

Managed care and a process of integration in health care sector. A case study from Poland¹

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Abstract

For more than 40 years Polish health care sector structures were fully – financially, proprietarily, organizationally and managerially – integrated. The law introduced in 1991 initiated development of a system of contracts between public payer and a few independent medical services’ providers. After a few years, new legislation enabled much faster movement from the integrated model of provision towards separating public “third party payer” from health services’ providers. In the context of “cost and quality control” institutions being not accurately developed, cost-per-case contracts proved to be one of the weaknesses of the system. They did not ensure effective outcomes and by enhancing structure-disintegrating process they also destroyed those organizational and professional networks which could guarantee coordinated, continuous and high quality health care for people. The aim of the paper is to identify a causal nexus between contract type (financing rules) and tendency towards integration between health care providers. It is argued here that capitation prospective payment for wide packages of health care encourages spontaneous (bottom-up) vertical integration between primary and secondary care providers. Case study using descriptive analysis was done in order to contribute to better understanding of potential incentives to integrate in Polish health sector.

Keywords : managed health care, health economics, integration, capitation contracts, contractual relationships, physician agency, health care financing,

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1. INTRODUCTION

Dynamically increasing costs of healthcare in the context of fiscal constraints, budget deficits and a growing need of being competitive draw attention to institutional arrangements of health care systems. The growth of health care expenditures has been induced by technological progress, demographic changes as well as changes in health needs in modern societies. An other important reason why costs are growing is anchored by techniques of financing health care services as many of them do not respond to underlying market failures in the health care system – asymmetric information about health risks and health services' quality, moral hazard and limited providers' competitiveness (Arrow 1963, McGuire 2000)

Simultaneously, postulates of quality improvement and increase in universal access – to some extent opposite to cost containment - are very vivid in most of the European countries. As an answer to these postulates, since the beginning of the 80-ties, in many countries one could observe innovative institutional and organizational arrangements between health services' purchasers and providers, which enable d more active purchasing including better health care needs assessment and more efficient cost and quality control (see e.g. Robinson et Steiner 1998 and Kongstvedt 2003). The most dynamic ones among them were various forms of managed health care with its most famous European type – General Practitioner Fund Holding (GPFH) – that was introduced in the United Kingdom in 1991 (Goodwin 1998). Shortly speaking, the logic of GP-fundholding implies the association of purchasers' responsibilities with GPs' decisions on referrals and hence organizing purchasing and health care budget management around general (primary care) practice³ (Bevan et McLeod 2001).

Formally, Polish law has never promoted managed care arrangements. In 1998, the deputies of the Freedom Union Party submitted to the Sejm (the lower chamber of the Polish

Parliament) a draft bill of the Health Care Financed by Local Governments (The Health Care Organizations Act 1998). Among many other regulations the authors suggested development of the managed care system. The bill was not accepted, as there was not enough understanding for such forms of health care organization. For more than 40 years Polish health care sector structures were fully – financially, proprietarily, organizationally and managerially – integrated. Many local public institutions operated in the form of large integrated organizations including ambulatory specialist clinics, hospitals and emergency services as single structures securing care for large populations (Tymowska 2001a,b, Chawla et al. 2004). This is why presently integrated structures are mainly associated with large state-owned and poorly managed health care facilities (Tymowska 2001a,b).

Presently, few integrated organizations continue to exist in Poland (Chawla et al. 2004). Many outpatient clinics, which were leased to doctors and nurses, have separate contracts for provision of medical services. During years of transition (since 1990) two opposite processes were observed: in some public organizations integrated structures were being decomposed (with separation of some organizational units), while in the others new units (e.g. primary care or expanded ambulatory specialist services) were established in order to make better usage of their resources and obtain larger revenues under contracts with sickness funds. In 2001 Tymowska noted that *“it is quite possible that the only way to establish efficient structures is to break up the existing public organizations into small facilities, followed by their privatization and bottom-up consolidation.”* But unfortunately, as she next concluded *“the present system of contracting services with Sickness Funds does not promote consolidation, which fact contributes to the increase of the costs of transactions.”* (Tymowska 2001a, p. 91).

³ In this paper I use both terms (primary care/general practice) interchangeably.

However, in 2002, one of seventeen Sickness Funds (*Kasy Chorych*), following the second one of the above mentioned scenarios, implemented contractual arrangements typical for the managed care system, although the authors of the solution had never used the “managed health care” notion. Instead, they used to use “fundholding” term. In accordance with the contractual commitments, the primary care providers who realized so called *Pilot Programme*, organized health care for those patients who enrolled themselves to family doctors employed by these institutions. The managers of these institutions took on responsibility for coordinating treatment of the enrolled patients and for management of financial resources assigned for the health care packages broader than usual in Poland (ambulatory specialist services and laboratory/diagnostic tests were added). Capitation payment was the major technique of financing the providers engaged in the *Pilot Programme* (Tymowska et Kowalska 2002, Kowalska 2005a, Kowalska 2005b).

Although it was widely highlighted that main rationales for introducing the *Pilot Programme* arrangements were associated with an improvement of ambulatory services access and their costs’ rationalization, the focus of this paper is on the process of integration caused by new ways of financing the provision of ambulatory specialist services. Later, the author will discuss a close relationship between the problem of cost rationalization, the easiness of access and integration. In the paper it is argued that reshaping agency relationships between GPs and their patients and devolving budgetary responsibilities to primary care settings generated stronger incentives to establish new contractual relationships between primary and secondary health care providers. By “new contractual relationships” one should understand relationships created as a result of selective contracting in managed health care system with characteristics of spontaneous integration between primary and secondary care providers through formal institutions (contracts) as well as informal ones (trust-based co-operation).

The paper begins with a brief description of the “managed health care” institutions. Section 3 presents the rules governing Polish health care system during the period 1999-2002. Section 4 turns to empirical research and presents data, method and research hypothesis. Section 5 presents empirical evidence on the determinants and the process of integration in primary care sector. Section 6 concludes.

2. MANAGED HEALTH CARE INSTITUTIONS

Innovations, commonly referred to as managed health care, which include extending budgetary delegation to primary care physicians and allied workers, new ways of health care process organizing (usually involving strategies such as grouping physicians together and patient enrollment with a specific primary care provider) and GPs reimbursing by capitation payments are the institutional responses to the economic challenges of health care sectors: cost shifting, moral hazard of patients, services’ fragmentation, supplier induced demand (SID)⁴, pressures for access improvement, risk selection etc. (see e.g. Robinson et Steiner 1998, Mays et al. 2001, Kongstvedt 2003). As Phelps (2003, p. 368) perspicuously observes: *“Managed care organizations (MCOs) evolved as a response to a problem created by a solution to another problem. Health insurance exists fundamentally to reduce individuals’ financial risks. (...) But the traditional forms of that insurance (...) created another problem in return as they sought to reduce the financial risk – they altered people’s behavior[both patients and their doctors]in choosing medical care in an ultimately undesirable way [moral hazard]. Managed care evolved to help deal with that problem.”*

The term “managed health care” refers to the contractual relationships with health care providers established by managers who take on responsibility for securing the delivery of all or most of the health care for their enrolled populations. MCOs have a right to coordinate

treatment that their patients receive and are entitled to influence medical professionals' behaviour. Managed care organizations are mainly financed on capitation basis that motivates them to be effective in order to maximize financial surplus. The important idea is that by owning resources or being financially responsible for buying the entire continuum of health care services, MCOs will not be motivated to shift difficult cases away (cost shifting), nor to keep profitable patients in care when there is no longer a medical need to do that (SID). Managed care, by virtue of the incentives to create surplus, should also motivate to limit moral hazard of patients. On the other hand, the necessity of being competitive in the market should create for MCOs incentives to monitor and improve health care quality.

Some managed care organizations (MCOs) - particularly the American ones - are fully vertically integrated. The same group owns and manages services in the primary, secondary, acute, post-acute and sometimes long-term care units. These groups sign up a contract with a payer (or payers, e.g. insurance companies operating on the FFS basis, sickness funds, health authority etc.) and offer their enrollees services along the full continuum of care. Overall clinical practice is managed centrally. Depending on the type of MCO, patients *are* (as in staff HMO⁵ in US) or *are not* (as in PPO⁶ in US) constrained to go to physicians employed directly in the integrated group. In PPOs referrals are usually made to practitioners operating within providers' network based on selective contracting. Making appointments with doctors, who perform "outside" of the network, is generally associated with the individual co-payment strategy.

There are many financial incentives and management techniques used by MCOs executives in order to control costs and quality of services. Usually they are classified into the three categories (see Robinson et Steiner 1998):

⁴Which is called also moral hazard of medical professionals (for a review on SID see: McGuire 2000)

- Financial incentives (mainly capitation payment that is used both at organizational level and in relation to individual doctors);
- Techniques for managing clinical activity (prior authorization, pre-certification, principle of delivering health care services at the least intensive level, case management, admission diversion techniques, admission prevention techniques);⁷
- Patient-focused techniques (gatekeeping institution, co-payments, second opinion, watchful waiting).

3. POLISH HEALTH CARE SECTOR UNDER REFORMS: 1999-2002

Public health care system in Poland has been considerably restructured three times over the past 15 years, for the first time in 1991, then in 1999, and again in 2003. Since 1989, role of the leading provider of products and services performed by the central government has been gradually reduced (Tymowska 2001a,b, Włodarczyk et Zajac 2002, Chawla et al. 2004). Prior to 1993 a share of private providers in health care sector was not significant. The most important and far-reaching legislation acts that shaped contracting environment were the following: (1) The Health Care Organizations Act (1991), which introduced contracting in place of administrative relationships and since 1993 enabled private surgeries and other medical organizations to sign contracts for the provision of services to the people entitled to care financed from public resources, and (2) The General Health Insurance Act (1997), which introduced in 1999 a social insurance system in Poland and caused a vast increase in the number of private organizations holding public contracts. Presently, signing contracts is the principal way in which public funds could be used to secure services for the public, irrespective of whether a service is provided by a public or private provider. In 2002 the main

⁵ Health Maintenance Organization

⁶ Preferred Provider Organization

source of financing health care were public resources being at disposal of 16 regional health insurance funds (*Kasy Chorych*) and one health insurance fund for employees of military services. Health services in the public sector are provided free of charge at the time medical care is used.

In 2003, the system was restructured again. The purchaser/provider split was retained, but *Kasy Chorych* were replaced by a single national purchasing organization, the National Health Fund (NHF). The main reason for this change (as in New Zealand in 1997; see Ashton et al. 2004) was reduction of allegedly perceived inequities that were emerging as a result of regional purchasing. One can not say that such reconfiguration was due to cost reduction, because each regional sickness fund was replaced by NHF local department. All the revenues coming from insurance premiums flew into the National Health Fund. Health care needs' plans prepared by the health area administration and accepted by both NHF executive and Health Ministry were a basis for resource division. Central government administration's responsibilities for health care sector functioning and for the ways funds were flowing inside of the system increased significantly.

4. CASE STUDY

4.1. Aims and organizational rules of the *Pilot Programme*

As aforementioned, the *Pilot Programme* that was introduced in 2002 in one of the seventeen sickness funds (*Zachodniopomorska Kasa Chorych*) was a spontaneous and regional initiative. 8% of the local population (app. 100.000 people) were engaged in the project. The content and implementation of the *Pilot Programme* were inspired by GP-fundholding

⁷ Of all the cost controlling measures, utilization management had had the biggest impact in reducing the costs of healthcare in US (Robinson et Steiner 1998).

scheme, introduced in 1991 in the United Kingdom (Goodwin 1998, Mays et al. 2001). Some elements of GP-fundholding were also implemented in another sickness fund (*Lodzka Kasa Chorych*) but services' range offered there was not as broad as in the *Zachodniopomorska Kasa Chorych*. Instead, in *Lodzka Kasa Chorych* the contractual arrangements with GPs were a universal solution for the whole area, which helped to avoid some problems associated with "pilots" selection bias and small scale of pilot projects. Data gathered in *Lodzka Kasa Chorych* were used as comparators in the analysis in order to assess both the importance of the range of financial responsibility and scale of the project.

Since 1999 sickness funds were equipped with population-based global budgets to provide primary, secondary and tertiary services⁸ and community services for people within their geographic areas. Hospitalizations were financed according to *per diem* techniques. In ambulatory specialist (outpatient) clinics unit service financing (FFS) dominated. Primary health care services were delivered by self-employed GPs or practices grouping primary health care professionals (together with allied health professionals such as midwives and nurses). The basic method of primary care financing was capitation payment. Major technique of financing the primary care practices engaged in the *Pilot Programme* was also capitation payment (Tymowska et Kowalska 2002, Kowalska 2005a,b). In accordance with contractual commitments, the suppliers who realized the *Pilot Programme* organized health care for those patients who enrolled themselves to general practitioners employed by these organizations. Managers of these organizations took on responsibility for coordinating treatment of enrolled patients and for management of financial resources assigned for health care packages broader than usual in Poland (broadened by ambulatory specialist visits and laboratory/diagnostic tests).

⁸ Excluding highly specialized procedures under tertiary care, which were financed directly from the State budget.

In general, capitation payments are used most often when a probability of appearance of individual health care need is difficult to assess and when the information on both services' cost-effectiveness and health outcomes remains underdeveloped. Capitation contracts are the example of so called block contracts, which might be compared to a budget for a defined range of services (global budget). A purchaser (here the sickness fund) agrees to pay a provider a fixed sum in exchange for the access to a broadly defined range of services for a defined population of patients (Saltman et Figureas 1997). A rate of capitation payment for specialist ambulatory care was calculated by *Zachodniopomorska Kasa Chorych* by taking into account historical costs. By multiplying the capitation rate by the number of enrolled patients, global budget was acquired. The capitation rates for primary and ambulatory specialist care received under a contract with the Sickness Fund by the GPs participating in the *Pilot Programme* included resources for salaries (of the doctors and allied workers such as nurses), specialist consultations, laboratory and diagnostic tests. With capitation payment, a risk of unforeseen change in demand for health care and therefore the change in the level of expenditures is totally transferred to those who manage capitation budget. In budget setting procedure (i.e. setting the rate of capitation tariffs) these risks must be taken into account. In order to limit GP-fundholders financial risks, stop-loss arrangement was applied (by excluding from the budget most expensive diagnostic procedures).

The main purpose of the *Pilot Programme* implementation, as declared by *Zachodniopomorska Kasa Chorych's* establishment, was an improvement of specialist ambulatory care access (limiting waiting times for specialist consultation and improvement of specialist consultations' access in respect of space). In fact, there were deep differences between access conditions in rural and urban areas of the region. Due to services' quotas applied by the Sickness Fund, waiting times for specialist consultations equaled quite often 3-4 months. Among other aims of the *Pilot Programme's* implementation were: ambulatory

specialist health care services' costs rationalization, enhancing GPs' coordinating and agency roles (in order to match better health care resources with patients' health needs), patient empowerment, improvement of cooperation between primary care workers and specialist consultants, health care services' integration (coordination of multi-specialist treatment).

4.2. Data and method

The type of information used in the study is determined by data availability. Information for this research is based primarily on a set of interviews with key contracting personnel and both sickness funds' establishments. To maximise confidence in the validity of findings, triangulation method (*multi-method*) was applied (Keen et Packwood 1999). The survey data were supplemented by the analysis of relevant documents, including contracts signed between the payers and the providers, internal documents about all stages of the contracting process and also media coverage. Although the *Pilot Programme* introduced by *Zachodniopomorska Kasa Chorych* used to be the main subject of the analysis, nevertheless comparative data coming from *Lodzka Kasa Chorych* and practitioners that operated there in similar contractual conditions, was used in the analysis.

Whether an innovation works, and to what extent, depends on the context or circumstances in which it is implemented (see: Wyke, Malbon et al. 2001). According to the terminology used in qualitative methods, in this analysis an instrumental case study was applied. It enabled to get an exact interdependence between a specific context, contracting mechanisms and outcome of the institutional change (see Pawson et Tilley 1997). Comparing new institutional solution with universal health care insurance system in Poland puts this research into the frameworks of comparative institutional analysis (Williamson 1985).

4.3. Hypothesis

In the context of information scarcity and the cost and quality control institutions being underdeveloped, cost-per-case contracts (unit service financing) for specialist (ambulatory and hospital) care proved to be one of the main weaknesses of the Polish health care system. They did not ensure cost-effective health outcomes and by enhancing structure-disintegrating process they also have destroyed the cooperation bonds (formal and informal) between doctors of various specialties. Some of those structures were of low quality but quite many of them could guarantee coordinated, continuous and high quality health care for people.

There are many different types of integration and it is crucial to distinguish between them (for more information see: Perry 1989).⁹ Here we use the term “integration” under the definition proposed by Simoens et Scott, who observed that “*integration [vertical] in primary care can take the form of shifts in the provision of health care between primary and secondary care and of formal/informal contractual or co-operative arrangements between primary and secondary care providers*” (1999b, p. 8). This definition helps not only to identify which changes in the provision and finance of health care services constitute integration in primary care, but also to point out incentives for integrating activities of health care professionals.

In the study we argue that capitation prospective payments for wide packages of health care, applied in the *Pilot Programme* arrangements, encouraged the spontaneous (vertical) integration between primary and secondary care providers through formal institutions (contracts) as well as informal ones (i.e. suppliers’ networks created mainly on trust and reputation institutions). The relationships established were the result of creating opportunity of selective contracting by primary care providers.

⁹ For an extended definition and taxonomy of integration in primary care derived from economic theory and the health care literature see: Simoens et Scott 1999a, 1999b.

Becoming aware of the mechanisms and effects of such spontaneous integration should help decision makers to decide if such integration is welcome and to design adequate policy towards achieving expected level of integration.

5. RESULTS: DETERMINANTS AND PROCESS OF INTEGRATION

5.1. ADVANTAGES OF CONTRACTUAL NETWORKS

In the interviews motivations for creating various relationships between providers of medical care were assessed. Among GP-fundholders that responded questions there were three types of attitudes towards the process of entering into contractual relationships with secondary care providers. A strong motivation to create formal contractual relationships was typical for the first group and was associated with an inclination to take on financial responsibility for wider packages of health care for people. For these respondents benefits from the *Pilot Programme* implementation seemed to be obvious. A distance towards building contractual networks was typical for the second group of respondents. They highlighted importance of informal relationships and co-operation being developed on the basis of trust and reputation institution. Such attitude was typical for those GP-fundholders who were financially responsible for narrow packages of health care (mainly in the area of *Lodzka Kasa Chorych*). Generally speaking, **the weaker were financial incentives to monitor costs and quality of health services, the weaker was motivation for formalizing exchange relationships.**

In both cases many advantages of selective (formal and informal) contracting were emphasized. We list these advantages together with the incentives to create contractual relationships between medical care providers in a table 1.

Table 1. Advantages of contractual networks (both formal and informal ones) between primary and secondary care providers and incentives for creating them

- Ambulatory health care services' costs rationalization;
- Overcoming infrastructural and capital barriers for investment ;
- Quality promotion by setting high selection criteria;
- Improvement of information quality, content and circulation;
- Resource utilization control: reducing moral hazard of patients and health professionals
- Ambulatory specialist health services' accessibility improvement;
- Promoting family medicine philosophy : from a gatekeeper to a guide;
- Opportunity of co-operation in multi-specialist team of health professionals (educational function of networks);
- Better coordination of care and offering integrated care for patients ;
- Effective division of clinical responsibilities;
- Better communication between GPs and their patients;
- Building firm, long-term professional relationships (stabilizing the system);
- Transaction costs economies and managerial weaknesses limitation;
- Creating positive picture of general practice among patients;
- Strengthening GPs professional position.

Ambulatory health care services' costs rationalization

Introducing in 1999 the referral system and limiting the number of visits in contracts between sickness funds and ambulatory specialist care providers caused a decrease in the number of specialists' visits in the universal health insurance system. Setting quotas in contracts secured strict budgeting but at the same time it did not help to avoid cost-shifting from lower to higher levels of care. Cost-shifting strategies are present in many countries (Mays, Malbon et al. 2001). The process of cost-shifting in Poland resulted in a sharp increase in general costs as well as generated conflicts between medical professionals (Tymowska 2003, 2004a).

The causes of such situation were manifold. First, it were primary care financing techniques that encouraged cost-shifting. Capitation payments for a narrow range of services, without suitable institutions of professional supervision over contract realization (e.g. medical guidelines, precise requirements and professional auditors) together with the incentives to

maximize own surplus, stimulated GPs to refer patients to higher levels of care. On the other hand, the ways of compensating individual GPs were quite important as individual doctors were not the owners of practices, did not manage budgets and were not compensated through capitation payment (dependent on a number of patients enrolled). GPs were obviously not stimulated to work hard and then they were also motivated to refer patients more easily to higher reference levels. Opportunistic conduct of health care organizations, with a strong motivation to shift costs to other entities, patients avoiding bearing the prescription costs together with an existence of the patient's right to choose a place of treatment, in the context of missing standards and recommendations of medical procedures, caused a considerable increase in the number of hospitalized patients (Social Diagnosis 2000 and 2003 in: Tymowska 2001b, 2004b).

Another incentive was hidden in the ways of financing specialist services (according to fee-for-service /FFS/ rule). FFS payment, together with the incentives to exceed contractual services' quota, motivated specialist consultants to provide as much treatment as possible in order to maximize income¹⁰ and sometimes protect themselves against legal liability. In the first year of operation of universal health insurance system, some hospitals greatly exceeded contractual limits, expecting that, consequently, their contracts would be renegotiated (Tymowska 2001a,b). However, Sickness Funds paid only for a portion of additional hospitalizations, and that became one of the causes of debts in many hospitals.

One of most clearly declared aims of the *Pilot Programme's* implementation was health care services' costs rationalization, particularly limiting the cost-shifting phenomenon. The aim of cost rationalization was achieved e.g. by limiting number of unnecessary referrals (i.e. those that were not justified by health needs) and also by diminishing costs through selective

¹⁰ There is a rule that services exceeding the quotas set in the contracts but justified by medical necessity such as saving human lives are paid by public payer.

contracting (creating own networks of providers). The idea of selective contracting predicts possibility of negotiating lower tariffs for medical services or at least utilization review in exchange of guaranteeing higher volumes of services due to e.g. organizing ambulatory services in primary care settings or referring patients to “preferred providers” (see also: Glied 2000, Kutzin 2001, Phelps 2003, Getzen 2004). Economic benefits from selective contracting were thus bilaterate.

Economic function of network was also used by providers in regard to co-operation requiring some economies of scale (rebates for buying diagnostic services or small investments in diagnostic equipment). Creating networks of providers helps then to overcome infrastructural barriers and shortages of capital.

Quality promotion by setting high selection criteria

Bidding procedure was the providers’ selection basic method in the universal health insurance system (Chawla et al. 2004). It was known, however, that good relationships with the payer were also important determinant of signing a contract. There was no political agreement to exclude low-quality health care organizations and select for contracting only the best ones and those accepted by patients (Tymowska 2001a,b).

Possibility of selective contracting made GP-fundholders independent from those who did not enjoy good reputation as regards health services’ and communication quality. This aspect strengthened GPs’ professional autonomy. In general, such professional independence aids supervising quality by signing contracts with those providers that respect quality and communication requirements. Selective contracting plays “accrediting” role by “penalizing” those providers who do not meet contract requirements (with respect to both quality and effectiveness) and “rewarding” those who fulfill contract commitments.

The choice of providers should of course be based on professional attributes of health services rendered. In our interviews respondents declared that the basic criteria for providers selection were educational attributes (a specialization type and a degree), the opinion in medical circles, academic bonds, quality of communication (feedback information) between doctors, ethical and moral values (honesty, decency, loyalty) and also patients' preferences.

Improvement of information content, quality and circulation

The accreditation function of contracts is closely associated with the controlling function – the most important one as regards cost and quality control. Quality and costs management institutions require credible data on any purchased services and patients' health status. At the beginning of reforms, the lack of good information – particularly on costs, volumes and quality – increased transaction costs and made contract monitoring difficult. Experience of the social health insurance proved the merit weaknesses of the payer.

In the *Pilot Programme* the rules of cooperation between primary care and specialist physicians were defined in the contracts. Costs of specialist care and diagnostic tests were to be reimbursed on the basis of invoices and short reports (feedback information) on the diagnosis and treatment recommended. It helped GPs to gather all the necessary information on their patient's health status and therapeutic guidelines. The same rule of co-operation and medical activities' co-ordination was written formally in a paragraph of the General Health Insurance Act. But it was a new financing method, combining tightly costs' reimbursement method with feedback information circulation that made the formal rule work. In institutional language this method played an enforcement role and compelled the consultants to care for information given back to GPs.

Vast network of providers aids additionally to create uniform rules of reporting data on health services and health status of patients. Data gathered this way serves designing credible information systems with statistical profiles. Consequently, such profiles aid to create medical guidelines and monitor adherence to them, which is important as regards both costs and quality of care . There was a real improvement of the information content, quality and circulation.

Resource utilization control: reducing moral hazard of health professionals and patients

Effective costs' monitoring might mean limiting a tendency shown by some groups of patients to overuse health care services. Such a tendency is often interrelated with high unemployment rates and social benefits seeking behaviour. It was pointed out in the interviews that various form of co-operation help in limiting this type of attitudes. GPs' right to monitor secondary care providers and guide patients through the health care system is justified only when primary care markets are competitive (there is freedom of choice of GPs by patients and there is real choice between general practices) and the level of GPs education is high

Ambulatory specialist health services' accessibility improvement

In the pre-1989 system the possibility of choice of place of treatment existed only in some large cities. Patients had to stick to their administrative geographic areas. Since January 1999, patients have had a right to choose their doctors in ambulatory care clinics, or their hospitals, but only from among those entities that held contracts with sickness funds. Using ambulatory specialist services and laboratory tests requires referrals issued by primary-care doctors that hold contracts with sickness funds. Patients do not need referrals to see a psychiatrist, a gynecologist, an oncologist or an ophthalmologist. Sickness funds applied strict budgeting

techniques and limited number of services in contracts in order to control a justification of performing particular services. As there were no adequately developed institutions for professional (merit) supervision and there were essential information asymmetries between the payer and the providers, such methods turned out to be quite ineffective and based mainly on the administrative pressure. The weaknesses of a public ownership structure and administrative supervision methods have been thus revealed. Finally, the system of mandatory referrals and strict rationing of services provided by particular entities under contracts turned out to be a cause of serious administrative hardships and barriers of health care access for people.

Additionally, there were deep differences between access to health care in rural and urban areas. In the region of *Zachodniopomorska Kasa Chorych*, due to services' quotas applied by the sickness fund, waiting times for specialist consultations often equaled 3-4 months. Generally speaking, after introducing the *Pilot Programme* and changing the method of financing ambulatory health services in *Lodzka Kasa Chorych*, **there was considerable improvement in health care access (with respect both to waiting-times and spatial proximity), welcomed gratefully by patients and their family doctors**. It should be noted here that any change in specialist health care access was a derivative of the introduction of new financing methods and direct contracting with secondary care providers. Administrative rules of access (i.e. mandatory premium payments, referrals' system, sickness fund's enrollment rules, mandatory choice of one's own family doctor, limits issued by sickness funds) were left unchanged in the *Pilot Programme*. The change was that Polish GP-fundholders, similarly to British GP-fundholders (see Petchey 1995, Mays et al. 2001), had the opportunity to negotiate access conditions (in respect of waiting-time particularly) for their patients. The *Pilot Programme* implementation and individual contract conditions' agreements cut down waiting times essentially (to app. 1-2 weeks or even less than 1 week).

The incentive structure created by the *Pilot Programme* motivated also to limit spatial access' barriers. **The spatial access improvement was the result of individual contracting with the ambulatory specialist services' suppliers and arranging consultations directly in primary care practice facilities.** The GP-fundholders declared keeping that direction and arranging as many specialties "in place" as possible. In some cases the basic barrier that impeded putting that declaration in practice was poor building infrastructure and limited funds for necessary investments.

Incentives presented in the next paragraph are very important not only in terms of promoting and improving the quality of care but also for promoting the quality of working conditions in medical profession, which has been neglected for many years in Poland.

Promoting family medicine philosophy: from a gatekeeper to a guide

By the way of introducing universal health insurance system, family medicine model (WONCA 2002) was strongly promoted. A general practitioner was supposed to be a patient's guide (health care process' coordinator) first. Unfortunately, allocation mechanisms fostered rather gatekeeping than coordinating function. Incentives were not aligned with family medicine philosophy as financial responsibility of GPs was limited to primary care domain only. Among patients in Poland, similarly to the Americans in the 70-ties (Cochrane 2001, Getzen 2004), exist strong cultural customs to use specialist care (Social Diagnosis 2000 and 2003 in: Tymowska 2001b, 2004b). These customs deepen negative attitudes to any restrictions on access to ambulatory specialist care. The lack of acceptance for the system principles, which tried to promote GPs' coordinating role, manifested in the problems with communicating information on patients' health status and treatments recommended by specialist consultant. Neither patients nor specialist consultants cared for giving back family doctors any feedback information (Tymowska 2001b). There was formal legal commitment to

report such information on patient's health status and treatment recommended but there were no effective institutions to enforce that rule.

Opportunity of co-operation in multi-specialist team of health professionals

Being financially responsible for buying secondary services for patients and consequently functioning in health care providers' network aids to realize family medicine philosophy (mainly coordinate process of care and guarantee complexity of that care). Such responsibility together with GPs' greater autonomy in responding to a particular set of symptoms (i.e. deciding which treatment procedures are appropriate) and specifying who is better prepared to deliver them, makes GPs more responsible for the process and effects of cure.

Networking, by means of promoting better communication between doctors of various specialties, also favours a better co-operation between them. Trust and common standards of communication and behaviour are crucial for these relationships. Respondents responsible for secondary care for their patients emphasized strongly the importance (for decision making) of such communication and the value of feedback information on patient's health status and treatment recommendations.

In some of the interviews the "educational" and "risk-sharing" aspects of such co-operation were emphasized, too. Opportunity of co-operation in multi-specialist team of health professionals gives not only professional satisfaction but also enables reciprocal education, diminishing risks associated with medical decision making and limiting drawbacks of health services fragmentation.

Better co-ordination of care and offering integrated care for patients

The problem of service fragmentation is a global one, but becomes more intense if GPs' autonomy is not connected with natural financial consequences of medical decisions (referrals, drugs prescription etc.). Another result of such medical profession autonomy (together with various ethical attitudes) may be an increasing diagnostic and treatment methods differentiation, which does not foster the idea of equal health care access.

High quality of health services together with complexity of the offer are also sources of real competitive advantage in health care markets. One of the respondents described a mechanism of „run-away to the clinics” process in case minor providers are not able to provide patients with a full range of services. In such cases contractual relationships with the providers of highly specialized services are the only alternative for those who are compelled to compete with integrated health care delivery structures. The *Pilot Programme* experience confirmed such dimension of competitive advantage among those providers that were able to offer a broader range of secondary care services than the others. Great interest in joining the pilot scheme among primary care providers was the most convincing argument for that.

Effective division of clinical responsibilities and better communication between GPs and their patients

At the same time, relationships based on trust towards professional knowledge of health care providers enable limiting a phenomenon of unnecessary duplicating diagnostic tests, particularly at the primary-secondary interface, which is identical with decreasing costs of care as well as diminishing patient's fears and limiting medically unjustified contacts with health care system. In this context respondents emphasized the fact that referring a patient to the provider that is well known, enjoys good reputation and respects „rules of the game”

makes communication with a patient himself/herself easier and helps making him/her comply with his/her GP's and consultant's recommendations. **All of advantages presented above let GPs play better an agency role .**

System stabilization, transaction costs economies and managerial weaknesses limitation

Building relationships in medical circles on the basis of long-term contracts and building common organizational culture lay the foundations of stability of the system. Stability feature that is rooted in long-term, trust-based relationships is crucial for transactions with high assets specificity in order to diminish transaction costs (Williamson 1985). Any co-operation in the area of management, administration and organization of health care delivery aids in limiting managerial weaknesses implied by limited experience in management functions and low scale of economic activity (because providers are dispersed)

Creating positive picture of general practice among patients and strengthening GPs professional position

As in many countries, hospital jobs in Poland are regarded as the most attractive and prestigious by medical circles in spite of poor salaries (absolute and in relation to those in primary care sector). GPs in general are not at the professional forefront and perceive their role in the system as a marginal one. Higher income is then not enough to change the primary care perception and attract very talented physicians. The *Pilot Programme* arrangements increased the influence of primary-care doctors over the health system by making them partners for the consultant doctors as well as real agents of their patients, the ones who may be trusted and feel a guide for a patient.

5.2. IMPEDIMENTS OF INTEGRATION

The last group of respondents who were reluctant to create any networks of providers pointed out objective impediments of integration through building up both formal and informal relationships among providers. In a table 2 we present most of them

Table 2. Impediments of creating formal and informal networks of health care providers

- Specialties that do not require referrals from GPs (no possibility of the ex-ante control);
- Occupying a monopolistic position by primary care provider;
- Adverse demand side conditions (small-size markets);
- Anxiety about dispersing decisive function;
- Uncertainty (short-term contracts with sickness fund), instability (pilot status) of implemented changes;
- Lack of strong leadership, managerial weaknesses;
- Limited choice of partners for co-operation, working in isolation in rural and small-urban areas;
- Personal conflicts;
- Capital and infrastructural limitations.

Serious problems with monitoring services in those specialties that did not require GPs' referrals (mainly ophthalmology and gynecology) were pointed out in most of the interviews as a source of financial risks for GP-fundholders. Financing such services means that the buyer has no opportunity of ex-ante control over utilization of the resources. In one case only GP-fundholder developed for a wide scale in her own practice ophthalmology facilities. She achieved high level of product specialization and by attracting patients this way could expect higher demand for other services. Nevertheless, in most cases this area of GP-fundholders' activity was highly problematic. The managed health care idea requires a strong interdependence between the level of financial responsibility and a range of possibilities to control resource utilization.

Another barrier was caused by contractual rule, which set up minimum payment rate for those pilot practices that did not sign contract with specific provider. Pilot practices were put under obligation to sign at least 2 contracts with providers of one specialty. If a patient chose a provider that did not have any contract signed, there was motivation to pay only minimum tariff for the service rendered. If GP provider had a strong monopolistic position in the local market, the incentives to create network of providers and formalize exchange relationships with them were much weaker than elsewhere.

The analysis of the interviews shows also some impediments of „personal” nature: the lack of charismatic leaders in the local area, who would take on responsibility for creating co-operation relationships with other providers; the lack of managerial experience among the owners of primary care facilities; the lack of potential partners for co-operation (many practices in rural and small-urban areas work in isolation) and personal conflicts.

An other barrier was a consequence of instability of implemented changes (the importance of pilot status of new arrangements) and uncertainty associated with too strong a position of the payer (the sickness fund) and risk of continuous, not necessarily beneficial changes in contracting system.

Sometimes possibilities of integration were substantially determined by demand side characteristics (small-size market and limited opportunities for economic expansion that would justify integration). In some cases such expansion was impossible due to a strong segmentation of local markets and anxiety of dispersing local leadership and decisive (strong identity with own practice and its characteristics).

Integration is an example of corporationist tendency and – as Street and Place (1998) noted – corporationism development is possible and justified only if both sides of co-operation are deeply convinced that benefits flowing from such interaction are greater than benefits from

isolated functioning. And sometimes financial and professional incentives are too weak to awake trust, which is indispensable for firm co-operation (see. Goodwin et al. 2001). Trust-building process needs generally much more time than pilot enterprises encompass. Last of the barriers presented in the table 2 is one of the most serious in the context of decapitalized, post-communist economies. Infrastructural barriers and capital limitations are very difficult to overcome in the context of short-term contracting system.

6. CONCLUDING REMARK

The literature review and research results show that the main responses to the challenges created in the last decade by economic specificity of health sector consisted in encouraging contractual relationships between organizations (Mays et al. 2001). Delegation of financial responsibility and risk management from the payer to the medical services providers (GPs operating in the frameworks of the *Pilot Programme*) changed the nature of agency relationship between GPs (see Kowalska 2003) and their patients. The main consequence of that change was the enhancement of the incentives to monitor costs and quality of health services (Kowalska 2005a). On the other hand, the presence of stronger incentives to monitor health care quality and costs contributed to an essential change of contractual relationships between health care professionals. Briefly, we can conclude that capitation payments for primary ambulatory specialist health care, typical for managed care institutions, encouraged the spontaneous (vertical) integration between primary and secondary care providers through formal institutions (contracts) as well as informal ones (i.e. suppliers' networks created mainly on trust and reputation institutions).

In 2001 Tymowska observed that the process of integration in both large private facilities and some public ones in Poland can take two forms: the establishment of integrated organizations, with hierarchical structures subject to management (as in American HMOs), or building

networks of legally independent entities cooperating with each other (Tymowska 2001b). The professional networks created due to the *Pilot Programme* implementation were the example of the second one. The integration took the form of shifts in the provision of health care between primary and secondary care and creating co-operative arrangements between primary and secondary care providers.

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