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*Katarzyna Kowalska**

GP-FUNDHOLDING EXPERIENCE IN POLAND: HEALTH CARE ACCESSIBILITY IMPROVEMENTS

This paper is dedicated to the analysis of contractual arrangements typical for managed care (GP-fundholding scheme), implemented in 2002 by two Polish health insurance benefits funds. In accordance with contractual commitments in the pilot experiment, the primary care practitioners took on responsibility for coordinating treatment of enrolled patients and for management of the financial resources assigned for health care packages that were broader than customary in Poland. The major technique of financing was a capitation prospective payment. The main purpose of the analysis is to assess if this new method of financing and organizing primary and ambulatory specialist health care in Poland has created incentives to improve specialist health care accessibility, and if it has encouraged both cost supervision and co-operation between primary and secondary care doctors. The research is a type of qualitative and instrumental case study. It is also an example of the empirical application of institutional methodology to the analysis of Polish health sector contractual and organizational arrangements. Information for the research is based primarily on a set of interviews with key contracted personnel and health insurance fund management. The survey data were supplemented by an analysis of relevant documents, including contracts, internal documents and also media publications. The key finding is that there has been considerable improvement in health care accessibility, and that much progress has been made in generating information and communicating that information among health professionals concerning patients' health status and treatment recommendations.

Keywords: health care financing, managed care, GP-fundholding, accessibility, contracts, new institutional economics

JEL codes: D23, H51, I11, L12

INTRODUCTION

Fiscal constraints, budget deficits and the growing need to stay competitive have intensified the international debate on "cost-containing" institutional arrangements of health care systems. Simultaneously, the postulates of increased universal access and equity – to some extent the opposite of cost containment – are very clear in many developed countries. To answer these challenges and postulates many countries in Europe have

* Department of Economics, Warsaw University

introduced innovative institutional and organizational arrangements to enable more active purchasing (Robinson et Steiner, 1998; Mays et al., 2001). The most dynamic among these arrangements have been various forms of managed health care, with the most popular the British General Practitioner Fund Holding (GP-fundholding) scheme (the term "general practitioner" is a synonym for the terms "primary care practitioner/physician" and "family doctor"). In the context of the GP-fundholding, it has been widely admitted that putting the right incentives in place and managing care at the primary-secondary interface is of particular importance for promoting a cost and quality effective delivery of care. In short, the logic of GP-fundholding implies the association of purchasers' responsibilities with GPs' decisions on referrals and hence organizing purchasing and health care management around general practice (Bevan et McLeod, 2001).

The term "managed health care" is more general than GP-fundholding. (In the paper I use both the terms interchangeably). It refers to the contractual relationships between health care providers, created by managers who take on responsibility for securing the delivery of all or most of the health care for their enrolled populations. Managed care organizations have a right to coordinate treatment that their patients receive and are entitled to influence the behaviour of medical professionals. There are many financial incentives and management techniques used by managed care organizations' executives. Usually they are classified into three categories (Robinson et Steiner, 1998): (1) financial incentives (mainly a capitation payment that is used both at the organizational level and in relation to individual doctors), (2) techniques for managing clinical activity (such as prior authorization, the principle of delivering health care services at the least intensive level, case management, hospital admission diversion techniques, and so on), (3) patient-focused techniques (such as gate-keeping, co-payments, second opinion, and watchful waiting).

Formally, Polish law has never promoted managed care arrangements. Nevertheless, in 2002, two of seventeen sickness funds (Zachodniopomorska Kasa Chorych and Łódzka Kasa Chorych), using their autonomous position, introduced contracting rules typical for the managed care system. The sickness funds' management signed pilot contracts with some of the health care providers. In accordance with the contractual commitments, the managers of the organizations taking part in the experimental arrangements took on the responsibility for coordinating treatment of the enrolled patients and for management of financial resources assigned for the health care packages, which provided more benefits than was usual in Poland.

A capitation payment was the major technique of financing the providers engaged in both pilot schemes.

The primary purpose of the analysis presented in the paper is to assess if those pilot arrangements were more effective at reducing costs and increasing quality (mainly in terms of accessibility) in the financing of primary and ambulatory specialist health care in two regions of Poland. The original contribution of the paper is the analysis of selected Polish health sector financial and organizational arrangements from an institutional perspective. The institutional approach refers to the analysis of the incentive structures generated by innovative contracts. Comparing a new institutional solution with the preexisting universal health care insurance system in Poland puts this research into the framework of comparative institutional analysis (Williamson, 1985).

The paper begins with a brief description of the Polish health care system during the period 1999-2002 and the analysis of the contracting environment. Section 2 presents data, method and the research hypothesis. The results are presented in Section 3, and are grouped around three questions: What was achieved? How was change achieved? What was the problem? Last section concludes.

1. OVERVIEW OF THE POLISH HEALTH CARE SYSTEM[1]

1.1. Background

The public health care system in Poland has changed considerably since 1989 (Tymowska, 2001a; Tymowska, 2004; Włodarczyk et Zając, 2002; Chawla et al., 2004). The most important legislative acts that shaped the contracting environment were The Health Care Organizations Act (1991) and The General Health Insurance Act (1997). The first of these introduced contracting in place of administrative relationships. At present, signing contracts is the principal way in which public funds are used to secure services for the insured. In 1999, in accordance with the second act, a social health insurance system was introduced in Poland. Between 1999 and 2003 the major source of financing health care was public resources at the disposal of the so-called sickness funds (16 regional sickness funds and one nationwide Corporate Sickness Fund). In 2003, the system was restructured

[1] The following paragraphs in section 1 are based on Kowalska (2007).

again. The purchaser-provider split was maintained, but sickness funds were replaced by a single national purchasing organization, the National Health Fund (NHF). The main rationale for this change, as in New Zealand in 1996/1997 (Ashton et al., 2004), was the reduction of allegedly perceived inequities that were emerging as a result of regional purchasing.

1.2. Contracting environment

There were some serious problems in the Polish health care system that stimulated the implementation of the pilots. I present them below (see also Exhibit 1).

Exhibit 1

Rationales for a change

Necessity of ...
• combining the results of the health care needs recognition and priority-setting processes with the structure of services being purchased; • changing providers' selection methods; • lowering transaction costs; • decreasing unnecessary hospitalization rate; • improvement of health services accessibility; • changing emphasis of the role of GPs: from gatekeeper to guide; • internalizing costs of medical treatment; • integrating and coordinating health care services.

Source: author's own

In the Polish health care system, given the experience of the communist period, a very important function to be realized by a contract institution was to make widespread *the philosophy of financing according to health needs* in place of *the philosophy of financing according to resources*. A contract institution means the departure from the safe world of financing the existing resources of health care organizations towards financing based on cost-effectiveness/benefit analysis (Tymowska, 1993). A contract institution should promote and support health care needs recognition and assessment and, as a consequence, combine the structure of purchased services with the results of both "needs recognition" and "priority setting" processes.

Sickness funds were equipped with population-based global budgets to provide primary, secondary, tertiary and community services for people within their geographic areas. Primary health care services were delivered

either by self-employed GPs or practices grouping primary health care professionals together. The major technique of primary care financing was capitation payment. In ambulatory specialist (outpatient) clinics unit service financing dominated. The bidding procedure was the basic method for selecting providers. However, it was known that good relationships with the payer were also an important determinant of signing a contract. There was no political agreement to exclude low-quality health care organizations and select for contracting only those which were best and accepted by patients (Tymowska, 2001a,b). A lack of good information on costs, volumes, and quality increased transaction costs and made contract monitoring difficult. The experiences of the general health insurance period proved the essential weaknesses of the payer, although one could observe a "learning by doing" process.

In the previous system the possibility of choice of place of treatment existed only in some large cities. Patients had to keep to their administrative geographic areas. Since January 1999, patients have had the right to choose their doctors in ambulatory care clinics, or their hospitals, but only from among those organizations that signed contracts with sickness funds. Referrals issued by primary-care doctors were required to see specialist doctors or to conduct laboratory tests. Patients did not need referrals to see a psychiatrist, a gynecologist, an oncologist or an ophthalmologist. As mentioned above, sickness funds provide a justification for performing particular services applied strict budgeting techniques and a limited number of services in contracts. As there were no adequately developed institutions for professional (merit) supervision, and there were essential information asymmetries between the payer and the providers, such control methods turned out to be quite ineffective and based mainly on administrative pressure. Finally, the system of mandatory referrals and strict rationing of services provided by particular providers under contracts turned out to be a cause of serious administrative hardship and a barrier to health care access for people.

In the process of introducing a general health insurance system in 1999, a family medicine model (WONCA, 2002) was strongly promoted. General practitioners were supposed to be a patient's guide and health care process coordinator. Unfortunately, allocation mechanisms fostered a gate-keeping rather than coordinating function. Incentives were not aligned with family medicine philosophy, as the financial responsibility of GPs was limited to the primary care domain only. Among patients in Poland, similarly in the United States in the 1970s (Getzen, 1997; Cochrane, 2001), strong cultural customs existed to use specialist care (Tymowska, 2001b, 2004). These

customs deepened negative attitudes to any restrictions on access to ambulatory specialist care.

A lack of acceptance of system principles manifested itself in problems with communicating information to the GPs on their patients' health status and treatments recommended by specialist consultants. Neither patients nor specialist consultants cared about giving family doctors any feedback information (Tymowska, 2001b). There was a formal legal commitment to report such information as a patient's health status and recommended treatment, but there were no effective institutions to enforce that rule.

Implementation of the referral system in the case of ambulatory specialist care and limits in contracts between specialists and sickness funds on the number of visits caused a decrease in the number of specialists cases and thereby secured strict budgeting. At the same time, it did not help to avoid cost-shifting from lower to higher levels of care (reference levels). This cost-shifting phenomenon is present in many countries (Getzen, 1997; Mays, Malbon et al., 2001). In Poland, the process of cost-shifting generated a sharp increase in general costs (Tymowska, 2003). It was mainly primary care financing techniques that encouraged cost-shifting. Capitation payments for narrow range of services, without suitable institutions of professional supervision over contract realization (e.g., consultation and procedure standards, precise requirements and professional auditors) together with the incentives to maximize surplus, stimulated GPs to refer patients to higher reference levels. On the other hand, the ways in which individual family doctors were compensated was quite important, as individual GPs were not the owners of practices, did not manage budgets, and were not compensated through capitation payment (dependent on the number of patients enrolled). GPs were obviously not stimulated to work hard and so they were also motivated to refer patients more easily to higher reference levels. Another incentive was hidden in the methods of financing specialist ambulatory services, according to a fee-for-service (FFS) rule. An FFS payment, together with incentives to exceed contractual services' quota, motivated specialist consultants to provide as much treatment as possible in order to maximize income and sometimes protect themselves against legal liability.

The opportunistic conduct of health care providers, with strong incentives to shift costs to other organizations and thus to escape prescription costs, together with the existence of the patient's right to choose a place of treatment in the context of missing standards and missing recommendations of medical procedures, resulted in a considerable increase in the number of hospitalized patients, including at tertiary-care and teaching hospitals. In the

first year the new financing principles were in operation, some hospitals remarkably exceeded contractual limits expecting their contracts to be renegotiated. However, sickness funds paid only for a portion of additional hospitalizations, and that became one of the causes of debt in many hospitals.

It should also be mentioned here that the cost-shifting problem depicted above, obviously important from an economic perspective, is closely associated with the quality of health care, through service fragmentation, treatment differentiation, and weak incentives for quality control. The problem of service fragmentation becomes more intense if GPs' autonomy is not associated with the natural financial consequences of medical decisions.

2. CASE STUDY

2.1. Aims and organizational rules of the pilots

As mentioned above, the Pilot Programme introduced in the Zachodniopomorska Sickness Fund (Zachodniopomorska Kasa Chorych) was a spontaneous and regional initiative. Eight percent of the local population (approximately 100,000 people) were engaged in the project. The content of the Pilot Programme was inspired by the GP-fundholding scheme, introduced in the UK in 1991 (Goodwin, 1998; Mays et al., 2001; Kowalska, 2005). A sort of GPFH was also implemented in the Łódzka Sickness Fund (Łódzka Kasa Chorych), but the range of services offered there was not as broad as in the Zachodniopomorska Kasa Chorych. Instead, in the Łódzka Kasa Chorych the contractual arrangements with GPs were a universal solution for the whole area.

In accordance with contractual commitments, the suppliers who conducted the Pilot Programme organized health care for those patients who enrolled with family doctors employed by these organizations. The managers of these organizations took on the responsibility for coordinating treatment of the enrolled patients and for the management of financial resources assigned for health care packages broader than customary in Poland (broadened by ambulatory specialist consultations and treatment plus laboratory and diagnostic tests). In the Łódzka Kasa Chorych, GPs were supposed to be paid only for the first specialist consultation and not for any resulting long-term specialist treatment.

The major technique of financing the general practices engaged in the Pilot Programme was capitation payment (for more information on capitation financing see Tymowska et Kowalska, 2002) (A purchaser [here both sickness funds] agrees to pay a sum in exchange for access to a broadly defined range of services for a defined population of patients). A rate of capitation payment for specialist ambulatory care was calculated by the sickness funds on the basis on historical costs. With capitation payment, the risk of an unforeseen change in demand for health care and therefore a change in the level of expenditures is totally transferred to those who manage the capitation budget. In the budget setting procedure, these risks must be taken into account. In order to limit GP-fundholders' financial risks, a stop-loss arrangement was applied (see below).

The major purpose of the Pilot Programme implementation was to improve specialist ambulatory care access (limiting waiting times for specialist consultation and improving geographic access to specialist consultations). In fact, there were deep differences in access between rural and urban areas of the region. Due to services' quotas applied by the sickness fund, waiting times for specialist consultations quite often amounted to three to four months. Among other aims of the Pilot Programme's implementation were: costs rationalization for ambulatory specialist health care services, enhancing GPs' coordinating and agency roles (in order to enable better assessment of patients' health needs), patient empowerment, improvement of cooperation between primary care workers and specialist consultants, and health care services integration (coordination of multi-specialist treatment).

2.2. Data, method & hypothesis

The information for the research is based primarily on a set of interviews with key contracting personnel (all the providers participating in the Pilot Programme, which amounted to ten general practices with an enrollment varying from 6,000 to 24,000 insured individuals and six GPs from the area of the Łódzka Kasa Chorych) and managers of each of the sickness funds. To maximize confidence in the validity of findings, a triangulation method was applied (Keen et Packwood, 1999), i.e. the survey data were supplemented by the analysis of any relevant documents, including contracts signed between the payers and the providers, internal documents concerning all stages of the contracting process and also press releases.

According to the terminology used in qualitative methods of analysis, an instrumental case study was applied in this research (Stake, 1994). This method makes it easier to obtain exact interdependence between a specific context, contracting mechanisms, and the outcome of the institutional change (Pawson et Tilley, 1997; Wyke, Malbon et al., 2001). Comparing the results of the pilots with the consequences of the universal health care insurance system in Poland puts this research into the framework of comparative institutional analysis (Williamson, 1985).

As emphasized in the introduction to this paper, the primary purpose of the analysis was to assess whether pilot arrangements were more effective at reducing costs, and increasing quality and accessibility of ambulatory specialist health care. There is no theoretical prerequisite to maintain that managed care (here GP-fundholding) is always better than other forms of insurance and health care delivery (Glied, 2000), but it was expected that *the delegation of financial responsibility and risk management from the payer to the medical services providers (GP-fundholders) should create incentives to monitor costs and promote quality (mainly in terms of accessibility).*

In the next section the results are presented and discussed. The comments are grouped around three questions: What was achieved? How was change achieved? What was the problem?

3. RESULTS

The system of mandatory referrals (issued by GPs) for diagnostic procedures and ambulatory specialist health care, together with capitation payments for limited health care packages (primary care only) – both introduced by The General Health Insurance Act (1997) – caused the problem of cost-shifting (see section 1) and thereby contradicted the idea of aligning therapeutic decisions with the financial responsibility for those decisions. The Pilot Programme contracting system, with the techniques of capitation payments for much broader health care packages, created at least institutional frameworks for learning such a responsibility. The change in the scope of GPs' financial responsibility caused the movement from soft to hard budget constraints (Kornai, 1998). Thereby the structure of property rights was subject to change. Cost-shifting opportunities were limited. The rules of the Pilot Programme did not allow surpluses to be invested in practice facilities and equipment. All financial resources that were not used had to be given back to the sickness fund. Therefore, the basic incentive for

owners to control health care costs was either avoidance of a budget deficit or willingness to extend the purchases of ambulatory services.

A more scrupulous analysis proved also that non-pecuniary incentives were very important for explaining physician behaviour. These non-pecuniary incentives were related to opportunities to pursue professional concerns (to improve services to patients, to have a real impact on the therapeutic process, to have access to more accurate information on the health status of the patient and thus to make it easier to coordinate care, and to gain reputation). Two crucial areas of health care quality improvement and cost rationalization or creating conditions to monitor both of them, that were achieved during the pilots, are presented in the next subsection.

3.1. What was achieved?

(1) Ambulatory specialist health care access improvement

Universal administrative rules of access, such as: mandatory premium payments, a system of referrals, the sickness fund's enrollment, the mandatory choice of one's own family doctor, and limits issued by sickness funds were left unchanged in the Pilot Programme, but those patients who were engaged in the experimental arrangements suffered much less intensely from hardships associated mainly with limits on the numbers of ambulatory consultations allowed.

Non-financial costs of using health services, such as stress, long waiting times, and fear associated with uncertainty, substantially influence access conditions. Polish GP-fundholders, similarly to British ones, had the opportunity to negotiate access conditions (especially with respect to waiting times) for their patients (Petchey, 1995). As mentioned above, due to services quotas applied by sickness funds, waiting times for specialist consultations quite often amounted to three to four months. The individual agreements on contract conditions in the Pilot Programme helped to cut down waiting times to approximately one to two weeks or even and occasionally less than one week.

Decisions to seek care are influenced by availability of services in the area (i.e. distance to health care organization, ease of travel to a doctor, travel costs incurred by patients) and cultural customs of intensive or low use of health care services. In Polish villages and small towns, the use of specialist health care services is much less intensive than in metropolitan areas (Tymowska, 2001b, 2004). Therefore, the improvement of geographic

access to specialist consultations was of key importance for the Pilot Programme designers. The travel costs incurred by patients (not so high in absolute terms) used to be an essential barrier to access in regions where structural unemployment prevailed, such as the area under research. To avoid wasting time or paying for tickets, people refrained from going to doctors when their illnesses did not seem to be so serious. A relatively frequent result of such decisions was the necessity of subsequent costly hospitalization.

The incentive structure created by the Pilot Programme limited spatial barriers to accessibility. This spatial access improvement was the result of individual contracting with the ambulatory specialist services suppliers and the arrangement of consultations directly in primary care practice facilities. The GP-fundholders declared that they wished to continue in that direction, arranging as many specialist consultations "in place" as possible. In some cases a basic barrier to organizing ambulatory specialist care in that way was poor building infrastructure and restricted funds for necessary investments.

An important determinant of access is the way the service delivery process is organized (registration system and its adequacy to cultural customs and patient behaviours). As principles of registration are better suited to the individual needs of patients, the only reservation that should be raised refers to the way that information on the Pilot Programme principles circulated among patients and medical circles. The way the information on the Pilot Programme was disseminated did not foster good relationships between primary and secondary (specialist) care providers, and did not help to build any comparative advantages associated with health care access improvement. Nevertheless, there was considerable improvement in health care access (with respect to both waiting time and proximity), welcomed gratefully by patients and their family doctors.

(2) Collecting data on the purchased services and patients' health status by GPs

Quality management in health care requires credible data on purchased services and patients' health status. The rules of cooperation between primary care and specialist consultants were defined in the contracts. Costs of specialist care and diagnostics were to be reimbursed on the basis of the invoices issued together with short reports of the diagnosis and recommended treatment. Such feedback helped GPs to collect all the necessary information on the patient's health status and adequate therapeutic

guidelines. The same rule of cooperation and coordination of medical activities was written formally in one of the paragraphs of the General Health Insurance Act (1997). But it was this new financing method (combining cost reimbursement with feedback information circulation), and not formal legislation, that made the official rule work. In institutional language this financing method played an enforcing role and compelled the consultants to care for information given back to GPs. There was a real improvement in information quality. In Exhibit 2 I present some of the advantages of collecting and managing complex information directly at primary care site as reported during the interviews.

Exhibit 2

The advantages of collecting and managing information directly by GPs

- creating a basis for the development of both organizational (information transfer between medical professionals) and clinical (on structure and process quality) standards;
- creating data systems as a basis for statistical profiling;
- the opportunity for GPs to coordinate health care process;
- a basis for offering more integrated services (complex treatment);
- creating a sense of greater medical responsibility and GPs' engagement in the therapeutic process;
- an exchange of medical experience and knowledge between GPs and specialist consultants that encourages an increase in professional qualifications among GPs;
- selection of truly "difficult" cases for specialist consultation and treatment, which promotes better specialization in health care;
- creating a better basis for diagnostic process (by taking into account coexisting illnesses);
- more effective contract monitoring by *ex-post* analysis of controversial cases;
- identifying patients with high risks of getting ill, with data on using emergency health care or participation in screening tests;
- working out professional criteria of health care provider selection and a basis to check the quality of purchased services;
- an ability to learn about patients' preferences in relation to the medical service providers and an assessment of these opinions in the context of medical information received from consultants, and – in case of any discrepancies – the opportunity to inform the patient of the medical justification of a chosen treatment, or else, to change the provider;
- limiting the phenomenon of unnecessary duplicative diagnostic tests, particularly at the primary-secondary interface (diminishing patient's fears, limiting medically unjustified contacts with the health care system);
- requirement of communicating information that compels constant cooperation between health professionals representing various medical specializations or circles;
- rationalization of health care costs.

Source: author's own

3.2. How was change achieved?

Supervising specialist health care costs and quality turned out to be a significant issue, as interviews revealed an existence (in some cases) of the phenomenon of offering much more treatment than was clinically necessary by ambulatory clinics. A group of health care professionals stated in interviews that *a general system [payment methods] motivates specialist consultants to tell patients that they are seriously ill, even if they were not.* Further existence of such behaviour was strongly dependent on the range of GPs' financial responsibility and the lack of medical treatment standards. Under the Pilot Programme, the incentives to control unnecessary treatment episodes were stronger than outside the pilot. 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. Capitation prospective payments for wider packages of health care encouraged the spontaneous (vertical) integration of primary and secondary care providers through formal institutions (contracts) as well as informal ones, i.e. supplier networks created mainly on the basis of trust and reputation (for more information on the process of integration in pilot arrangements see Kowalska, 2007).

Initiatives such as the Pilot Programme proved to have the potential to mitigate risks of cost-shifting. The analysis did not provide any proof that GPs were attempting to select specialist consultants based on their connections with hospital staff and facilities. High qualifications and reputation in medical circles were the most crucial factors that had an influence on decisions not to refer patients unnecessarily. Ethical codes and consciousness of the necessity to compete by quality for primary care patients also proved to be important.

An important result of introducing capitation payments for wider packages of health care were more restrictive criteria of choosing co-workers and providers of care. Competitive conditions for doctors applying for a contract were created. New rules of provider and co-worker selection were also supported by adjusting capitation payment to specialization degrees (qualification certificates). Signing a contract with health professionals helped constrain health expenditures by limiting the number of unnecessary referrals and by decreasing costs of specialist treatments as a consequence of selective contracting. Selective contracting and the creation of networks of providers aided the search for economies of scale and helped to overcome financial barriers (particularly at the time of investment). Selective

contracting played an "accrediting" role by "penalizing" those providers who did not meet contract requirements (with respect to both quality and effectiveness) and "rewarding" those who fulfilled contract commitments.

A basic method of health care resources utilization review was a direct monitoring of treatment recommendations issued by specialist consultants. Contractual paragraphs committed providers of specialist ambulatory health care to report to GPs precise information on diagnosis and recommended treatment. The same requirement was set by law previously but there were no institutions to enforce the rule. This rule was subject to many conflicts between medical professionals, as traditionally they were accustomed to a wide scope of professional autonomy, interpreted as lack of any form of medical supervision. Moreover, stronger utilization review and selective contracting changed significantly the ways in which financial resources flowed through the local health care system. Most denials of claims pertained to services for which referrals were not required. Most often quality of feedback information and classification of services rendered were questioned.

Any denied claim causes distress and conflicts between contractual partners (McElfatrick et Eichler, 2003). Clearly, any provider should know that a claim will be denied before the service is given, but – as Larsen concludes – *few people read their contracts* (Larsen, 2001, p. 40). Additionally, the potential to eliminate opportunistic behaviour by using ex-post methods of monitoring may be depleted as soon as the poorest providers of care are eliminated from the local market due to selective contracting. These are the main reasons why *ex-ante* methods of monitoring, such as monitoring referrals, second-opinions, peer-review, precertification and so on, should be applied in managed care, particularly with respect to hospital services.

Direct monitoring of health care resources utilization helps to limit the moral hazard of medical professionals, and avoid duplication of diagnostic procedures. It should also promote coordination of GPs and support the creation of cooperation ties between medical professionals. Direct monitoring could not exhaust methods used to supervise health care costs and quality. There is a need to design a complex institutional framework for limiting the moral hazard of medical professionals. The interviews allow us to point out the institutions which limit both the opportunities of physicians to induce unnecessarily health care demand, and to weaken the incentives to shift costs outside the domain of their financial responsibility (see Exhibit 3).

Exhibit 3

Examples of institutional ways of limiting opportunities to induce unnecessarily health care demand and of reducing the incentive to shift costs

- restrictive licensing of health care professionals;
- permanent education of health care professionals (as it limits tendencies to refer patients to hospitals);
- bringing clinical decision making and resource management closer together in the hands of primary care professionals (via capitation payments for a wider range of health services);
- second-opinion programmes;
- creating trust-based networks of medical professionals representing various medical specializations or circles;
- precise requirements for each reference level of care;
- creating guidelines, pathways and protocols for diagnostically related groups (DRGs);
- monitoring the standards' implementation;
- creating conditions that encourage quality competition for patients (e.g. constructing capitation rates according to the level of health professionals' specialization or practice's accreditation certificates).

Source: author's own

3.3. What was the problem?

Using contracts effectively as a risk management tool requires data systems; accurate, reliable, and timely information about the health needs of the population (services utilization in the previous years, the characteristics of the population enrolled in the managed health care plan, i.e. age, health risks, etc.); and quality of services provided. One of the fundamental problems recognized just after the Pilot Programme was implemented regarded information accuracy and reliability. Due to service limitations introduced earlier by the Zachodniopomorska Sickness Fund, health care needs in some specializations (particularly those that did not require having a referral issued by a GP) turned out to be underestimated. GP-fundholding helped to improve specialist health care access. This improvement, with respect to those services that were accessible without referrals, induced a quickly uncontrollable growth of demand among patients. In order to control this demand, a 'steady state' (a period of transition) could have been applied, which would have helped to gather accurate and reliable information on real health needs with respect to those services. A steady state was applied in the United Kingdom before GP-fundholding was introduced. But this method also has its weak point: it creates risks of maintaining moral hazard in the

form of 'budget inflation' (Wilton et Smith, 1998, Croxson et al., 2001). Another way is to exclude those services from the domain of GPs' financial responsibility, but it might weaken economic incentives to control costs.

Another problem with demand recognition was associated with health needs seasonality (e.g., during holidays). The elements of seasonality are quite common in health care (Aliotta, 2001; Cochrane, 2001) but they are difficult to grasp in formal capitation payment models (Glazer et Shmueli, 1995). Seasonality is a real impediment in health care expenditure planning. Long-term contracts that guarantee future flow of funds predictability, a financing elasticity rule that enables shifting money between various budgets and reserve funds help to overcome this problem.

CONCLUDING REMARK

As predicted by the research hypothesis, general practitioners engaged in the pilot arrangements very quickly realized the need to monitor health care costs and promote quality. Paying directly for ambulatory specialist services was a catalyst that encouraged them to think of ways to rationalize expenditure through supervision, and to satisfy their patients through improvements in health care quality and accessibility. GPs were looking for opportunities to sign contracts with those specialist consultants who agreed to work at the primary care facilities. They also tried to develop primary care activities for their patients.

The Pilot Programme experience proved that bringing clinical decision making and resource management closer together in a publicly funded system in the hands of primary care professionals could be justified. The reason why this is so is that the real ability to supervise health care quality and costs is in hands of a payer (agent) who disposes of adequate professional knowledge to assess a need for health care services. Such an agent needs to be genuinely interested in his principals' (patients) health status. Paying for those services provides a financial motive. The sickness fund – a remote bureaucracy – was not able to achieve the same result, as it used mainly administrative methods of control, and was not motivated by the fact that patients exit the health care organization.

To sum up, there was considerable improvement in health care access (with respect to waiting times and proximity of specialist consultants),

welcomed gratefully by patients and their family doctors. There was also much progress in generating information about patients' health status and treatment recommendations and the communication of that information among health professionals. Monitoring invoices and reports on the diagnosis and recommended treatment helped to eliminate to some extent the opportunistic behaviour of the providers and to create professional networks based on trust and reputation. The latter served · to improve ways of monitoring costs and quality parameters.

A more scrupulous analysis proved that non-pecuniary incentives were helpful in explaining physicians' behaviour. As in many countries, hospital jobs in Poland are regarded to be 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 marginal (Malbon et al., 2001). A 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, individuals who may be trusted and be a guide for the patient. One should remember of course that all those extra-financial benefits were an immediate result of a new contracting (financing) system, not an ideology, good-will, or strong ethical incentives.

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