



**A Resource
For Managing
Health Sector
Reform**

Issue Brief



Provider Market Analysis and the Health Sector in Transitional Economies

Provider Market Analysis (PMA)

Provider Market Analysis has proven to be a useful tool in understanding and dealing with change and reform in societies with transitional economies. PMA is based on DDM tools for analyzing the organization of health care delivery in a defined area. Applied research carried out by the Harvard-Jagiellonian Consortium for Health under the DDM Poland project focused on the delivery of ambulatory personal health care services (illness treatment and personal preventive services) in Krakow, a major Polish city. The goal was to identify key issues for Poland's new health funds and for government supervision based on a better understanding of the market.

The Krakow experience

The Krakow study described the different types of health care organizations that are delivering personal ambulatory services. The analysts quantified the shares of the different provider types in numbers of units, service volume provided, and total expenditure by public and private sources. They then documented the size and composition of informal and unofficial payments for ambulatory personal health care.

Sources of data developed for the study included a provider survey, a household survey, and an analysis of

secondary data, including municipal and provincial reports of utilization and expenditure. Innovative use was made of telephone surveys, possible in urban Poland.

Principal research findings

Results of the study included:

- ❶ Private providers comprise a sizable share of all provider units, volume, expenditure, and effort. Public polyclinics account for only 32 percent of all physician effort in Krakow, whereas private *npzoz* and individual practices account for 44 percent of all effort. In contrast, public providers delivered 54 percent of all ambulatory contacts.
- ❷ Slightly over half of the total spending on ambulatory care services in Krakow is private, almost entirely household out-of-pocket spending. Almost three-fifths of this private spending is for drugs.
- ❸ Of the amount spent on other household payments to providers, about two-thirds is for formal, i.e. posted payments, and only one-third is for informal, i.e. gray payments.

Discussion of the results

Almost all ambulatory services are included in the benefit package to which current enrollees in the new insurance scheme are entitled. Yet,

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current insurance financing approximately equals the amount available in public expenditures alone. This means that the expenditure on current consumption of the entitled benefits is about double the amount available to pay for it. In addition, over one-third of the total volume of consumption of this set of services is currently being provided outside the public system.

As other studies have shown, there is sizable demand for private health care as well as significant household spending on ambulatory care to support this demand in transitional economies.

What are the implications for the success and development of health insurance?

Many populations are accustomed to meeting a large part of their entitlement outside the public system. If insurance does not cover access to non-public providers, people may come to feel that insurance does not fulfill its implicit contract in terms of the coverage by the benefit package. In cases where insurance does not have sufficient money from the traditional ambulatory care allocation to cover these services, additional funds might be found by:

- ❶ Reallocating money from other types of services, such as inpatient services.
- ❷ Limiting support to public facilities (by using some of the available funds to pay for private providers) so that public providers reduce their costs. This would imply reducing staff, since physicians may already be more productive in public clinics
- ❸ Increasing patient contributions, i.e. copayments. A differential copayment for patients choosing private over public providers might raise funds from those most able to pay and provide patients with an incentive to use lower cost public providers.

How should decision-makers view these alternatives?

According to this analysis, decision-makers should be interested in whether those services consumed outside the insured benefits are important from a health or equity perspective. If the privately-provided, privately-financed care is mainly less important services consumed by more affluent groups, insurance managers may be willing to allow a gap between benefits promised and benefits provided to persist until contributions increase enough to cover the gap as earnings rise.

Alternatively, if the uncovered services are significant from a health or equity perspective, they will need to consider the options noted above. Of the three, a differential copayment could both ease the financing problem and provide better incentives to both providers and patients.

The PMA analysis showed that a whole-market perspective is needed to assess finance and provision reforms as long as there is substantial leakage of demand to different sectors and that this makes up a significant share of provider earnings. These conditions are present in most developing countries, including those with transitional economies.

The full study is M. Chawla, P. Berman, A. Windak, and M. Kulis, "Provision of Ambulatory Health Services in Poland: A Case Study from Krakow," Harvard-Jagiellonian Consortium for Health, DDM Report No. 68.1, Nov. 1999. A related publication is P. Berman, "Understanding the Supply Side," DDM Report No. 78, Sept. 1999.

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