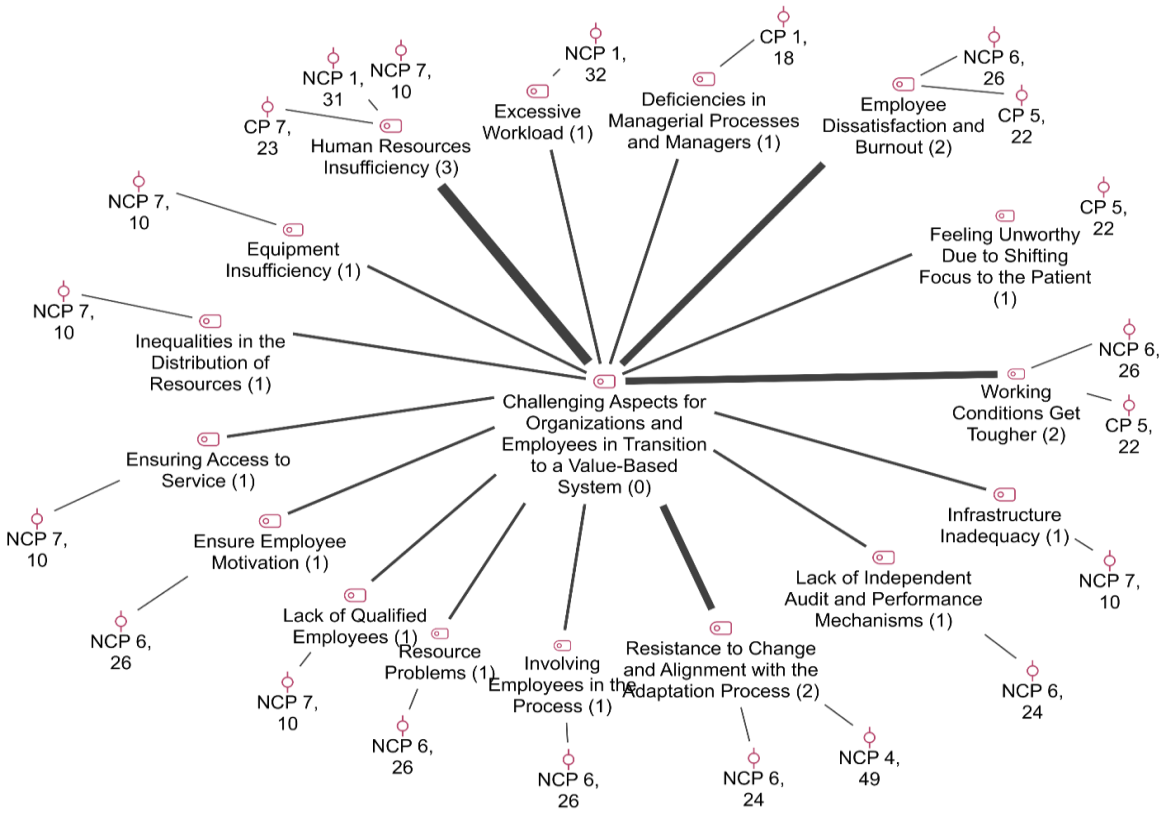


Figure 3. Challenges for Organizations and Employees in Transition to a Value-Based System

*The thickness of the arrows indicates the frequency of use of the code.

Figure 3 shows healthcare professionals' statements about the challenging aspects of the potential system change to value-based care. In this context, healthcare professionals foresee that the challenging aspects of system change will be more difficult for organizations. Resource-related issues are the sub-theme most emphasized by the healthcare professionals. In particular, it was highlighted that human resource shortages are a common aspect that will challenge both organizations and employees. The expectation that the shortage of human resources will lead to a possible increase in workload, more challenging working conditions and consequent lack of motivation and burnout were mentioned by participants as aspects of the shortage of human resources that will challenge employees. It was stated that the human resource shortage will challenge organizations to ensure employee motivation and to establish an appropriate and functioning system due to the importance of a skilled workforce. In addition, overcoming

resistance to change and ensuring adaptation to the adaptation process are also mentioned as aspects that will challenge organizations. Some of the participants' statements on this topic are given in Table 7.

Table 7. Statements on challenges

Statement	Participant
It really puts a huge burden on their existing workload. It would be unfair for us to say: 'You're going to take care of 40 patients in this ward and you're going to do these things on top of that,' people can say, 'Wait a minute, what are you talking about?' If the resources that I just mentioned are really there, if we have enough nurses, enough medical secretaries, enough managers, why can't we do these things, what is the difference between us and other countries? I mean, in the private sector, yes, you can provide some motivation, but in the public sector there is no point in doing certain things. If he is professionally in love with this job and idealistic, he will want to do it wholeheartedly. But if there is no such thing in him, you have to come up with something to motivate him. If you can't do that, then your hands are tied when the employees say, "Why should I do this? You can't make them do anything. Because they're a civil servant under a different law, and you can't really do anything. So we have to do some things to make them want to do it.	NCP 6
For one thing, there may not be enough human resources. One of the basic problems is that there may not be enough physicians, nurses, and support personnel. There is an efficiency problem in the public organizations, and this efficiency problem can cause problems.	NCP 1

After identifying the possible difficulties of the process, the participants' views on the priority areas that would make the institutions compatible with the value-based system and make the transition to this system successful were tried to be determined. The themes and sub-themes that emerged from the participants' responses are presented in Table 8. Some of the statements made by healthcare professionals on this topic are also presented in Table 8.

Table 8. Priority Areas to Regulation for Value-Based System

Main Theme	Sub Themes			N	%
			n	%		
Priority Areas to Ensure the Adaptation of Organizations to the Value-	Structural, Systemic	Adjustments in Care Delivery and Treatment Approach	14	38,9	36	51,4
		Culture and Awareness	6	16,7		
		Policies, Legal and Regulatory Framework	5	13,9		
		Resource Management	5	13,9		
		Political Authority and Decision Makers	3	8,3		
		Payment Methods	2	5,6		
		Training and Development	1	2,8		

Based System	Corporate	Care Delivery Process	8	23,5	34	48,6
		Sources	8	23,5		
		Corporate Culture, Values and Understanding	5	14,7		
		Technological Infrastructure and Data Analytics	4	11,8		
		Audit, Performance Measurement and Monitoring Mechanisms	4	11,8		
		Managerial Processes	4	11,8		
		Preparing for Transition	1	2,9		
TOTAL					70	100

Statement	**Participant**
Will physicians be happy? What role will the healthcare professionals play in this system? Will their workload increase? Since the current authority only cares about the satisfaction of patients... Because there is a minority, the health workers. There is a majority group, the patients, and since they are already considered in terms of quantity... Providing quality service, yes, but it is also important to ensure the satisfaction and professional fulfillment of healthcare professionals. Not just financially. The following can be considered when providing value-based health services If a system is created in which primary health care services are completely freed from the current system, emergencies, outpatient clinics, etc., then it may be useful. Like a referral system, that is, the deserving patient will be cared for in the way they deserve and where they deserve to be cared for. I mean, if the patient who just says he/she has a sore throat occupies the emergency room and prevents the patient with a heart attack from accessing health services, as is the case in this system, then we cannot talk about a value-based health care system.	CP1
Yes, in this general practice of our ministry, family medicine was introduced and a step system was tried. It did not work very well in Turkey. That is, if it becomes a functioning system. In general, I think that each step will be more relaxed, patients will receive more efficient service, and the number of patients, that is, primary care patients, secondary care patients, tertiary care patients, will receive a better quality and more effective service at lower cost after they are separately formed and directed.	CP 2
"I mean, because in this sector, in this kind of service, rather than conceptualizing it in the sector, the main players and a large segment that is influential in policy making are healthcare professionals. So, first of all, healthcare professionals need to believe that this will actually add value to patient outcomes, that it will add value, that it will be a positive development. Otherwise, we can only work on the infrastructure, but the most important thing is the political will. Politicians and political will. Here the things of the decision makers are very important, their competence is very important. Yes, the word competence here.	NCP 2
"I mean, you can't explain this to people right away in the current system, you can't teach it, but starting from scratch, from a university education, the system will evolve in this way. It can be trained that way. They are also based on educating people at the root of everything. I mean, they also need to be supervised, that is to say, qualified personnel need to be trained in order to implement them.	NCP 5

The priority areas that participants think will enable organizations to adapt to the value-based system were evaluated under two sub-themes: structural, systemic (macro) and organizational

(micro). Evaluations on macro areas (n=36) are higher than evaluations on micro areas (n=34). This may mean that the participants think that the regulations in structural, systemic areas are more prioritized.

Regulations regarding the care delivery process were the most frequently mentioned topic for both macro (n=14) and micro (n=8) domains. At the macro level, the importance of preventive health care and public health was emphasized for the care delivery process and treatment approaches. Participants particularly emphasized the need for cascading and the establishment of a well-functioning referral chain. It is widely believed that the proper functioning of cascading will reduce hospital congestion, prevent waste and reduce costs, and provide benefits in terms of access to services by providing the right treatment in the right place for the right need. The emphasis here is on the will of the political authority and decision-makers, and on making the policy, legal and regulatory framework compatible and applicable to the system. It is considered important to establish a system that provides integrated and holistic service delivery to the patient, and to emphasize home health services to ensure patient follow-up. At the micro level, it was stated that an appropriate environment and culture of cooperation should be created in the organization, where the service delivery process can be provided in an integrated manner, and that the necessary organizational, technological infrastructure and audit mechanisms should be brought to an appropriate level. At the macro level, it is pointed out that there is a need for regulation, particularly in relation to culture and raising health awareness in society. Both service providers and recipients need to be encouraged to adopt a holistic and quality approach to care. At the micro level, increasing the quality and quantity of the human resources and the availability and appropriate distribution of other resources are the most important areas. The organizational culture needs to be built in a way that supports the understanding of value and quality service delivery, and management processes need to function in a way that supports this culture. It was stated that management should be based on merit and that competent, experienced and expert managers who are informed about the unit to which they are appointed should be put in charge to improve the quality of services provided to patients and to consider the welfare of health care providers. Some of the statements made by the participants on this issue are given below.

Having determined the participants' views on the issues that will challenge the organization and staff in the transition to a value-based system and the priority areas that will ensure compliance with the regulation, we wanted to determine their assessments of the responsibilities of clinical

and operational leaders in the process of transitioning to a value-based system. The major themes and subthemes that emerged from their responses to the questions posed for this purpose are presented in Table 9. Some of the statements made by healthcare professionals on this topic are also presented in Table 9.

Table 9. Views on the Responsibilities of Clinical and Operational Leaders in Transition

Main Theme	Sub Themes	n	%
Responsibilities of Clinical and Operational Leaders in System Change	Engaging employees in the process	11	39,3
	Characteristics of leaders and applying change management	6	21,4
	Ensure that necessary systems are in place	6	21,4
	Clearly define plans, goals, and activities	3	10,7
	Value-driven management approach	2	7,1
TOTAL		28	100

Statement	Participant
Otherwise, the employee who does not see that his/her feedback is taken into consideration will be lost in that system after a while and will only do what he/she is told. However, our care professionals need to work with a multidisciplinary team spirit so that they feel valued and that they belong to the organization. If they feel that they belong to the organization, and if the criticism that they make gets positive or negative feedback, I think the leader there can make the organization more valuable by solving a lot of problems. It can also make the employees feel more valuable.	NCP 3
Here, the main task of the operational leaders is to ensure and support the training and development of the healthcare professionals who will provide health services... By ensuring the welfare of them, both in terms of salary policy and social opportunities, to ensure their motivation and to ensure that they start work as happy individuals... Because only a health worker who ensures his own self-motivation and feels secure in every respect can then move on to the step of giving importance to "values"	NCP 7

When analyzing the statements of healthcare professionals, it was found that the primary responsibility of clinical and operational leaders in a potential system change to value-based healthcare was seen as involving employees in the process (n=11). To ensure employee involvement, participants indicated that they should make employees and their ideas feel valued and that their feedback is important, adopt and implement methods to ensure employee satisfaction and motivation, keep employees informed about the process and how it works at every stage, and support them with education/skills development. Managers are expected to believe in change, understand people, have problem-solving skills, be experienced and competent, and have a management approach that prioritizes values. In addition, another important issue mentioned by the participants is that in order to realize the change to a value-based system, managers should ensure that the necessary infrastructure and systems that will help provide accessible health care

delivery, such as audit mechanisms and tracking systems, are designed and maintained in the organization. It was also emphasized that it is important to have clear plans, objectives and activities to be carried out. The following are some of the statements made in this regard.

Participants' Views On Their Organizations' Readiness To Transition To A Value-Based System: After determining participants' views of the current system and the value-based system, health care professionals were asked questions to determine their views on the problems they observed in their organizations, the care delivery process, the comprehensiveness of the provider network, clinical and operational informatics, and the financial strength of their organizations to determine the readiness of the organizations for potential change.

The themes and subthemes identified regarding the clinical and operational problems observed by participants in their organizations are presented in Table 10.

Table 10. Clinical and Operational Problems Observed in Organizations

Main Theme	**Sub Themes**	**n**	**%**
Clinical and Operational Problems Observed by Employees in their Organizations	Human Resources Challenges	6	19,3
	Problems Related to Technological Infrastructure and Data Management	6	19,3
	Problems Related to the Care Delivery Process	6	22,6
	Problems with Resources	4	12,9
	Problems with Monitoring Mechanisms	2	6,4
	Problems Related to Managerial Processes	2	6,4
	Payment Methods	2	6,4
	Corporate Culture	1	3,2
	Awareness	1	3,2
TOTAL		30	100

Participants made 30 evaluations about the clinical and operational processes they observed in their organizations. According to these evaluations, the most commonly cited clinical and operational problems are human resources (n=6), technological infrastructure-data management (n=6), and care delivery process (n=6). All of the problems related to human resources, which received the highest evaluation, were mentioned by public and city hospital employees. In particular, the length of working hours, unfavorable working conditions and excessive workload of physicians and nurses providing clinical services were mentioned. It is stated that clinical professionals, who are the building blocks of service delivery, should be motivated, an environment where they can spare time for their families should be created and they should not be

expected to provide services at an intensity based on 24/7 working basis. In addition, it was noted that inequities in workload distribution occur due to the improper functioning of audit mechanisms. The majority of the problems related to technological infrastructure and data management were again assessed by public and city hospital employees. The problems related to technological infrastructure and data management raised by private hospital employees are related to the lack of full digitalization of data, rather than the availability of appropriate infrastructure and data analytics systems.

Problems related to the care delivery process include inadequate time allocated for treatment, access to services, patient participation and follow-up.

Problems encountered in areas such as managerial processes and supervision mechanisms were again only mentioned by public hospital employees.

From this perspective, it can be concluded that the problems faced by public, private and city hospitals are different, and this difference means that they may focus on different priorities in the care delivery process.

Following the participants' general assessments of the problems they faced in their organizations; they were asked to evaluate more specific aspects of their organizations in order to get an overall picture of their readiness for a value-based system. To this end, firstly, their evaluations of the care delivery process of their organizations were revealed. According to the responses of the participants, the themes and sub-themes formed regarding the service delivery process of the institutions and their opinions are presented in Table 11. Some of the statements made by healthcare professionals on this topic are also presented in Table 11.

Table 11. Assesments on the Care Delivery Process

Main Theme	**Sub Themes**				**N**	**%**
		Opinions	**n**	**%**		
Assessments of organizational care delivery processes	Supporting Clinical Innovation/Innovation Idea	Positive	5	41,7	12	20
		Negative	7	58,3		
	Clinical Standards and Protocols	Positive	8	72,7	11	18,3
		Negative	3	27,3		
	Systematic Measurement of Patient Satisfaction	Positive	5	55,6	9	15
		Negative	4	44,4		
	Consideration of Patient Needs	Positive	4	57,1	7	11,7
		Negative	3	42,9		
	Ensuring Patient Participation	Positive	2	33,3	6	10
		Negative	4	66,7		

	Ensuring Coordination and Integration in Care Delivery Process	Positive	2	33,3	6	10
		Negative	4	66,7		
	Service Quality and Standard	Positive	4	80	5	8,3
		Negative	1	20		
	Patient Satisfaction	Positive	1	25	4	6,7
		Negative	3	75		
TOTAL					60	100

Statement	**Participant**
Now we say that we have a holistic approach where the patients themselves are involved in the care. In the care of our patients, it is very important to us not only that health care professionals provide the care and the patient follows it, but also that the patient participates in that care. In other words, if we give the patient the work that he/she can do, and if we make sure that the patient participates in care, the patient will recover faster, be more motivated, and feel better. They don't feel worthless. So we encourage participation in care and try to involve our patients as much as possible	NCP 3
Patient satisfaction surveys are conducted in inpatient, outpatient and emergency services. As you know, there is a guide published by the Ministry of Health on satisfaction practices. According to this logic, all public organizations address the questions contained in their surveys to the patients. Nothing more or less is asked. And you know that there are conditions for this, such as monthly face-to-face interviews, in the period they want, and they fulfill the survey practices in accordance with these conditions. But this is not the case in the private sector, of course, because in the private sector patient loyalty is important, satisfaction is one of the most important criteria. In terms of patient satisfaction, yes, they are inspired by a survey like the Ministry of Health's survey, but they also add their own questions. The things they specifically want to measure are added	NCP 6
Absolutely. Our head nurse of nursing services has a routine meeting with our charge nurses every month. This responsible meeting is also a meeting with an agenda. In one item, we receive feedback on innovation studies, scientific studies or innovations and studies that people want to do in their own fields. We express that we are always open to these ideas, and if there are any ideas about it, whether it is a decision we can make or not, we present it to the board and give this feedback to our friends. Innovation is very important for us because, as I said, we are in serious competition both professionally and institutionally.	NCP 3
"Obviously, this is a cultural thing. In Turkey, clinical innovation, openness to innovation, etc. are not very suitable for our culture. The new assistant doctor does whatever the physician says. They cannot have their own ideas and thoughts. Likewise, if the chief physician says it, the infection control committee approves it. In fact, even if they say the exact opposite of what they said 2 minutes ago, whatever the chief physician says, he says exactly the same as "Yes, you are right, Pasha". So in our culture there is a lot of clinical innovation and so on, maybe in very big health groups, private health groups, but not in Turkey in general. You know, the people who implement it are the ones at the top, it goes down from the top, but I don't think there are many people from the bottom who express opinions like this would be good in this field. I see it in practice.	NCP 2

When participants' opinions of their organizations' care delivery process were examined, it was found that positive opinions on the topics were more common (n=31). The highest positive

evaluations were found in the themes of existence/implementation of clinical standards and protocols (n=8), systematic measurement of patient satisfaction (n=5) and consideration of patient needs (n=4). It should be noted that the majority of the positive evaluations on the themes, especially on the systematic measurement of patient satisfaction, belong to the employees of private and city hospitals. Again, the theme of taking patient needs into consideration in treatment planning and process was generally evaluated positively by private hospital employees. Ensuring patient participation and ensuring coordination and integration in care delivery were generally evaluated negatively by the employees of all organizations. The theme of supporting the idea of clinical innovation was generally evaluated negatively (n=7) and all of the positive evaluations (n=5) belonged primarily to the employees of private and then city hospitals.

Thus, it can be concluded that private hospitals are more prepared for a possible shift to value-based healthcare than public hospitals in terms of the care delivery process. Because their primary goal is to make a profit in addition to providing healthcare services, private hospitals that value patient and employee satisfaction make special efforts to support clinical innovation, work in an integrated and coordinated manner, and systematically conduct measurements such as patient satisfaction. Some statements on this topic are presented below.

Table 12 shows the themes and sub-themes and the corresponding opinions formed according to the responses to the questions asked to determine the participants' views on the comprehensiveness of the provider network of the organization. Some of the statements made by healthcare professionals on this topic are also presented in Table 12.

Table 12. Assessments on Scope of Provider Network

Main Theme	**Sub Themes**				**N**	**%**
		Opinions	**n**	**%**		
Opinions on the comprehensiveness of the organizations' provider network	Continuity of Care	Positive	4	30,8	13	39,4
		Negative	8	61,5		
		I don't know	1	7,7		
	Organization Specific Performance Standards	Positive	2	18,2	11	33,3
		Negative	7	63,6		
		I don't know	2	18,2		
	Clinical Scope	Suitable	1	11,1	9	27,3
		Not Suitable	8	88,9		
TOTAL					33	100,00

Statement	**Participant**

It should definitely start with public health :) In other words, it should start with prevention and raising public awareness. Everything starts at home first, you know. That's why I say that we have come too far up to the 3rd step, that is, before, those village midwives, nurses, doctors, health centers were very good structures. They were the points that solved this issue at the source. Was it enough, no, I mean, their role is also up to a point, but public health is very important. I mean, there are families who run to the hospital when their baby's fever rises a little at home. So we need to teach what can be dangerous and how dangerous it can be, we need to increase health literacy. Medicine, medicine, medicine... I mean we are addicted to too many medicines. We are far away from preventive health services. So I think we need to allocate time and budget for these first. If we solve these points, we will be comfortable with the other steps. Where to start, it should start before people get sick.	NCP 6
The disease is not an issue that can be solved by the patient coming to the hospital for 10 minutes. In other words, at a certain age, people should be followed up for certain tests and then maybe directed to clinics and secondary care centers. Measures can be taken to protect and take precautions without solving the problem only in the hospital. In other words, when a physician comes to the hospital, he/she may not be able to deal with the patient in its entirety, as there are too many things that a physician can do in ten minutes. He has to produce the solution at that moment... So I think the issue can be solved by orienting towards preventive medicine and guiding people.	NCP 5
Continuity of care is closely linked to patient follow-up. The system is not conducive to follow-up. If you want to follow up with a patient, you have to make an extra effort. You have to involve the patient in the process; if the patient is not involved, you cannot follow up. Unfortunately, the system does not create a record for follow-up.	CP 1
There is a performance-related software used by our human resources. The evaluations related to this software, people evaluate themselves, their individual manager evaluates them and it is also approved by the top senior manager, and after that evaluation, performance evaluations, we meet with people one-on-one and discuss with them how their deficiencies can be completed and where they need to be improved. As I said, we also have performance evaluations in the form of rewards, where we support them with bonuses. We have a system that we use in this way.	NCP 3

When the responses of the participants were analyzed, it was determined that the opinions expressed by the organizations on the scope of the provider network were generally negative (n=23). The majority of participants indicated that they were unable to provide continuity of care (n=8). Patient follow-up, especially as expressed by clinical professionals, depends more on the patient's participation. Organization-specific performance standards were not set by many organizations (n=7).

According to the participants, public and city hospitals are based on the standards developed by the Ministry of Health, and public hospitals in particular fail to fully implement these standards. All of the participants who stated that organization-specific performance standards are set and that these standards are followed seriously are employees of private hospitals. Regarding the clinical scope, the participants stated that the disease is a phenomenon that should be dealt with

through preventive services and public health approach before it occurs. After discharge, the patient should continue to be taken care of and controls and follow-up should be ensured. However, it was stated that clinical coverage was not carried out in this way in the organizations where the participants worked (n=8). From this point of view, it can be concluded that the healthcare organizations operating in Turkey are not ready for the change to value-based healthcare in the scope of provider network. Some of the statements on this subject are presented below.

Table 13 presents the themes and sub-themes formed in line with the answers given to the questions asked to determine the participants' views on the clinical and operational informatics of the organization they work for, and their views on these themes. Some of the statements made by healthcare professionals on this topic are also presented in Table 13.

Table 13. Assessments on Clinical and Operational Informatics

Main Theme	**Sub Themes**				**N**	**%**
		Opinions	**n**	**%**		
Assessments on Clinical and Operational Informatics of Organizations	Existing Information System is Appropriate and Adequate	Positive	8	72,7	11	30,6
		Negative	3	27,3		
	Data-Driven Decision Making in the Organization	Positive	5	55,6	9	25
		Negative	4	44,4		
	Systematic Collection and Measurement of Data	Positive			7	19,4
	Data Analytics Specialist	Positive	5	83,3	6	16,7
		Negative	1	16,7		
	Auditing of Stored Data	Positive	2	66,7	3	8,3
		Negative	1	33,3		
TOTAL					36	100

Statement	**Participant**
This is where city hospitals make a serious difference. The infrastructure of the information systems, what we call the neural network of the system, has been very fine-tuned. It has gone far beyond the hospital software program and patient data entry. It has gone to artificial intelligence. We are now using business intelligence, so we have systems that interpret the data that we get and process the data very well, even receiving and processing data from medical devices. You know, we used to give the patient a piece of paper and send it to them. Now all these medical devices talk to the informatics infrastructure. Because the city hospitals are currently following HIMSS standards, everything is completely based on information systems and data analysis. So I think one of the biggest contributions of these city hospital projects is obviously this, electronic patient records and digitization of everything.	NCP 6
The organization never decides on its own. A letter comes from the ministry or higher authority and that's how it happens. In other words, it cannot make a change according to its own data, you know, these are completely quality or according to the ministry's data, not the organization's own data, but according to the ministry's data...	NCP 4

It was found that the themes created for the clinical and operational informatics of organizations were generally evaluated with positive statements (n=27). In terms of clinical and operational informatics, it can be concluded that the gap between private and public is not as wide as in other areas. It is stated that the information systems available in the organizations are generally appropriate and sufficient (n=8). Especially "e-Nabız" integration in some organizations is evaluated very positively. While public hospitals use information systems affiliated with the Ministry of Health, private and city hospitals use their own software, which enables data collection on both clinical and non-clinical processes.

Participants expressed the highest number of negative opinions about data-based decision making (n=4). When the responses were analyzed, it was found that these negative opinions were expressed especially by public hospital employees. This situation was associated with the inability of organizations to make decisions on their own and according to their own data, as decisions are generally made at the ministry level in public hospitals. Data-driven decision-making is a process where decisions are made based on objective data and statistical analyses. This indicates that despite the existing infrastructure for data collection, there is a lack of utilization of the collected data in the decision-making phase in clinical and operational areas. Analyzing all the statements on sub themes, it can be interpreted that IT is the area where organizations are most prepared for a possible change to a value-based system.

Table 14 presents the themes and sub-themes formed in line with the answers to the questions asked to determine the views of the participants on the financial strength of the organization they work for and their opinions on these themes. Some of the statements made by healthcare professionals on this topic are also presented in Table 14.

Table 14. Assessments on Financial Strength

Main Theme	**Sub Themes**				**N**	**%**
		Opinions	**n**	**%**		
Assessments on the Financial Status of Institutions	Population-specific Costing Methods	There is	3	21,4	14	33,3
		No	7	50		
		I don't know	4	28,6		
	Financial Resources and Budget Allocated	Adequate	4	33,3	12	28,6
		Inadequate	8	66,7		
	Resources and Distribution	Inadequate			5	11,9
		Positive	2	50	4	9,5

	Budget for Training and Talent Development	Negative	2	50		
	Budget for Improvement and Change	Positive	2	50	4	9,5
		Negative	2	50		
	Technology and Infrastructure Budget	Positive	1	33,3	3	7,1
		Negative	2	66,7		
TOTAL					42	100

Statement	**Participant**
I do not see it possible to transition to a value-based system in terms of cost and finance. While the cost situation is difficult to manage even in the current system, I think it will be more challenging in a value-based system.	CP 4
Of course, it would be too optimistic to think that the transition to a natural value-based system will happen tomorrow. I mean, first of all, there has to be the will of the public sector and the adequacy of the budget. I don't see this as very valid at the moment.	NCP 2
So there has to be quality against value, and there has to be a fee. In order for us as an institution to get all the quality certificates that we are talking about now, there has to be a fee for that, these are all paid documents, and if you want to provide a quality service in return, you have to allocate a budget for that. If you allocate a budget, if you provide a quality service, you already have good values, so I think these are elements that complement each other. And in this we already have a management that is aware of this, and in our organization there is definitely a budget allocated for these values on the financial side.	NCP 3

It was found that participants' assessments of the financial status of the organization were mostly negative (n=26). The majority of healthcare professionals (n=7) indicated that they do not use costing methods specific to the patient population in their organizations. It was noted that (n=3) of the employees who reported using such costing methods were from private hospitals. In general, the financial resources and budget of the organization were reported by the participants (n=8) to be insufficient for system change. The participants who reported that the financial resources and budget allocated are sufficient were also private hospital employees. (n=4). Regarding the issue of resources and allocation, opinions were generally expressed as inadequate (n=5), and all these opinions belonged to public hospital employees. Based on participants' views of the financial strength of their organizations, it can be concluded that the organizations are not financially ready for the change to value-based care. Some of the statements on this topic are presented below.

3. DISCUSSION

Value-based healthcare is a concept that has gained increasing attention in the healthcare sector in recent years. Studies in the literature show that many countries have adopted value-based methods

to improve their healthcare systems and have achieved positive results (Sorenson et al., 2013; Kamae, 2010; Teperi et al., 2009; Özsarı, 2018). Although there are theoretical studies in Turkey, there are not enough comprehensive studies on practice. However, the results of our study show that even though the delivery approach in private and city hospitals is not labeled as "value-based health care", it is carried out in parallel with this type of care delivery and with the same objectives as the delivery of value-based health care. The fact that service providing in public hospitals cannot be realized in exactly this way can be attributed to the fact that the legal legislation and regulations are too binding for the public sector, and therefore they cannot go beyond them to provide services. In fact, when we look at the expectations of both public and private healthcare professionals from the system, these demands are in line with the promises of the value-based healthcare system. When the results of the study are examined, it can be seen that health professionals criticize Turkey's current health care system mainly in areas such as the care delivery process, lack of resources and disruptions in distribution, problems in access to care, and quality and safety problems.

Amarat (2021), in his study examining stakeholder perspectives on value-based healthcare, reported that participants identified the lack of a holistic approach and the provision of immediate solutions as systemic design problems within the Turkish healthcare system. They also described issues related to service delivery, rising costs, and sustainability as implementation-related problems. According to the participants, problems in healthcare service delivery are among the most significant issues. They associate these problems with dissatisfaction, lack of trust, and the absence of standards, and they believe that these issues can be resolved through value-based healthcare services. These findings are consistent with those of our study.

Ergin (2019), when examining the outcomes related to the creation of value, suggested that creating value could be the solution to similar problems within the Turkish healthcare system. In particular, the inability to provide care in an integrated and holistic manner, the problems in the cascading and referral chain that will ensure this, the problems in the functioning of family medicine, the inability to provide holistic treatment and follow-up of the patient, the quantitative and qualitative shortage of other resources, especially labor force, preventing quality and equal service provision, geographical and wage-based service access problems and inequalities are the problems that are dealt with on the basis of the value-based health care approach (Porter ve Teisberg, 2006; Porter ve Lee, 2013; Kim, Farmer ve Porter, 2013).

In this study, all participants agreed that a value-based system could be considered in place of the current healthcare system. The majority of participants (69.2%; n=9) believed that transitioning to a value-based healthcare system is possible for Turkey. They noted that existing regulations are well-prepared to support the value-based system, there is a supportive will, and the technological infrastructure is robust. Most of the participants who believed in the feasibility of transitioning to value-based healthcare also emphasized that certain preliminary changes are required, and the transition would be a long-term process. The most frequently highlighted sub-themes for change by the participants were "Education and Awareness," "Management and Leadership," and "Resource-Related Changes."

These findings are consistent with Ergin's (2019) study, which also emphasized the importance of education and management adjustments to meet the needs of value-based healthcare services. In our study, 30.8% of the participants (n=4) stated that transitioning to a value-based healthcare system is not feasible under current conditions. The infeasibility was attributed to socio-cultural differences in the society, and particularly the lack of infrastructure and resources in public hospitals, as well as the inefficiencies in managerial processes. These findings align with Amarat's (2021) study, where some participants expressed that transitioning the Turkish healthcare system to value-based services would not be easy. Similarly, literature indicates that stakeholders in the healthcare system often describe value-based healthcare as a utopian vision or an ideal system (Reinhardt, 2006). However, over time, with implementation and development, it becomes apparent that it is more than just a utopian vision. Based on the findings of our study and the literature on value-based healthcare, it is believed that If implemented with the necessary changes, value-based healthcare can be a suitable reform for the Turkish healthcare system and an ideal method to meet the needs.

In particular, the expectations of clinical professionals overlap with the promises of value-based systems. However, clinical professionals are less likely than non-clinical professionals to believe in a value-based healthcare system. The quantitative deficiency of the workforce, the level of awareness of the society, the culture of resistance to change prevailing in Turkey, the belief in the experience and merit of the leaders appointed to health organizations, especially public hospitals, and the belief that the patient-oriented nature of this system will be misunderstood and make them feel less valuable, and most importantly, the belief that this system will not be sustainable as in previous systems, are the biggest obstacles to the confidence of clinical

professionals, the building blocks of the value-based system, in the transition to the system. As Porter and Teisberg (2007) stated in their study, the fact that clinical professionals, especially physicians, are the most important factor in the implementation of value-based health services reveals the importance of convincing and preparing clinical professionals and ensuring their voluntary participation in the process. Nillson et al. (2017) stated that it is important for healthcare providers to involve their employees in the transition process and ensure that they understand value-based health goals and principles and have the necessary skills and knowledge. The findings of our study confirm this recommendation. It was emphasized by the participants that organizations should prepare for the process by raising public awareness, making radical changes, and aligning the care delivery approach of clinical professionals with the value-based system. It was also stated that the most important task for clinical and operational leaders is to prepare employees for the process, support their education and development, care their ideas and feedback, apply methods that will provide motivation and incentives, and ensure their participation in decision-making. Our findings align with those of Ergin (2019), who emphasized that creating value for healthcare employee is contingent upon motivation and recognition, salary and compensation, and the adequacy of healthcare staffing.

The shift to a value-based healthcare model can often represent a radical transformation for healthcare providers, and the success of this change is closely linked to their readiness for this new approach. The first step in preparing is for healthcare providers to shift their focus from volume to value. When the findings of our study are analyzed, it is seen that the majority of participants stated that they had not heard of value-based healthcare before the interview. When asked to define what value means, participants most frequently associated value in healthcare with holistic, integrated care and preventive health services. These were followed by themes of patient-centered care, quality service delivery, reasonable cost and cost-effectiveness, and efficiency. Based on these insights, participants stated that in order to create value, patient-oriented, quality care should be provided at reasonable cost, in a holistic and integrated manner. These perceptions of value are very consistent with definitions of value-based services in the literature (Porter and Teisberg, 2006; Block, 2016; Terrell, 2018; van Citters et al.,2014; Nilsson et al. 2017; Elf et al., 2017; Gordon, Chang and Burrill, 2018). In Ergin's (2019) study, participants' evaluations of what value-based healthcare means to them were categorized into three themes: "cost-quality relationship," "cost-efficiency relationship," and "cost-preventive healthcare relationship." In Amarat’s (2021) study,

participants' responses regarding the concept of value were clearly articulated under a single theme. Accordingly, value-based healthcare encompasses the measurement of service costs, the effective and efficient use of resources, the achievement of desired health outcomes, and the integration of services. While our findings align with these studies, our study indicates that the concept of value is most frequently associated with holistic, integrated care and patient-centered care. In contrast, Ergin (2019) and Amarat (2021) found that cost-related perspectives were more predominant. This suggests that, over time, the importance of patient-centeredness and integrated care has begun to be more widely recognized. Considering the aspects of the system that employees criticize, their expectations from the system and their perspectives on value, it can be concluded that shifting the focus from volume to value will not be very difficult for Turkey. The important thing here will be to ensure stability, will and support.

Determining readiness for change to value-based healthcare requires a comprehensive view that considers many dynamics, including organizational structure, care delivery process, financial status, provider network scope, and integrated clinical and operational informatics. This picture will enable service providers to have foresight about the areas that need to be changed and adjusted in their organizations while preparing for value-based health care delivery. When the findings of our study were analyzed, it was found that the organizations were most prepared for value-based system in terms of informatics. In areas such as the availability of integrated informatics systems, data collection and evaluation, easy access to data, and infrastructure, both public, private, and city hospital employees gave positive evaluations about their organizations. It was found that only in public hospitals the data collected was not used in decision-making, and the reason for this was the tendency to implement the decisions taken by the Ministry of Health in public hospitals. It was determined that the most unprepared aspect of the organizations for the change towards a value-based system was their financial strength. The majority of healthcare professionals, especially public hospital employees, do not consider their financial competence and the allocated budget sufficient to make changes. In particular, the funding and support allocated to areas such as education/skill development and resources were generally evaluated with negative statements. Most of the positive evaluations of the financial strength of the organization belong to private hospital employees. Considering all areas such as care delivery process, scope of service provider network, financial strength, and informatics, it is concluded that public hospitals operating in Turkey are not fully prepared for the transition to a value-based system but can be prepared with

some adjustments. Tracking the value created and the costs incurred for each patient requires information technology platforms capable of collecting, analyzing, and reporting data (LaPointe, 2016; Jensen & Ward, 2016). Studies on value-based healthcare indicate that it is a fundamental strategy for enhancing value in healthcare services and that transitioning to learning health systems is necessary in the future (Menear et al., 2019; Porter, 2010). Arshoff and Knapp (2020) have identified several key elements that may be important in transforming healthcare services into value-based systems. These elements include investments in education, training, and development within the health system, conducting a wide variety of trials and pilot projects, and sharing lessons learned and experiences with stakeholders. In order for the value-based system to be easily implemented in public hospitals in the long term, first of all, there needs to be a radical change in the mind-sets and health awareness of both society and providers. Private hospitals and city hospitals, on the other hand, seem to be more prepared for value-based service delivery, and even if they do not call it a value-based system, they are making great efforts to provide services in parallel with the concept of value-based care delivery.

4. CONCLUSION AND RECOMMENDATIONS

Implementing value-based healthcare requires a strategic agenda that combines the vision of its founders with practical experience. Providers must prepare for change by understanding the principles and concepts of value-based healthcare and taking the necessary steps to align their current practices with these principles. Providers should understand the principles of value-based healthcare and consider steps such as measuring health outcomes, adopting new financial models, using integrative technology, engaging leadership and management, educating employees, and identifying mechanisms to motivate stakeholders to act in a value-based manner. Studies in the literature indicate that when healthcare organizations focus on value-based care, they will achieve a number of benefits, including improved patient outcomes, higher patient satisfaction, and lower costs. In this way, the health needs of the society will be better met and health services will be provided in a more ethical and human-centered approach. Therefore, healthcare organizations should be prepared to adopt and implement this approach.

In conclusion, the value-based healthcare model emerges as a viable and applicable option for Turkey's healthcare system. However, for this transition to be successful, healthcare institutions

must undertake comprehensive preparations. This preparatory phase will facilitate the adaptation of institutions and healthcare personnel to this new system and, in the long term, enhance the quality of healthcare services.

There are certain limitations to this research that must be considered. The findings are based on qualitative research data obtained from a limited sample in a specific province of Turkey within a defined time frame, which makes generalization to the entire country impractical. Consequently, future research should be conducted with broader and more diverse sample groups to examine the long-term effects. Furthermore, it is recommended to use quantitative research methods to measure the impacts of transitioning to value-based healthcare. More research is needed to determine how healthcare providers and stakeholders will adapt to this new model and what factors will influence its success. In this context, comprehensive analyses should be conducted to ensure an effective transition from the current healthcare system to a value-based healthcare model. The strengths and weaknesses of the system should be identified, and opportunities and threats should be assessed. Future studies should consider the socio-demographic characteristics of the population, compare the previous and new healthcare systems, and plan the transition process by identifying areas that require change.

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