Çalışma İlişkileri Dergisi
Journal of Labour Relations

Challenges of Performance Management for Health-Care in Public Sector: The Case of Turkey

Kamu Sektöründe Sağlıkta Performans Yönetiminin Zorlukları: Türkiye Örneği

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Ocak 2015, Cilt 6, Sayı 1, Sayfa: 20-36
January 2015, Volume 6, Number 1, Page: 20-36

P-ISSN: 2146-0000
E-ISSN: 2146-7854

Çalışma İlişkileri Dergisi
Journal of Labour Relations

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YAYIN TÜRÜ / TYPE of PUBLICATION
PERIODICAL - ULUSLARARASI SÜRELİ YAYIN
YAYIN ARALIĞI / FREQUENCY of PUBLICATION
6 AYLIK - TWICE A YEAR
DİLİ / LANGUAGE
TÜRKÇE ve İNGİLİZCE - *TURKISH and ENGLISH*

PRINT ISSN
2146 - 0000
E - ISSN
2146 - 7854

Ocak 2015, Cilt 6, Sayı 1, Sayfa: 20-36
January 2015, Volume 6, Number 1, Page: 20-36

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Ayhan Görmüş[1]

Abstract

In Turkey, neoliberal health reforms gained acceleration with Heath Transformation Programme which has been practiced since 2003. In this context, primary health-care has been transformed into "family medicine model", secondary and tertiary health-care have been converted to "public hospital unions", and financing and delivery of health-care have been separated from each other, General Health Insurance has been established, and performance management system which establishes relationship between produced health-care and wages has been put into practice as payment system. However, the system has both some significant challenges in practice and unfavourable impacts on health-care system. In this sense, the study aims to discuss the impacts of performance management system for health-care in public sector on team service dimension of health-care, quality of health-care, health expenditures, unfairness in performance payments, redundant medical interventions and overuse of medical equipments and drugs. The study analyses secondary data from the public institutions by using descriptive analysis method. Fundamentally, in the research, it is argued that performance management for health-care in public sector has some challenges and unfavourableness in practice.

Keywords: *Heath Transformation Programme, Performance Management, Pay for Performance, Capitation Based-Payment, Fee-for Service*

Öz

Türkiye'de neo-liberal sağlık reformları, 2003'den beri uygulanmakta olan Sağlıkta Dönüşüm Programı ile hız kazanmıştır. Bu bağlamda, birinci basamak sağlık hizmetleri "Aile Hekimliği Modeline", ikinci ve üçüncü basamak sağlık hizmetleri "Kamu Hastaneleri Birliği'ne" dönüştürülmüş, sağlık hizmetinin sunumu ve finansmanı birbirinden ayrılmış, Genel Sağlık Sigortası kurulmuş ve bir ücret sistemi olarak, üretilen sağlık hizmeti ve ücretler arasında ilişki kuran performans yönetimi sistemi getirilmiştir. Ancak, bu sistemin hem uygulanmasında önemli bazı zorluklar hem de sağlık sistemi üzerinde olumsuz bazı etkileri bulunmaktadır. Bu anlamda, bu çalışma kamu sektöründe sağlıkta performans yönetiminin sağlık hizmetinin ekip hizmeti boyutu, hizmetin kalitesi, sağlık harcamaları, performans ödemelerindeki adaletsizlik, gereksiz tıbbi girişimler ve tıbbi malzeme ve ilaçların aşırı kullanımı üzerindeki etkilerini tartışmayı amaçlamaktadır. Bu çalışmada, deskriptif analiz yöntemi kullanılarak kamu kurumlarının ikincil verileri analiz edilmektedir. Bu araştırmada, temel olarak, kamu sektöründe sağlıkta performans yönetiminin uygulamada bazı zorluklarının ve olumsuzluklarının bulunduğunu ileri sürülmektedir.

Anahtar Sözcükler: *Sağlıkta Dönüşüm Programı, Performans Yönetimi, Performansa Dayalı Ücret, Kişi Başına Ödeme, Hizmet Başına Ödeme*

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Introduction

Health systems comprising of management, delivery, supply, and economic support of health-care are shaped by historical, cultural, economic, social, political and geographical structures of each country. There are two extreme points of health-care: universal health-care systems which are practiced by countries where health-care offers as a social right under state guarantee and market health-care systems which are practiced by countries where health is a purchased and sold service in market. In the world, health-care systems can be found in different spectrums between both the extreme points (Feo, 2008:225).

Especially, after the 1970 economic crisis, by the reinforcement of international organizations, health-care systems have begun to transform from the universal to the market. This is because it is claimed that public health-care expenditures reached to unsustainable levels and public health-care was inefficient and had poor quality. In this context, the transition in health-care systems has created a new policy climate which suggests reducing public responsibility on health; boosting choice, markets and individual responsibility for health; transforming national health-care into insurance-based health-care systems; privatising health-care and a discourse which refers to the patient as a client. Health-care reforms are not directly made as oriented health labour force. However, health-care reforms which are made for reducing public expenditure, increasing efficiency in health and privatisation of health-care have led to reduce the number of health staff in the public sector, encourage to use outsourcing so as to increase the number of health staff, increase workload of manpower for health and also got worse working conditions, weaker job security and lower wages (Navarro, 2009:424).

After 1980, Turkish health-care system has been significantly influenced by the efforts of transforming economy and society through the neoliberal policies. In this context, the neoliberal transformation in health-care has been still ongoing under the name of Health Transformation Programme (HTP) which has been supported by World Bank. In the scope of HTP which was started in 2003, primary health-care was entirely transformed into the family medicine model, and financing and delivery of health-care were separated from each other, and all social security institutions were gathered under a single roof and performance management launched to be practiced, secondary and tertiary health-care were transformed into public hospital unions.

The study is limited with performance management practices in Turkish public health sector. Also, the study argues that performance management for health-care in public sector poses some challenges and unfavourableness in practice in terms of being a team service of health-care and weakening quality of health-care and has adverse impacts on health labour force and health system. This research is developed from secondary information and data which has produced by the public institutions by using descriptive analysis method. In this line, first part of the study is briefly summarized the background of financing for health workforce. Next part of the study discusses challenges and unfavourableness of performance management.

1. Background

In Turkey, salaries of health staff who were employed in public servant status had been paid by general budget until 1989. After 1989, health staff also begun to be distributed as supplemental payment 50% of income which was obtained from revolving fund of hospital as well as their salaries. With Law No. 4618 dated 2001, which was amended some

substances of the Law No. 209, supplemental payment which is paid to health staff was rearranged. Additionally, a revolving fund for each province was established including all primary health-care institutions by the same law. And then, supplemental payment was linked to the performance of health staff by the arrangement which was renewed in 2003 (Berliner, 2007:30-32).

After HTP, 2004 Fiscal Year Budget Law brought with some arrangements. With these arrangements, performance management system has come into practice to encourage the motivation and productivity of health staff who were employed in public hospitals in terms of service quality, productivity and patient satisfaction principals (OECD, WB, 2008:49). In 2004, performance management system which had started with the individual performance indicators was added the institutional performance indicators in 2005. And then the system has become more extensive in 2006 by being included the financial and managerial indicators (Akpınar ve Taş, 2013:170). Thus, total performance payment has been determined on the basis of the institutional performance as well as individual, financial and managerial performance indicators. Also, institutional performance is measured on five categories: access to examination rooms, hospital infrastructure and process, patient and caregiver satisfaction, institutional productivity (bed occupancy, average length of stay) and institutional service targets (caesarian-section rate, share of doctors working full time, surgery points per surgeon and per operating room, and the reporting of scores for the performance monitoring system to the Ministry of Health MoH). Each of the five categories has equal weight in terms of institutional performance (OECD, WB, 2008:49). Therefore, financial resource of health staff who was employed by MoH consisted of two components: basic salaries from general budget and supplemental payments from revolving fund. The source of revolving fund comes from the incomes which are obtained from health-care purchased by Social Security Institute (SSI) and individual payments which are paid for health-care that are not covered by SSI. However, the administrators of health institutions should take into consideration the balance between incomes and expenditures as well as loans, cash position and the needs of health institution, while paying supplemental payments for their health staff (MoH, 2007:14). For the payment system, physicians have to get bonus from their medical activities to earn supplemental payment. As for non-physicians health staff, they have to work actually to earn supplemental payment. In this respect, supplemental payments for health staff were not an income which was paid smoothly and stably (Nesanır, 2007:275).

With performance management, firstly, proportions of weights of all medical activities which are performed by physicians are graded. Therefore, medical activities become measurable in terms of quantity and monthly. Non-clinic physicians and other health staff who cannot be graded in terms of their medical activities and health administrators are graded on the basis of the average score of health institution. This is because health-care is a team service. Thus, total performance of the institution is targeted to be reflected to all of health staff. Performance management system has been put into practice as an arrangement that all physicians, staff and administrators get a share from institutional revolving fund in proportion of their score. In other words, all of health staff has become a partner on surplus value of health institution in proportion of their contributions. Also, full-time working of physicians has been encouraged by creating a supplement payment difference between part-time and full-time working in accounting scores of physicians (Aydın and Demir, 2006:44). The most positive effect of the performance management on

health system is an increase in full time working physician rate as it is showed in Table 1. Thus, MoH argues that physicians whose productivities are already insufficient have been increased in public hospitals (Akdağ, 2011:250).

Table 1: Full-Time Working Physicians in MoH (2002-2007)

	Rate of Full-Time Working Physician (%)	Rate of Part-Time Working Physician (%)
2002	11	89
2003	25	75
2004	42	58
2005	53	47
2006	58	42
2007	66	34
2010*	93	7

Source: MoH, 2008:38; *Akdağ, 2011:250

The performance management system encourages volume of examining patients, writing prescriptions, performing medical operations, requesting laboratory tests, using medical technologies more, and prioritising medical interventions with high score (Pala, 2005:74; Berliner, 2007:31; Kart, 2013:111-112). In other words, for physicians, the more you perform medical activities, the more you get supplemental payment. As it is showed in Table 2, this approach of performance management resulted in boosting the rates of bed occupancy and bed turnover by years, while leading to a decrease the ranges of bed turnover and average residency durations in hospital.

Table 2: Rates of Capacity Utilisation in MoH (2002-2012)

	Range of Bed Turnover (Daily)	**Rate of Bed Occupancy (%)**	**Average Residence (Daily) in Hospital**	**Rate of Bed Turnover (%)**
2002	3.7	60.6	5.7	38.8
2003	3.5	61.4	5.6	39.7
2004	2.8	68.2	5.6	44.8
2005	2.8	65.2	5.2	45.8
2006	2.6	67.5	5.2	47.9
2007	2.5	64.8	4.7	50.7
2008	2.5	63.8	4.5	52.1
2009	2.5	65.0	4.6	51.4
2010	2.5	64.3	4.4	52.9
2011	2.2	66.4	4.3	55.9
2012	2.2	66.4	4.3	56.3

Source: MoH, 2013:102, 104, 106, 108

Referring to Table 3 and 4, figures display that the performance management system made an increase significantly in the number of medical examinations and hospitalised patients of surgeries, and nominal wages of physicians, in particularly after 2004. However, the health staff satisfaction survey which had been performed by of MoH in 2010 reported that 31.4% of health staff stated that pay for performance had positive effect on quality of health-care (MoH, 2010b:32).

Table 3: Volumes and the Changing Rates of Medical Examinations, Hospitalised Patients and Surgeries in MoH (2002-2007)

	The Number of Medical Examinations	Rate of Change by Years %	The Number of hospitalised patients	Rate of Change by Years %	The Number of Surgeries	Rate of Change by Years %
2002	66,231,841	0	2,806,588	0	836,518	0
2003	68,957,525	4	2,896,540	3	921,349	10
2004	91,257,412	32	3,735,026	29	1,395,954	52
2005	164,758,149	81	5,081,439	36	2,288,489	64
2006	189,422,137	15	5,379,198	6	2,895,930	27
2007	209,630,370	11	5,619,404	4	3,344,161	15

Source: MoH, 2008:49

Table 4: Average Net Supplement Payments for Physicians and Health Staff in Secondary Heath-care Institutions

	Head Physician (TL)	Specialist Physician (TL)	Practising Physician (TL)	Non-physician Health Staff (TL)
Before 2004	867	400	290	123
2007	5,464	4,166	1,830	584
2010*	-	4,541	-	643

Source: MoH, 2008:17; *Akdağ, 2011:249

* Supplement payments have begun to be paid smoothly in secondary health-care institutions since 2004.

With Law no: 5947 related to full time working of health staff which has come into force in 2010 rearranged the supplemental payment. For the rearrangement, supplemental payment for physicians and dentists became in varying proportion between 500% and 800% of their total salary, payment and all compensations. As for non-physicians, supplemental payment became in varying rates between 150 and 250 % of their total salary, payment and all compensations. However, the main opposite party opened a case to Constitutional Court to stop the execution and repeal the Law no: 5947, by claiming to be unconstitutional of determined only maximum limits of supplemental payment. As a result of the case, the Law no: 5947 was found to be a contrary rule of legal security in Constitution Article no: 2 by Constitutional Court and then Court decided to give a period of 9 months to the government to rearrange the law[2]. In the basis of the decision of Constitutional Court, minimum levels for supplemental payments were determined by Law No: 6111 which came into force in 2011. Thus, supplemental payment for non-physician health staff has been detected a minimum level which was determined by MoH. Thereafter, supplemental payments in determined level have begun to be paid for periods spending in leave (annual leave, maternity leave, x-ray leave, sick leave) or shortage of institution income. However, the problem that supplemental payment is unfair and disproportionally distributed among physicians and health staff is still ongoing as a different problem (Görmüş, 2013:233).

2. Financing Sources of Health Workforce in Public Sector

Expenditures for health workforce constitute approximately 65-80% of total health expenditures (Saltman and Von Otter, 1995:8). Therefore, health workforce costs have a significant place for performance budget strategies which reduce cost in health service

[2] Constitutional Court, 16.07.2010 Docket No. 2010/29, Decree No. 2010/90.

finance and target to ensure the sustainability. Measuring the productivity and efficiency of health-care focuses considerably on performance appraisal because health-care is a labour intensive sector (Lethbridge, 2004:2). In this regard, methods for increasing performance in health-care depends fundamentally on performance appraisal systems in which health staff are forced or encouraged to increase the productivity and efficiency of health-care.

In Turkey, wages of health labour force in public sector are composed of salary which is paid from general budged and supplemental payment that has been paid from revolving fund of health institution since 1989. In 2004 performance management system began to practise on basis of the individual performance indicators. Firstly, the institutional performance indicators were included to system in2005, and then the financial and managerial indicators were also integrated with performance management in 2006. Today, in practice, before supplemental payment is distributed to health staff, shares for National Treasury, Children Protection Institution and MoH are deducted from total revenue of health institutions (approximately 20% total revolving fund). 35% for primary health-care, 50% for secondary and tertiary health-care of rest of the total institutional revolving fund revenue is allocated to address the needs of health institutions. Finally, remaining of revolving fund revenue is paid to health staff as supplemental payment (maximum 40% total revolving fund). However, health institutions can distribute a part in range of 0-40% of the total institutional revolving fund revenue as supplemental payment to health staff (Erkan, 2011:430). While total amount which will be paid for health staff is detecting, institutional performance is also put into the formulation. An institutional performance score is calculated as a value in range of 0-1 for each health institution and the individual performance-based scores are multiplied by the institutional performance value. For example, if a health institution decides to allocate 40% of its total revolving fund revenue to health staff and its institutional performance score is 0.6, in this case, in reality, the health institution can only devote 24% of its revenue to health staff (OECD, WB, 2008:49). After Law no: 5947 related to Full Time Working of Health Staff in 2010, supplemental payment for physicians and dentists distributes in varying proportion between 500% and 800% of their total salary, payment and all compensations. Supplemental payment for non-physician health staff is paid in varying rates between 150 and 250 % of their total salary, payment and all compensations.

Table 5: Rates of Distributed Supplemental Payment in MoH (2001-2007)

	Total Revolving Fund Revenue (TL)	**Distributed as Supplemental Payment (TL)**	**Rates of Distributed as Supplemental Payment (%)**
2001	1,024,000,000	226,000,000	22.07
2002	1,961,000,000	431,000,000	21.98
2003	2,919,000,000	523,000,000	17.92
2004	4,827,000,000	1,275.000,000	26.41
2005	7,542,000,000	2,157,000,000	28.60
2006	9,480,762,776	2,923,134,053	30.83
2007	11,079,680,545	3,409,611,700	30.77

Source: MoH, 2008:16

Recently, supplemental payment has become the main source of finance for physician payments and secondary source of finance for non-physicians payments since 2004. As it is showed in Table 5, the proportion of distributed supplemental payment in total revolving fund revenue increased nominally from 22.07% in 2001 to 30.77% in 2007.

Table 6: Expenditures for Health Staff in Total Consumptions of MoH (2005-2012)

	2005	2006	2007*	2008*
General Budget Expenditures of MoH (Except Green Card) (000 TL)	4,960,154	5,624,693	6,572,017	8,037,975
Revolving Fund Income of MoH (Thousand TL)	7,542,000	9,480,762	11,079,680	-
Expenditures for Health Staff in General Budget of MoH (000 TL)	4,398,013	4,854,398	5,035,110	5,437,867
Expenditures for Health Staff in Revolving Fund of MoH (000 TL)	2,157,000	2,923,134	3,409,611	-
Total Expenditures of MoH (General Budget+Revolving Fund) (000 TL)	12,502,154	15,105,455	17,651,697	-
Total Expenditures for Health Staff of MoH (General Budged+Revolving Fund) (000 TL)	6,555,013	7,777,532	8,444,721	-
Rate of Expenditures for Health Staff in General Budget of MoH (%)**	88.67	86.31	76.61	67.65
Rate of Expenditures for Health Staff in Revolving Fund of MoH (%)**	28.60	30.83	30.77	-
Rate of Expenditures for Health Staff in Total Expenditure of MoH (%)**	52.43	51.49	47.84	-

Sources: MoH, 2007:14; * MoH, 2010a:31-32; ** Calculated by author

For Table 6, expenditures for health staff in MoH are compensated by general budged and revolving fund. Referring to Table 6, the proportion of expenditures for health staff in general budget decreased from 88.67% in 2005 to 67.65% in 2008. Besides, in Table 6, it is seen that proportion of expenditures for health staff in revolving fund budget increased from 28.60% in 2005 to 30.77% in 2007. It is seen that revolving fund budget become gradually more important in terms of compensation of expenditures for health staff. Although the share of expenditures for health staff in total health expenditures was varying between 65% and 80% in the world, the same proportion in Turkey decreased from 52.43% in 2005 to 47.84% in 2007. Apparently, weight of supplement payment on wages of health staff, in particularly physicians, grow up gradually by years.

2.1. Performance Management in the Family Medicine Model

The wages of family physicians and health staff have been determined by the capitation based-payment which varies by the number of those who are enrolled to family physicians, depending on the potential resource intensiveness of providing health-care for that category of persons. For example the highest payment coefficient is pregnant women (adjustment factor of 3). Capitation payments are calculated by computing the total number of points by multiplying the number of enrolees in each category by the adjustment factor points for that category. For example, specialist family physicians are paid at the rate of TL 3.139 per point for the first 1,000 points for a maximum of TL 3,139. Non-specialist physicians are paid at the rate of TL 2.4 per point for the first 1,000 points for a corresponding total of TL 2,400. Also, capitation based-payment method composes of some performance criterions such as level of socio-economic growth of area, expenditures of family health centre, expenditures of medical test and consumable, risk groups of enrolee, mobile health services and other expenditure components which are not born by family physicians (WB, 2013:8). But, for the standards which are determined by MoH, if family

physicians perform their work inadequately, they will face with a wage deduction as far as 20% of their wages.

The wages of family physicians in Nederland which practice family medicine system, compose of fee-for services for a limited part of their wages and capitation based-payment which are paid by insurance of enrolees for rest of the their wages. Since family medicine services are financed by tax income in United Kingdom, whilst more than half of wages of family physicians is being paid by capitation-based payment, fee-for service method is used for the rest of their wages. In Germany, family physicians register to all kind of health services which are daily performed by them and then their wages are paid as fee-for service on the basis of the medical activities by diagnosis-related groups (DRGs) which are daily performed by insurance. In Portuguese and Cuba, family physicians offer primary health-care for a fixed-wage (MoH, 2004:20-23; Kılıç, 2007:13).

In Family Medicine Model, the wages of family physicians and health staff are paid on the basis of the number of working day, except their annual leave, sick leave and training periods. However, monthly wages for family physicians cannot exceed 6 times of the highest gross wages which are paid 4/B contracting health staff. This cannot exceed 1.5 times for family health staff.

One of the most important disadvantages of the capitation based-payment model which is practised by family medicine model is that family physicians and staff are not encouraged to offer much more health-care. Since quantity and quality of health-care which are offered by family physicians and staff do not determine their wages, it cannot be mentioned that the payment model enables to an increase or variety in health-care. However, other one of the most considerable disadvantage of the capitation based-payment method is that family physicians make an effort to increase the number of their enrolees and minimise health-care. Besides, in terms of practice and sustainability, family medicine model has serious problems as follows (Tatar, 2006:110-111, Çelik, 2007:184-185);

- There is no relationship between the number of enrolees and the quality of health-care,
- Family physicians may be reluctant to enrol patients who have serious health problems,
- People under risk may experience difficulty in accessing to health-care.

Since capitation based-payment for family physicians emphasises on the number of enrolees, this results in an unethical competition among family physicians to increase the number of enrolees. However, health-care cannot be offered as a competition-based among family physicians; on the contrary it is a public service that should be offered as a team which consists of physicians and health staff in qualification and quantity which are needed to increase quality of health-care and health levels of society. In this respect, capitation based-payment which creates a competition among family physicians both can disrupt labour peace and result in ethical debates by relating between enrolee and payment.

2.2. Performance Management in Public Hospital Unions

Employment of the health administrators, specialists and officers with performance-based contracting has begun as a new employment form in secondary and tertiary health services since Decree Law No: 663 came into force in 2011. In the new employment form, job contracts of the health administrators, specialists and officers can be automatically ended up

on the basis of whether they achieve the performance criteria and institutional targets in attachment of the job contracts or not. Thus, a new stratification employment type with higher wage but lower job security has been constituted in public hospitals (Görmüş, 2013:214). It means that health administrators, specialists and officers with new performance-based contracting are deprived of job security which other public administrators and staff have. Also, it is argued that performance-based contracting employment is contrary to that sentence of Article 128 of the Constitution: "*The fundamental and permanent functions required by the public services that the State, State economic enterprises and other public corporate bodies are assigned to perform, in accordance with principles of general administration, shall be carried out by public servants and other public employees"* (Tengilimlioğlu, 2011:33-34).

The decree has not contained in an arrangement for health staff that produce health-care in hospitals depending public hospital unions. Thus, fixed-wages and performance based payments keep on being paid for health staff, as it is mentioned above. Therefore, it will not be repeated. However, the decree has brought with detailed arrangements on payments for health administrators, specialists and officers with performance-based contracting. For the article 33 of Decree Law No: 663; 200% for general secretary, 150% for medical, administrative and fiscal services presidents, hospital administrator, head physicians and vice head physicians, 100% for managers and specialists, 75% for deputy managers, 50% for office clerks of the highest wage which are paid for 4/B contracting health workers as fixed-wage by general budget are paid as fixed-wage by general budget. Health administrators who are employed on the basis of the performance-based contracting status are also paid a supplemental payment at varying proportions according to their academic careers and whether they are a physician or not. For instance, if general secretary in public hospital union hold one of the professor, lecturer or assistant professor titles, the highest proportion of his/her supplemental payment can rise up to 550% of his/her fundamental wage. For example, if a specialist physician is appointed as a general secretary, the highest proportion of his/her supplemental payment can rise up to 400% of his/her fundamental wage. The highest supplemental payment for others has been determined as 300% of their fundamental wages. The similar supplemental payment differences have been also made for presidents of medical, administrative and fiscal services, hospital administrators, and head physicians and vice head physicians. To sum up, all health administrators who are employed in performance-based contracting status are paid a supplemental payment at varying proportions according to their academic career and whether they are physician or not by revolving fund as well as a fixed-wage at varying proportions of the highest wage which are paid for 4/B contracting health workers. Moreover, proportions, procedures and principles of supplemental payment are determined by MoH with the appropriate opinion of Ministry of Fiscal by considering components comprising of roles, educational status, working conditions, working times, contributions and performances of health administrators, specialists and officer clerks as well as hospital group. Leave and severance payment rights of health administrators, specialists and officer clerks with performance-based contracting are like 4/B contracting health workers.

Health administrators with performance-based contracting should run public hospitals like a business by taking consideration profit/loss and benefit/cost principles. They have to operate the public hospitals with profit-minded approaches and achieve the institutional targets in order to be able to keep in charge. Therefore, as a possible result of this, health staff will be forced to increase their performances and contracting health workers

will be made redundant to decrease the cost, and exhaustion in health staff will increase by linking increases in workload of health staff (Görmüş, 2013:215).

3. Discussion

The first studies related to performance management go back to F. Taylor's work measurement and F. Gilbert's work and motion studies. In the results of the studies, it was detected that how long jobs took to perform and which process jobs were passed to perform. Thus, managers used the measurement results to compare with reel working times that were performed by workers. Then, performance appraisal studies have developed towards the identification of performance standards and criteria to evaluate the existing performances of workers.

Recently, performance management is known as a process that knowledge, skill, and competence of labour force are appraised and monitored; training requirement is determined by being revealed weaknesses of labour force and organizational career plan is conducted together with individual career plans. In this respect, major goals of performance management can be counted as follows:

- Finding out degrees of understandable and adoption of institutional targets by labour force,
- Providing attainment of the institutional targets in at least minimum level,
- Making up a stable and dynamic work environment.

Actually, ranking labour force from better to worse is not one of the main objectives of performance management and can result in negative effects on labour force. On the contrary, the major objective of performance management should be to bring in skill to workers through training by detecting the weaknesses of workers by performance management (Selamoğlu and Özveri, 2010:23). Also, performance management can provide data to managers for making true decision, determining relation between promotion and reward and choosing true crew for true job. Using performance outputs in determination of wages will create wage differentials by creating competition among workers. This situation, if performance appraisal errors are taken into account, can disrupt labour peace among workers.

As it is pointed out above, performance management does not mean to create a payment system by measuring the number of goods or services which are performed by workers. Performance management means evaluating, measuring, monitoring of individual performance to boost organizational performance. Performance management is an approach comprising of organisational targets and sharing the workload to realize organizational aims. And it also assists employees to understand organisational aims (Martinez and Martineau, 2001:1). Performance management should be practised to plan training requirement analysis, to keep dynamism in workplace and develop knowledge, skills, and competence of workers who have inadequate performance.

Performance management has been practiced by MoH since 2004 to promote motivation and productivity of health staff. Since system began to be practised, wages and workloads of physicians as well as rates of capacity utilisation and the number of medical examinations, hospitalised patients and surgeries have relatively increased. Admittedly, wage increases for non-physicians have not been as much as wage increases for physicians while their workloads have enhanced more than workload of physicians. Even, annual salary increases in some years were not reflected to fixed-wages of non-physicians. This is

because they were paid supplemental payment. In MoH, performance management system consists of capitation-based payment in primary health-care which bases on the number of enrolees for determination of remunerations and *fee-for service* in secondary and tertiary health-care *which is determination of a remuneration amount for individual services or service packages* (Veit and Hertle, 2012:11). The fee-for-service model is one of the pay for performance methods which rewards volume tests, scans, specialist examinations and hospitalisations more while not punishing poor and redundant health-care outputs. Some services which have higher performance scores like qualified medical operations are overvalued while other services like ordinary medical operations are undervalued. Physicians who try to reduce complications and do the best for their patients are paid less supplement payment and can appear like financial losers (RWJF, 2009)., the system in Turkey which is named as a performance management which is used in public hospital unions refers entirely to fee-for service. In this sense, the payment method is more profitable for providers who supply medical materials, equipments, devices and drugs; while not having characteristically incentives to develop quality or efficiency of health-care (Steinbrook, 2009:1036). Pay for performance means enhancing or reducing payments through fee schedules, bonuses or other incentives which are based on performances on certain measurements of quality and value (Spivey and McDonald, 2007:2). In other word, pay for performance can be defined *as the use of incentives to encourage and reinforce the delivery of evidence based practices and health care system transformation that promote better outcomes as efficiently as possible* (Forrest, Villagra, and Pope, 2006:83).

Also, offering health service for more performance in scope of pay for performance system may substantially disrupt the holistic patient-oriented approach offering service suitable for patient's requests, needs and expectations, establishing good and positive communications with patients and prioritising patient satisfaction (Hayran, 2009:13). In pay for performance system, quality of some health-care which do not take part in schedule or have relatively less performance score than other services may get worse. This is because there is no promotion for the services. If there is not an adequate risk adjustment in pay for performance system, this may generate unwillingness on physicians to give health-care. If adequate funds are not established, it may boost the practice costs for pay for performance. The pay for performance system should be evaluated in all its parts, and monitored the effects on patient access, practice costs, quality of health-care and results for unexpected situations, before the payment system put into practice (Forrest, Villagra, and Pope, 2006:84). However, it has not reported yet any evidence which proved the cost effectiveness of pay for performance in the studies on the cost effectiveness of pay for performance on primary and secondary health-care. Also, the majority of the studies consist of expert opinion and experiences. Although pay for performance emphasises on evaluating quality of health-care, there are not still any indicators which are agreed on quality of health-care. Evaluating the health-care with pay for performance systems is seemed one of the most significant challenges in terms of quality of health-care. Although quality of health-care is important in terms of balance among feasibility, usefulness and appropriateness of HTP, the quality indicators which are agreed on accuracy to evaluate quality of health-care are limited. Also, evaluating quality of health-care requires being determined different indicators which vary by each health-care process and outcome which is performed by physicians to reach targeted aims (Veit and Hertle, 2012:8-9). Besides, style and form of health services can vary by knowledge, skill, and opinion of physicians and other health staff. Therefore, drawing clearly

boundaries of health-care which are offered by physicians and other health staff is almost impossible. Also, rapid changes in medical knowledge make difficult the assessment of accuracy, suitability and quality of health-care. Moreover, even if performance indicators for pay for performance system are identified, there is no evidence-based data related to accuracy of none. This situation leads a lot of problems, as supplemental payments are unfairly distributed among physicians and other health staff (Aydın, 2007:259-270).

Performance management method may lead to be performed medical interventions in out of specialization fields of physicians to increase their performance scores. And then this results in medical and ethical problems in health-care. This is because there is no any incentive which refers to patient in the method. Fee-for service which is predominantly used in USA is specified as one of the main factors of rapid increase in health expenditures. And health expenditures in USA have caused to become a country which has the highest spending on health in the world. The Medicare Payment Advisory Commission reported that "*the current unrestrained (fee-for-service) payment system has created a rate of volume growth that is unsustainable*" (Steinbrook, 2009:1037). The payment method has also revealed other ethical problems, as treatments and drugs which are recommended for patients are decided by insurance companies because of economic worries, but not physicians. The US Institute of Medicine, in its 2001 Crossing the Quality Chasm report, claimed that quality of US health-care was lower, as opposed to benchmarks based on existing evidence, and that one of the major reasons in poor quality health-care was the payment mechanism (Gemmill, 2007:21). DRGs have been developed in countries such as United Kingdom and Nederland to eliminate relatively unfavourableness of fee-for service. In DRGs method, a fixed payment which has been previously defined at variable proportions by diseases which is diagnosed is paid to physicians to avoid redundant medical interventions (Tatar, 2006:108-109; Çelik, 2007:180-182). In France, majority of general and specialist physicians are paid on fee-for service which varies by national wage scale. In France, fee-for service method has been practised since France Hospital 2007, it has identified a code and a wage on the base of the Euro for each medical activity. However, it resulted in increasing the numbers of redundant medical interventions which are ignored indication of diseases and emerging ethical problems on necessitation and quality of health-care (Türk, 2007:169).

Country practices demonstrate that pay-for performance systems which only emphasise quantities of health-care, encourage increasing the demand in health-care because of asymmetric knowledge, and make wages more flexible. As it is demonstrated by data in above tables, in order to increase the performance scores, pay for performance system in health-care encourages physicians and general practitioners to boost volume of prescriptions, medical operations and tests as well as usage of medical technologies and prefer medical activities with higher scores, regardless quality and necessitation of health-care. Also, the payment system leads to a competition among hospitals to admit more yielding patients (Aydın, 2007:270; Kart, 2013:111-112). Therefore, while physicians are competing to offer health-care for more patients, incomes of SSI which are obtained from premiums are transferred to MoH to meet the health-care costs of citizens. And then the incomes are transferred to providers from MoH to meet the needs of health institutions such as medical consumables, devices and drugs. Since majority of the needs of health institutions are imported from abroad, the incomes are transferred from providers to foreign companies which produce medical equipment's, devices and drugs. Shortly, pay for performance system in Turkey actually plays an intermediary role in transferring of resources to foreign capitals. Performance management in health-care has led to an increase in consumption of

health-care and import for medical devices, medical consumables and drugs since 2004 by creating a real or artificial demand. Referring Table 7, import figures for medical devices, medical consumables and pharmaceuticals tend to significant increases by years. The figures in below confirm our argument.

Table 7: Import for Medical Devices, Medical Consumables and Drugs, Turkey, (Million $) (2002-2013)

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Medical Consumables	126.36	153.43	191.92	213.5	240.7	296.1	329.54	288.42	400.44	523.53	495.52	510.86
Orthopaedic and Prosthetic Devices (except dental)	77.18	83.43	115.99	156.39	196.64	207.14	266.43	244.86	273.53	285.39	303.34	346.07
Other Medical Devices	85.12	96.82	140.07	182.72	185.02	260.84	277.4	68.28	77.04	322.08	299.29	324.34
Diagnostic Imaging Devices	68.7	93.23	155.33	212.99	248.65	275.39	310.88	230.82	275.28	309.79	287.75	288.38
Other Electronic Devices	48.54	73.61	113.8	163.03	182.22	198.06	196.63	344.01	364.14	205.77	179.93	214.96
Drugs	-	2,419*	2,710*	2,845*	3,036*	3,841**	4,743**	4,427**	4,786**	5,092**	4,353**	-

Sources: Ministry of Development, 2014a:17;
* Union of Chambers and Commodity Exchanges of Turkey, 2008:6
** Ministry of Development, 2014b:8

In Turkey, performance management which put into practices to increase the productivity and efficiency in health-care emphasises entirely the quantity of health-care, but not quality (Karahisar, 2015:249). Fee-for service which is one of the performance management methods provides some opportunities to physicians to get more supplemental payment from per unit medical performance by boosting quantity of their medical interventions. The payment methods which encourage physicians to increase quantity and kind of health-care may cause a decrease in separated time for per-patient by physicians and an increase in medical errors, redundant diagnoses and treatments. This is because the performance management system was entirely set up on client satisfaction (Elbek and Adaş, 2009:38-39). Therefore, this approach may lead to transform health system from health-care for boosting health level of society to health-care for boosting supplemental payment. This poses one of the most important disadvantages of performance management methods.

In pay for performance method, supplemental payment for 4/A permanent non-physicians staff who compose majority of health workers is taxed in terms of income tax, while not being share cut of personal social security, except 4/B contracting health workers. However, a part of supplemental incomes for physicians and dentists have begun to be reflected to their social security after the Law No: 5947, on condition that shares of employee and employer are cut of their supplemental payments. This distinction results from being covered 4/A permanent health staff and 4/B contracting health workers by different social security laws (Law No: 5434 Government Retirement Fund for 4/A permanent health staff, Law No: 506 Social Security for 4/B contracting health workers). Not cutting social security share on supplemental payments for 4/A permanent non-physicians staff have also revealed an informality which results from underreport. The informality for 4/A permanent non-physicians staff will cause to get a lower lump sum payment and pension, when retiring and they will suffer from the losses of right and income in terms of retirement.

Conclusion

To examine and contribute researches on performance management for health-care in public sector, we tried to discuss the impacts of performance management on team service dimension of health-care, quality of health-care, health expenditures, unfairness in performance payments, redundant medical interventions and overuse of medical equipments and drugs. The study which is performed by using descriptive analysis method detects that performance management for health-care posses some challenges and unfavourableness in Turkish practice.

In Turkey, performance management in public health services practices in two forms: capitation based-payment for family medicine model and fee-for service for public hospital unions. But the impact on health system of the performance management is still a debated topic. Because, health-care which is needed in an uncertain and unpredictable time cannot be substituted and postponed is a labour-intensive public service which is a high social benefit. With this aspect, health-care differs from other market and public services. Performance management in health-care has some challenges. This is because it is not clearly drawn boundary of health-care which varies styles and forms by knowledge, skills, and opinion of physicians and health staff due to change rapidly in medical knowledge, and cannot be clearly evaluated accuracy, suitability and quality of health-care. In this respect, no matter what performance indicators are, guaranteeing entirely a fair method for performance payment is always difficult. This is because there is no evidence-based data on basis of the accuracy of performance indicators which has been agreed by everyone. This poses a significant challenge in terms of performance management. Also, unfair income distribution in healthcare causes deterioration of labour peace in health institutions. In this line, this argument is confirmed by the health staff satisfaction survey of MoH. In the survey, it was reported that 8% of health staff thought "the income distribution among health staff was fair" (MoH, 2010b:32).

Competitive among physicians which is brought with pay for performance results in medical and ethical problems in health-care. Also, pay for performance in health-care which is one of the flexible payment methods has led to be offered health-care as an individual service on the basis of the competitive by encouraging competition among physicians, but not collaboration. With this aspect, this approach weakens quality of health-care. Whereas, health-care as a team service on the basis of the solidarity and collaboration is a component increasing quality of health-care. In this line, the health staff satisfaction survey of MoH which reported that 31.4% of respondents gave an answer as “pay for performance has positive effect on quality of health-care” confirms this result. Also, in the same survey, 33.1% of respondents stated that “they are not pleased with pay for performance” (MoH, 2010b:32).

With the family medicine model which is one of the subcomponent of HTP, wages of family physicians and health staff are determined by the capitation based-payment method. With capitation based payment, establishing relationship between the number of enrolees and payments of family physicians and staff poses some challenges in terms of unethical competition among family physicians, quality of primary health-care and labour peace.

Although the performance management for health-care makes a significant increase in the rates of bed occupancy and bed turnover and a significant decrease in the ranges of bed turnover and average residency durations in hospital, it results in dropping down quality of health-care. Also, the performance management in health-care leads to boost

health expenditures and import for medical devices, medical consumables and drugs because of redundant medical interventions and overuse of medical equipment's and drugs. The most important reason for this are established relationship between payments of physicians and their performed health services.

The performance management in health-care has been the most positive effect on full time working of physicians. Full-time working of physicians has been encouraged by creating a supplement payment difference between part-time and full-time working in accounting performance scores of physicians. Thus, the number of full time working physicians has significantly increased in public hospitals.

With performance management in health-care, supplemental payment has become the main source of finance for physician payments and secondary source of finance for non-physicians payments. While supplementary payments and salaries of health staff are being taken into account by income tax assessment, supplemental payments of 4/A permanent non-physicians health staff, except all physicians, dentist, and 4/B contracting health workers, are ignored in accounting of their social security premiums. Also, this situation leads to informality which results from underreporting of total income of 4/A permanent non-physician health staff. Consequently, 4/A permanent non-physician health staff will face to get less pension than their right when retiring in future.

Finally, health-care is a humanistic service and the need. Therefore health-care should be adapted to patient needs and encouraged to rise up constantly quality of health-care. Pay for performance systems which establish relationship between health-care and wages should be opted out (Belek, 2009:458). Global payments may be better method than pay for performance to improve quality of health-care and prevent redundant health-care.

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