

PRIVATISATION AND PROFESSIONAL DYNAMICS

ABSTRACT

The organisation and delivery of health care throughout the world is undergoing significant organisational, social, and economic changes. These changes have important implications for the professional status of medicine since they affect the dominance, autonomy, and authority of medical practitioners. In this article we examine the professional dynamics which underlie the process of privatisation in the field of health care in Slovenia and place it within the context of these global changes. To this end, we look first at realised and potential privatisation among primary health care doctors in Slovenia. We continue by illustrating the forms of organisation within the private sector preferred by practitioners - solo practice versus group practice - and ask what method of privatisation of public health care centres they regard as most acceptable. We take these as indicators of the widespread professional orientation of Slovenian doctors towards managed care and accountability rather than to the highly autonomous forms exemplified by the traditional solo practice. We then turn to the factors that affect doctor's decision to move from the public to the private sector. We close with a discussion of the two phases in the privatisation of health care in Slovenia which are characterised by different practitioner preferences with regard to the form and organisation of the private sector, as well as by different motivational structures affecting the individual's decision to move into the private sector.

Keywords: privatisation, practitioner aspirations, professional dynamics, primary health care, social capital

Introduction

The reintroduction of private practice in Slovenia was one of the stated goals of the reform of the organisation of the health care system proposed by the 1992 Law on Health Care and Health Insurance. By 1998 the number of medical practitioners in the private sector was growing at an average annual rate of 1.26 (Health Insurance Institute

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of Slovenia 1998). Growth was highest in 1995. Since 1995 it has decreased steadily for all groups of medical practitioners - general practitioners (hereinafter: GPs), specialists and dentists. As a result, only about one fifth of physicians were employed (or self-employed) in the private sector in 1998. This proportion was highest among dentists (37%), and much lower among GPs and specialists (about 15%) (Comparative Tables on Health Care Reform in Phare Countries 1998).² The transition from the public sector to the private sector thus shows a significant initial push that slowed down during the second half of the 1990s, which calls for an explanation. Was this slowdown in privatisation the result of systemic obstacles and political disagreements with regard to the pace and scope of privatisation among the major institutional actors in the field, or simply the effect of decreased interest in private practice on the part of practitioners and therefore a sign that a balanced equilibrium had been reached between the private and public elements in the Slovenian health care system?

The recent slowdown of privatisation of health care in Slovenia stands in contrast to the recommendations by the EU to the CEEC (or countries in transition), which emphasise the need for the privatisation of the primary care supply, together with the restructuring of state-owned hospitals. Similar recommendations have been made in the past by other international organisations. Recently, however, assessments of the efficiency of public health care in Slovenia have appeared which make it right to question the level and speed of privatisation. In 1998 the London-based Economist Intelligence Unit (EIU) placed Slovenia an enviable seventh out of 35 European countries in the area of the state of health of the population and the health care situation (Židanik, Košir 1999). Of course the health of the individual is only conditioned to a small extent by the accessibility and quality of health services, with life style, the availability of social support and other social, natural and genetic factors playing a much more important role. Nevertheless, we can agree with those who believe that - comparatively speaking - the Slovene model of organisation of health care in the form of public health centres has a great many advantages. Furthermore, western democratic countries have in the last two decades typically made efforts in the direction of managed care and limitation of doctors' autonomy because of the increasing financial pressures of the health-care system on the welfare state. In the process of increasing control over doctors' work and working conditions by the state and by insurance funds, new organisational forms have emerged which represented a step away from the traditional solo practice in the direction of group practices and even the position of salaried primary physician. Viewed from the point of view of this global trend the reform of Slovenian health care in the direction of privatisation thus seems at first glance to be unnecessary, since it would mean a step in the other direction from that which other countries are trying to achieve. Two factors, however, should not be overlooked. First, while central and eastern European countries have till now experienced strong and direct state intervention in health care, this has been weak in western countries. The increasing role of the state in western democracies in the 1980s and the reduction in the role of the state in the countries of central and eastern Europe are thus not necessarily opposing trends but most likely an indication of a certain convergence of health systems in the direction of the state which advocates an

active health policy but in a way which allows health services providers considerable business, administrative and working autonomy. Second, to the extent that the fall in the growth of the private sector in Slovenia is the consequence of the blocking of privatisation potentials and aspirations among doctors currently employed in the public sector, this is a sign that despite its many positive elements the system contains oppositions and conflicts, the solution of which is indicated in the form of spontaneous privatisation or the transition (flight?) of doctors from the public to the private sector. Restraining the aspirations of doctors for a move to the private sector without a simultaneous adaptation of the public sector so as to accommodate their demands would be extremely non-productive for the public health system itself.

In order to provide some answers to the above mentioned questions, we decided to look at where Slovenian primary care physicians stand with respect to privatisation and what are their professional preferences. By such focus on physicians we hope to show the professional dynamics that stands behind the spontaneous transition from public to private sector. We advance the thesis that the privatisation of health-care in the countries in transition, which over the last forty years have experienced a high level of bureaucratisation and administrative control of professional work, has triggered a specific response on the side of doctors who conceived the private practice as a solution to their accumulated professional and material problems and aspirations. Doctors employed in large medical organisations such as local public health centres are today seeking to increase their professional autonomy and control over working conditions by moving into the private sector. In order to test this thesis we analyse the factors which affect the decision of the individual practitioner to move from the public sector to the private sector - from the position of salaried physician to private practitioner. We ask whether doctors' aspirations towards private practice are driven by opportunity structures, material (business) goals, or non-material (professional) factors. The approach we take in this study will allow us to see whether the development of private sector parallel to the public one depends largely on opportunity structures that were brought about by the changes in state regulation, or the individual-level factors and variations among doctors are also involved. With respect to the later, we are in particular interested in the role of professional factors such as professional aspirations and job satisfaction. We examine the extent to which doctors' aspirations and job satisfaction differ across different work arrangements (private as opposed to public), and the extent to which they represent the driving force behind their decision to open a private practice.

Professional autonomy in the changing health-care environment

For a long time, from at least the turn of the century, medicine provided a model of 'the profession' since it was characterised by a very high degree of autonomy, authority, and dominance. Its high autonomy was based on the ability of doctors to make clinical

decisions without the intervention of a third party, and to regulate their working conditions and the members of the profession. It also possessed a high level of authority which was reflected in the trust of the general public and patients in the doctor's technical knowledge and moral position. Furthermore, its high status was a result of the fact that it established a dominance over other occupations in the medical sphere.

The power and prestige of the medical profession reached their zenith in the 1950s and 1960s. Some sociologists argue that medicine has lost much of its status as a profession over the last twenty years in the struggle to devise effective mechanisms for controlling health-care costs. Sociologists conclude this on the basis of findings which point to a weakening of doctors' clinical autonomy and of their autonomy in setting working conditions such as owning or renting premises and equipment, control over their work schedule and fee schedule, and choice of patients (McKinlay 1988; McKinlay, Arches 1985; McKinlay, Stoeckle 1989). For these authors, autonomy represents a central aspect of the doctor's professional status. Others have argued that medicine's status has remained largely intact. Although its autonomy has decreased, it has remained a dominant profession in its field (Freidson 1986; 1994; Hafferty, Light 1995). According to this argument, professional dominance is critical factor in the doctor's professional status, and as long as doctors as a group remain dominant in the division of labour in health care, they will retain their status as professionals, although they lose some of their clinical and working autonomy. A third group argues that the doctor's professional status has been challenged primarily because of a reduction in authority (Haug, Lavin 1981; Haug 1988). This argument has several aspects to it: an increase in the medical knowledge of patients and in their involvement in treatment decisions, an ability to assess the quality of the health service, and a growing lack of confidence in doctors' technical knowledge.

The above changes in professional status and prestige came about as a result of efforts on the part of the state and private payers to control the terms, conditions and content of medical work, in order to check the rise of expenditure. Practice protocols, treatment guidelines, restrictions in referrals to specialists and the limited number of medicines available for prescription, as well as the replacement of peer control by more formalised forms of quality assessment, are the institutional innovations which currently shape the nature of the medical profession. They represent the externally based efforts to increase control over doctors' work. The emergence of practice protocols and medical effectiveness research has also been accompanied by internal forces of change such as the rise of administrative and technical elites which have brought about a new kind of control and led to conflicts within medical institutions. The conflicts between physicians and external and internal actors, which tend to limit doctors' autonomy by raising considerations and priorities other than technical/medical ones, are not in themselves counter-productive. But they need to be resolved within a context of a balanced polyarchy (Dahl 1971) in which disparities in the power of individual parties are not so large as to lead to the long-term submission of one party to the other. When the needs of other significant parties are subordinated they, in time, mobilise to counter this dominance. This is the central thesis of recent work on professions: the professional character and

dynamics in a specific country reflect the specific configuration of countervailing powers which struggle for dominance in the field by forming coalitions (Abbot 1988; Halpern 1988; 1992).

Empirical health care policy networks are all structured around the dominant actor. These can be professional organisations, the state, or insurance sector. The strength of the dominant actor is defined by institutionalisation and the establishment of a monopoly within the field, as well as by the fragmentation of the field of the other party. But in the fluid health-care environment alliances are shifting. One such asymmetric arrangement has recently been undergoing a visible transformation: the arrangement where professional associations are the dominant actors. The “veto power” of the so-called “medical lobby” is weakening in a number of countries. As Hafferty and Light (1995) show, the AMA and major physicians’ organisations in the USA, which had long been accustomed to a privileged seat at the policy table, found themselves - unexpectedly - excluded from Hillary Rodham Clinton’s health care task force: “Vice President Gore warned the AMA that it would no longer dominate health reform, while President Clinton labelled the AMA ‘just another special interest group.’” Another example is provided by Germany, where internal weakening of the representation of the medical profession has taken place. In the early 1990s the federal union of insurance doctors, which includes office-based doctors, was for the first time unable to achieve a balance between the demands of different doctor groups (Hassenteufel 1996). At present, it seems that the balance among different forces in the health care environment is shifting towards the insurers. This process indicates that while at the individual level doctors have experienced a weakening of their autonomy and authority due to the external and internal forces of control, at the collective level organised medicine is losing its ability to exert a dominant influence in an increasingly crowded policy environment. Its influence is, however, still a long way from disappearing.

Thus, the health-care environment in which physicians practise has changed dramatically. But changes have also occurred in the workplace and in the kinds of relations doctors establish among themselves. Hafferty and Light (1995: 133) describe this in the following way: “In less than a generation of providers, the solo practitioner has given way to the group practice, which itself has become buried under a mosaic of practice networks, institutional arrangements, and organisational schemes”. This pressure upon doctors has been very strong in the USA, where a variety of managed care arrangements and practice networks have been introduced (HMOs, IPAs, PPOs, etc.). While one route for change in the content of doctors’ work involves efforts to alter work directly (via different kinds of protocols, guidelines, and restrictions), the other route involves changes in the terms of work (e.g. pay, hours) and conditions of work (organisational structure, employment status).

Some authors have fiercely criticised the weakening of professional autonomy. Freidson (1994), for example, suggests that the prevalent bureaucratic model of regulation of the health care domain which emphasises standardisation and reliability should be replaced by a professional model which rests on flexibility and the discretionary judgement of professionals. Health policies should thus aim at supporting those work

arrangements which nourish professionalism, strengthen the profession's collective commitment, and encourage things such as peer review and the exercise of colleague control. But peer review and colleague control is something generated and supported within a system characterised by peer relationships. It is not supported by a system composed of dominant technical and administrative elites with strong tendencies to "manage" rank-and-file doctors. Furthermore, while elevating peer control as the only valid means of control over doctors' work, this argument downsizes the role of the public and users as potential partners. For this reason Hafferty and Light (1995) propose an alternative to Freidson's call for an increase in doctors' autonomy. They argue that we should reconsider whether autonomy should remain the pivotal issue in understanding recent professional dynamics. They suggest that the notion of autonomy and technical/medical expertise which implies exclusion from any outside review should be supplemented by a notion of accountability which does imply a certain risk of incursions by outside experts into medical domain, but in the form of a partnership between doctors and these experts, as well as a partnership between doctors and the public at large, in particular when dealing with the issues of quality.

Privatisation of the health-care system in the countries in transition is nowadays inevitably placed within the professional dynamics framed by the global issues of autonomy, accountability, and deprofessionalisation. To assume that the transition from the public sector to the private sector is a mere reflection of the financial (business) interests of doctors is too short-sighted. I agree with Hartley and Light (1995: 145) who warn that: ".../medicine can never return to its promise of placing the public's interests ahead of its own so long as policy makers create an incentive structure that treats - and thus defines - professionals as economically motivated actors. This is not to argue that economic incentives are not an effective or rational vehicle for change. But, policy that treats physician behaviour as economically determined will play a role in creating such a beast." One should thus evaluate the move of doctors from the public to the private sector in terms of the professional dynamics triggered by such a move. To this end our study pays special attention to the issues of professional aspirations and job satisfaction among doctors.

Although studies of doctors' satisfaction with their work are quite rare, they nevertheless point to the fact that autonomy, authority, and dominance - the three aspects of professional status - are related to doctors' satisfaction. But even in the USA, where twenty years ago doctors viewed with horror the prospect of "deprofessionalisation" which came in the form of managed care, and where control over clinical autonomy is very high compared to other countries, they seem to accept the intervention of third parties - either patients or insurers - as a rule of the game. Still, their satisfaction varies according to more specific parameters within this general frame of managed care. Doctors who have retained dominance within the health care field and are more autonomous in terms of work schedule and payment, those who work in groups of 5 to 10 as opposed to solo practices or very small and very large practices, as well as those whose patients express general confidence in their doctors, are more satisfied with their work (Warren et al. 1998). Others have found that satisfaction is related to self-employment (Baker,

Cantor 1993), working in group practices rather than solo practices (Skolnik et al. 1993), and to control over working conditions and a lack of bureaucratic regulation (Chuck et al. 1993; Lammers 1992). When doctors work in practices as salaried staff, their satisfaction increases if they are involved in organisational decisions on issues such as hiring, adopting new services, or resolving patient grievances (Barr, Steinberg 1983).

Since doctor satisfaction affects both quality of care (Skolnik et al. 1993) and patient satisfaction (Linn et al. 1985) it is a critical topic not only for doctors but also for patients and health care administrators. In our study we will look at yet another consequence of doctor satisfaction, namely their propensity to leave public institutions and move to the private sector. Studies conducted in other national contexts have found that when doctors are not satisfied with their working conditions, they are indeed quite likely to “exit” a given practice and move elsewhere (Lichtenstein 1984; Mick et al. 1983). Both the effect of doctor satisfaction on patient satisfaction and quality of health care, and on doctors’ propensity to stay in a given job represent sufficient reasons that one engage in a study of professional aspirations and satisfaction among the Slovenian physicians, especially those employed in public sector.

Privatisation potential among Slovenian primary care practitioners

In this section we examine the latent privatisation potential of Slovenian doctors in primary health care. To this end we distinguish between actual and desired transition to private practice. We talk about actual transition in the case of doctors who have already opened a private practice, and about desired transition in the case of physicians still employed in public health care institutions who are nevertheless seriously considering leaving the public sector and opening their own private practices.

Because the sample was designed according to the principles of the quota sample, the ratio between the number of doctors employed in the private and public sectors is given in advance: 75 doctors from the private sector and 87 from the public sector.³ Within the public sector doctors were sampled at random. For this reason the ratio between those considering a transition to the private sector and those not considering such a transition corresponds to the actual situation in the population. This ratio is illustrated by the question below.

Do you ever consider opening a private practice yourself?	
very frequently	15%
frequently	23%
sometimes	16%
rarely	22%
never	24%

More than a third of doctors employed in public health care institutions (38%) think very frequently or frequently about leaving the public sector and moving into the private sector. The majority of doctors thinking about moving into the private sector have already applied for a licence to run a private practice. These account for 34% of the total sample of doctors employed in the public sector. Thus not only do these doctors sympathise with the possibility of private practice, they have also already taken the first step in that direction. The aspirations of primary care practitioners to private practice are therefore very high. The reduction in the index of growth of private practice over the last three years is in marked contrast to the potentials and aspirations for private practice that appear among the doctors themselves.

If the primary care doctors who would like to be in the private sector were actually employed in the private sector, the total number of private practitioners at the primary health care level would increase from the present figure of 20% to around 48%. This would mean that the public and private sectors would be balanced in terms of the number of doctors. Doctors themselves are also in favour of a balance of the two sectors rather than the dominance of one over the other. Just over 60% of them feel that the two sectors should be balanced and competitive. This means that they should provide the same services and that between them there should not be a segmentation of users by upper and lower social dividing lines. Such a balance is of course very difficult to maintain, as we stressed in the introduction, since current business conditions and the great dependence on the state in the administrative sense do not enable the long-term competitiveness of public institutions.

Solo practice versus group practice

The private health sector can be organised in very different ways in terms of the size of organisations and the employment conditions of doctors. In the introduction we noted that the number of 'solo practices' around the world is falling and that an increasing number of doctors are opting for group forms of medical practice. Their satisfaction with the level of cooperation within group practices is increasing, provided that the groups are of medium size. Groups of this kind preserve the working autonomy of the individual doctor and at the same time there is a high level of participation in administration. Another feature of such groups is that they enable the development of a social climate favourable for stronger inter-colleague relations but without the excessive dependence that develops in very small groups.

Let us see now which form of group practice is preferred by Slovenian doctors. The question was phrased as follows: *'If you had the opportunity of founding your own private organisation, what form of private practice would you choose?'* As many as 62% of doctors employed in public health care institutions favour group private practice (see Table 1). There are significant differences among doctors of different medical specialisations. The majority of dentists (64%) prefer individual practices, while other specialists favour a group form of private practice.

We also compared doctors employed in the public sector who wish to move into the private sector with those who are not considering private practice. There are no major differences between them. The majority of doctors currently expressing an interest in setting up a private practice prefer group practices to individual practices (59%).

Where do doctors see the advantages of group practices over solo practices? The majority of doctors feel that the main advantages are the following: a group practice enables the assistance of colleagues in urgent cases, professional consultation with colleagues, and easier organisation of turns of duty and substitution in cases of absence. Viewed overall, the advantages of group practice as compared to solo practice are given the lowest assessment by private practitioners (1.35 on a scale of 0 'no differences' to 2 'considerable advantage'), and the highest assessment by doctors not considering private practice (1.53).

The disadvantages of group practice are less marked than the advantages. Private practitioners assess its disadvantages slightly higher than other doctors (0.9 versus 0.75). All categories of doctors however see the greatest disadvantage of group practice in the sharing of equipment and premises with other colleagues. The various disagreements and the supervision by colleagues enabled by a group practice are less disturbing for doctors, and a lesser obstacle to their autonomy, than the sharing of premises and equipment. Owning of equipment and office is thus an important aspect of autonomy for Slovenian doctors.

Table 1
Views of doctors on various forms of private practice.

	Private sector	Public sector (total)	Public sector (wishing to move to private sector)	Public sector (not wishing to move to private sector)
Form of private practice				
individual private practice (% yes)	n.a.	38%	41%	36%
group private practice (% yes)	n.a.	62%	59%	64%
Renting premises and equipment (% yes)	n.a.	87%	95%	81%
Privatisation of health care centres				
Institutions in public ownership/ doctor-employees	0.59	0.48	0.21	0.68
Institutions in public ownership/ doctor-tenants	1.21	1.40	1.67	1.22
Institutions in corporate ownership/ doctor-managers	0.67	0.68	0.56	0.76
Employee buy-out of institutions.	0.32	0.33	0.47	0.24
Institutions sold on market.	0.13	0.07	0.03	0.10

Note: Agreements with different statements describing privatisation options for public health centres are measured on the scale 2 'strongly agree', 1 'agree', 0 'disagree'.

Renting of premises for private practice in existing health centres - yes or no?

Of the private practitioners surveyed in our research only 7% rented business premises within public health care institutions. All others rented or purchased premises on the private property market. When we asked doctors employed by public health care institutions whether, if they had the opportunity to open a private practice, they would attempt to rent premises within health centres, as many as 87% replied that they would (see Table 1). This proportion is even higher among those doctors who are currently considering a move to the private sector - 95% of these would like to rent a consulting room within a health centre. Most of these are general practitioners and other primary care specialists, although the proportion is also high among dentists (75%).

This means that among doctors employed by public health care institutions who are currently considering moving into the private sector, the preferred form of private practice is a group practice operating within the premises of existing health centres, though with a greater degree of autonomy than is permitted by the current management structure of health centres and the status of employed doctor. As some doctors told our researchers in in-depth interviews, they also want more flexible interconnection into working and business groups according to their own affinities, i.e. beyond the limits of existing collectives in health care institutions. This triggers an important dilemma: who should be the subject of a contract with a health centre in the case of renting premises, and the subject of a request for the granting of a concession? An individual private practitioner, a small group of doctors organised into one of the available legal forms, or the entire existing collective? This last option is the preference of pharmacists (Kogovšek-Vidmar 1999) who feel that collectives in pharmacies have achieved a level of social capital which it would be wrong to throw away. However, since collectives in pharmacies are in size and social dynamics very different from collectives in health centres, especially large ones such as at the Ljubljana Health Centre, the only optimal solution from this point of view would be one which permits the greatest possible plurality of forms and methods.

Viewed as a whole the advantages of renting property within health centres are given the highest assessment by those doctors in the public sector who are considering opening their own private practices, and the lowest by private practitioners. Between these two groups of doctors - those who chose private practice in the first period of privatisation and those who are choosing it now, in the second period - a considerable difference thus exists with regard to the preferred form of private practice. Normative regulation of the development of the private sector in medicine in Slovenia would have to take these differences into account. Lastly, the preference of doctors for organisation into private practices under the wing of health centres corresponds to a trend which can also be observed in other branches of the services sector - a tendency towards the decentralisation of services and the centralisation of infrastructure.

Privatisation of public health care institutions

Given that doctors employed in the public sector express considerable interest in renting premises for private practice within health centres, we can expect them to support a method of privatisation of health centres which would allow them to do this. In this connection we posed the following question to the doctors we surveyed: *'The privatisation of public institutions is imminent. What form of privatisation of health centres do you support?'* The doctors were asked to choose from five scenarios the two that seemed most acceptable to them and to give them the values 2 'most acceptable' and 1 'acceptable' depending on how strongly they agreed with them.

Table 2
Privatisation of public health centres

Method of privatisation	Most acceptable (2)	Acceptable (1)	Total (1+2)
A. Health centres should remain in state (municipal) ownership, with doctors as public employees.	20%	14%	34%
B. Health centres should remain in state (municipal) ownership, with doctors renting premises in them as private practitioners.	55%	21%	76%
C. Health centres should be organised as public corporations managed by employees.	17%	35%	52%
D. Employees should gradually purchase health centres.	8%	20%	28%
E. Health centres should in whole or part be sold to the highest bidder.	2%	5%	7%

Let us look at the results. All categories of doctors, regardless of their employment status or area of work, agreed most of all with the following privatisation scenario:

'Health centres should remain in state (municipal) ownership, while doctors as private practitioners should rent premises in them.' As many as 76% of doctors chose this option (see Table 2). For 55% of doctors this also represents the most acceptable form of privatisation of public institutions. This is followed by the corporatisation of health centres, which is supported by 52% of the doctors surveyed but only represents the first choice of 17% of them. Other forms of privatisation enjoy considerably less support among doctors. The two privatisation scenarios which enjoy support among doctors thus presuppose an increase in the autonomy of institutions in relation to the state, one through the privatisation of the activities carried out in the institutions and the second by the route of the corporatisation of institutions and more autonomous

administration. This latter can lead to greater doctor satisfaction with the current situation, but only under the condition that doctors are able to participate in the administration of institutions. In the opposite case the result of this scenario is an increase in the strength of management in comparison to the state and employees.

Doctors employed in the public sector who are considering a move to the private sector are the category which most supports privatisation in the sense of renting premises in health centres (see Table 1). This corresponds to their other preferences with regard to the form of private practice. Such a method of privatisation of public institutions remains the most acceptable scenario for other groups as well, although to a somewhat lesser degree. With regard to the desired form of privatisation of public institutions, a partial split exists between private practitioners and doctors in public institutions not considering a move into the private sector on the one hand, and doctors in public institutions who frequently think about moving to the private sector on the other. While the first group incline to scenarios of 'weaker' privatisation (options A to C), the others favour a somewhat 'stronger' privatisation (options B to D) which does not only include the privatisation of activities but also of property by employees (in the form of an internal buy-out). Both groups however reject the sale of health centres on the market following the model of the ownership transformation of companies, and would like health centres to be transformed into networks into which individual group private practices could combine.

With the development of durable cooperation among the individual private practices renting premises in health centres, the networks would probably slowly transform into a network form of organisation. This is a specific organisational arrangement which fails to conform either to traditional definitions of markets or to hierarchies (Podolny, Page 1998). The characteristic of the network form of organisation is that actors (market competitors) pursue enduring and repeated exchange relations with one another, and lack a legitimate organisational authority to arbitrate and resolve disputes that may arise during the cooperation. Because of this, the network form of organisation requires a distinct ethic or value orientation on the part of the participating actors. Dore (1983) calls this orientation "the spirit of goodwill" since a high level of trust and norms of reciprocity and participation underlie the governance of the network form of organisation. Participants are committed to use their "voice" and listen to the "voice" of the other party, rather than opt for the "exit" (cf. Hirschman 1970), as on the markets. Perrow (1993), in his analysis of a north Italian network of small producers, argues that in comparison to larger, bureaucratic forms of organisation, small firm networks (or networks of small producers) provide individuals with greater autonomy and foster a greater sense of community. As we shall show in the following section, this is what primary health care practitioners in Slovenia want, and where they see the problem of current organisational arrangements within the public sector.

Factors of transition from public to private sector

In the previous section we have shown that a large proportion of doctors employed in the public sector would like to move into the private sector. The aim of this part of the paper is to respond to the question of the conditions under which individual doctors opt for private practice. We are interested in the factors - be they personal factors or features of the environment - which have contributed to the transition to the private sector to date, and in whether these same factors will also determine trends in the future. Thus a key question to be addressed in this section is whether doctors with different characteristics are more likely to end up in one specific health care sector than in the other.

Analysis of the factors influencing a doctor's decision to move into the private sector is based on a comparison of three groups of doctors: a) doctors who have already made this transition, b) doctors who are seriously considering a transition, and c) doctors who do not want to become private practitioners. By comparing the individual groups we will identify the factors affecting the move into private practice, and whether these have changed between the first (already completed) and second (potential) wave of privatisation. The dependent variable, i.e. 'the move to private practice', will be explained by the following sets of variables:

- structural opportunities,
- job satisfaction,
- work and professional aspirations,
- work-related value orientation.
- social and cultural capital.

The decision to set up a private practice, like all major decisions in the working life of an individual, is the result of weighing up the advantages and disadvantages that the decision will bring. In our analysis we have operationalised the advantages and disadvantages of the two options by means of the variables contained in the set 'job satisfaction'. Job satisfaction, together with value orientations and professional aspirations, represents the motivational basis of doctors for a move to the private sector. However, the actual decision is not only the result of a rational weighing up of advantages and disadvantages. It is also based on an evaluation of structural opportunities and the capabilities of the individual. We measure opportunities by means of the variables contained in the set 'assessment of the medical services market,' which includes an assessment of business risk and competition, and by means of socio-demographic variables. The capabilities of the individual are measured using the variables of social and cultural capital which equip the individual with a given life style and social network.

Structural opportunities

In this section we are interested in the extent to which the decision to move into private practice depends on structural opportunities as shown through the individual's evaluation of the medical services market, or his evaluation of the demand for services in the private sector. We can expect that the decision to move into the private sector will be taken by doctors who believe that such a decision does not involve major risk and that there is little competition in the market, and who can expect a large section of their patients to follow them into their private practice.

Let us look first at how the doctors surveyed assessed the business risk associated with the move into the private sector (see Table 3). Doctors who are not considering setting up a private practice give a higher estimate of the business risk associated with private practice (5.10) than those who are considering moving from the public to the private sector (4.8). Evidently the individual assessment of business risk is related to the decision to transfer from one sector to the other - the greater the perception of risk, the less the willingness to set up a private practice. At present private practitioners are most optimistic with regard to business risk (3.8), and disseminate this 'relative optimism' directly or indirectly among those doctors in the public sector who frequently think about leaving the public sector.

The assessment of business risk is not however linked to the estimate of the number of patients who would follow the doctor into his private practice. If we leave aside the doctors who for various reasons have not transferred their files from the public health care institution, and let this share equal 0%, estimates for all categories of doctors range from 70% to 80%. Private practitioners are followed into private practice by on average 73% of patients, and the expectations of doctors in public institutions are at the same level. Our figures do not show major differences between medical practitioners of different specialisations - dentists, general practitioners and other specialists. Provided that they obtain a licence, all expect a high level of loyalty from their patients.

Doctors employed in private practices give the lowest estimate of business risk and at the same time perceive the greatest competition in their own environment. Their assessment of competition is however still very low. On a scale from 0 (none) to 4 (very high) the average assessment was 1.15. For doctors in the public sector this assessment was 0.70. The difference is therefore statistically significant but extremely small. As many as 40% of private practitioners still judge that in their own environment they do not feel competition from other doctors or public institutions. Slightly more competition is felt by dentists than by general practitioners and other primary care specialists.

From this it follows that the estimate of business risk associated with the move to private practice is only weakly related to objective risk factors. Private practitioners take a considerable proportion of their patients from the public health care institution with them into their private practice and only feel competition in their environment to a very small extent (or not at all). We can say that the risk assessment that influences the move to private practice is more the result of the 'newness' of private practice and the lack of clarity associated with all social innovations of this type, than of actual conditions

in private practice. For this reason we can expect that interest in a move to private practice will increase as private practice becomes 'domesticated' with time as a normal form of organisation of medical activity.

Table 3
The role of structural opportunities

	Private sector	Public sector (total)	Public sector (wishing to move to private sector)	Public sector (not wishing to move to private sector)
Risk assessment				
expected risk (before privatisation)	5.2	5.0	4.8	5.1
risk today, when practice already operating	3.8	n.a.	n.a.	n.a.
Competition assessment	1.2	0.71	0.75	0.69
Gender				
male	45%	20%	18%	21%
female	55%	80%	82%	79%
Age				
28-35	7%	13%	9%	15%
36-50	61%	42%	50%	37%
51-70	32%	45%	41%	47%
Speciality				
dentists	57%	38%	38%	38%
general practitioners	28%	33%	32%	34%
specialists	15%	29%	29%	28%

Structural opportunities can also be observed by means of the variables of the mobility of certain categories of doctors into the private sector (gender, age, and specialisation). Let us first examine gender differentiation. We asked whether female or male doctors are more likely to end up in the private health care sector. At present the majority of doctors employed in both the public and private sectors are women. The proportion of men in the private sector is considerably higher than in the public sector (see Table 3). In the public sector the ratio of men to women is 20:80, while in the private sector it is 45:55. This means that a considerably larger proportion of men have opted for private practice and accepted the associated risks than women. However, among those doctors who are currently considering a transition to the private sector there is no significant difference between the number of men and women. The proportion of women considering leaving the public sector is the same as the proportion of women in the employment structure in public institutions (i.e. around 80%). Clearly the initial period of the introduction of the social innovation - which is associated with the acceptance of high risk and as the result of that higher risk, with an increase in social status - is over and

major differences between the sexes in the decision to establish private practices are not to be expected in the future.

Doctors in the public sector are on average somewhat older than their colleagues in the private sector (49 as compared to 46). A comparison between the numbers of young doctors, middle-aged doctors and older doctors shows that the transition to the private sector is mainly the decision of middle-aged doctors (see Table 3). These are the strongest category among private practitioners and doctors employed in public health care institutions who are considering a move into the private sector. In most cases young doctors begin their professional careers in public health care institutions where they obtain patients and experience, and are therefore represented to a lesser extent among private practitioners. Older doctors, especially those about to retire, tend not to think about changing their employment status and adapting to a new work situation and professional situation.

Another indicator of structural opportunities is the question of whether the private and public sectors differ in structure with regard to doctor specialisation or area of work at the level of primary health care. We differentiate between dentists, GPs and specialists. The proportion of dentists in the private sector is much higher than in the public sector (see Table 3). GPs are represented roughly equally in the two sectors, while the share of specialists is smaller in the private sector than in the public sector. In the future we can expect a balanced interest in private practice. The specialisation structure of those doctors considering a move to the private sector is similar to the structure of doctors not considering this move. In the first era of privatisation it was mainly dentists who made the move into private practice, with the result that a functional differentiation was established between the public and private health care sectors. The trend for the future is indicated by the possibility of a weaker functional division and the development of parallel systems, which means similar specialisation structures in public and private health care.

To summarise, structural opportunities played an important role in the decision for private practice in the first period of privatisation. The decision to move to the private sector was made with above-average frequency by dentists, men and middle-aged doctors. These are those categories of doctor who expected that they would encounter less risk in the market (dentists, for example), or who express greater tolerance of risk since this also brings higher status (men). In the second (potential) period of privatisation differences in specialisation and gender disappear, but age differences remain, though to a lesser extent. This means that it is the most active section of the doctor population which wishes to move into private practice, and this of course represents a special problem for public health centres. In the case of the realisation of doctors' aspirations for a move to private practice, health centres would to a large extent only be left with young doctors and older doctors who are frequently absent from work and less flexible in their working hours.

Job satisfaction

Job satisfaction is an important factor affecting the individual's motivation to change employment. Let us first look at general satisfaction with working life, which we have measured on a scale from 1 'extremely dissatisfied' to 5 'very satisfied'. Satisfaction is greatest among private practitioners (4.10) and lowest among doctors considering a move into the private sector (3.26). Although doctors not considering leaving public health care institutions are not as satisfied with their working life as private practitioners are, they do not express as much criticism as their colleagues who frequently think about looking for another job and setting up a private practice (see Table 4). To put it another way, the motivation for a move into the private sector is conditioned by dissatisfaction, or 'push' factors on the side of public health care institutions. On the other hand the high level of satisfaction among private practitioners testifies to the simultaneous operation of relatively strong 'pull' factors on the side of private practice.

Job satisfaction is also reflected in the centrality of work in doctor's life. On average respondents gave work an importance rating of 8 on a scale from 0 to 10. This means that they view the work they do as an important part of their life. The centrality of work is highest among private practitioners (8.26) and lowest among doctors considering a move to the private sector (7.70). Clearly the dissatisfaction of this last category of doctors with their working situation is reflected in the lower importance they ascribe to current work.

It is understandable that doctors employed in the public sector have significantly less influence within their working organisation than those employed in their own private practices. However, this influence is given the lowest assessment by doctors who wish to move into private practice. This is not a consequence of less activity in decision-making processes within the organisation, but of the greater expectations they nurture in relation to their own participation. Figures show that this is not a group of doctors who are resigned to their current status but doctors who represent the active nucleus within their organisation. These doctors attempt to have an active influence on decision-making processes (see Table 4), for which reason they come into conflict (1.56), organise other doctors in support of their proposals (1.56) and take their proposals directly to the management of the organisation (2.47), more frequently than their colleagues who are not considering leaving the public sector.

Table 4
Work satisfaction and aspirations

Work satisfaction and aspirations	Private sector	Public sector (total)	Public sector (wishing to move to private sector)	Public sector (not wishing to move to private sector)
Achieved professional status				
Dentists	0.32	0.33	0.32	0.35
General practitioners	0.75	0.75	1.27	0.44
Specialists	1.09	1.08	1.05	1.10
Desired professional status (% yes)				
	40%	30%	28%	33%
Professional activity				
Membership of professional associations	1.98	1.40	1.58	1.27
Membership of Medical society	79%	80%	88%	75%
Activity in professional associations	2.17	1.54	1.82	1.36
Participation at seminars/meetings	4.7	3.4	3.5	3.3
Membership of volunteer organisations	4%	6%	13%	3%
Job satisfaction				
	4.1	3.6	3.2	3.8
Satisfaction with influence				
	9.4	2.6	1.8	3.1
Satisfaction with relations				
with superiors, with the management	8.5	4.7	3.8	5.2
with doctor colleagues	9.1	6.6	6.3	6.7
with subordinates	8.9	6.7	6.0	7.0
Centrality of work				
	8.3	7.9	7.6	8.0
Identification with the organisation				
I make every effort to ensure its success.	98%	31%	19%	38%
I give to the organisation as much as it gives to me	0	46%	47%	45%
I am not particularly tied to this organisation.	2	22%	34%	15%
The problems of this organisation do not interest me.	0	1%	0%	2%
Participation in the workplace				
I draw my colleagues' attention to mistakes.	2.46	2.11	2.08	2.12
I try to persuade colleagues of my views.	2.46	2.06	2.26	1.94
Because of my views I come into conflict.	1.31	1.43	1.56	1.35
Employment aspirations				
I would like to continue with my current work.	88%	67%	52%	77%
I would like to take on more responsible work.	12%	9%	14%	6%
I would like to be more autonomous at work.	18%	33%	41%	28%
I would like to achieve a management position.	4%	2%	1%	2%
I would like to do better paid work	46%	81%	85%	79%
Conception of work				
Work gives you a social position.	22%	7%	5%	9%
Work brings you income.	79%	69%	76%	63%
Work keeps you busy.	6%	16%	15%	17%
If you work you come into contact with people.	3%	12%	12%	12%
If you work society benefits from you.	9%	14%	9%	17%
Work is interesting in itself.	78%	79%	79%	79%

If we compare the total working environment of doctors in the public and private sectors we can state that private practitioners work in a much better working climate than doctors employed in the public sector (see Table 4). This applies both to relations between colleagues and relations with superiors and medical staff. There are particularly big differences in relations between doctors and the management of the organisation. In the public sector these are assessed as being extremely poor. An important quality of the private sector is that not only are doctors more satisfied in general with relations in their working environment than doctors in the public sector, but that relationships of colleague control also operate among them. In the introduction we stated that colleague cooperation and peer control require specific work arrangements and that they are very unlikely in large bureaucratic organisations dominated by technical and administrative elites. As we can see, doctors in the private sector indeed more frequently 'draw the attention of colleagues and juniors to mistakes' and more frequently make use of 'persuasion'. Employees of public health care organisations are more frequently involved in conflicts in the workplace and exert pressure on the management by means of the mobilisation of their colleagues.

Those most critical of the cooperation between different groups of employees within a given health care centre are in fact those who are considering leaving the public sector. For them various forms of dissatisfaction accumulate: dissatisfaction with work, with influence and with mutual relations. For this reason it is not surprising that they also express the lowest level of identification with the organisation by which they are employed. These doctors reply, to a greater extent than others, that they are not particularly tied to their working organisation (34%). Doctors not considering leaving a public institution are slightly more closely tied to the organisation, though still less than private practitioners. Almost all private practitioners describe their attitude to the organisation in the following way: *'I make every possible effort to ensure the success of this organisation'* (see Table 4).

On the basis of these results we can say that the motivation for a move into private practice is conditioned both by negative factors on the side of public institutions (by a low level of satisfaction with working life and low corporate identification), and by positive factors on the side of private practice (greater satisfaction and greater identification). Another indication of the strength of positive factors on the side of the private sector is the fact that as many as 87% of those employed by public health care institutions feel that they would more easily find better employment (whatever individuals imagine by this - better paid employment or more autonomous employment) in the private sector than in the public sector. This means that doctors employed in the public sector who wish to move to the private sector would only gain through the reorganisation of their medical activity in the form of smaller working groups and business groups in which they would have more autonomy in their work and autonomy in choosing their colleagues. The current low level of cooperation among different groups of employees, and by comparison the high level of cooperation in the private sector, confirm the necessity of such changes.

Work and professional aspirations

What kind of employment would doctors most like if they had the opportunity to change their current employment? Those employed in public health care institutions would like employment which is better paid (see Table 4). As many as 81% of them would like to do work which was better paid, as compared to 46% of private practitioners. From this point of view there are no major differences among doctors employed in the public sector. A significant difference does however occur with regard to autonomy at work. A larger proportion of doctors considering moving into the private sector would like to do more autonomous work (41%).

Greater autonomy at work is also one of the most frequent responses to the open question of the reasons which were decisive in the cases of doctors choosing to set up a private practice. The question was only intended for those doctors already working in private practice. In their answers the notion of autonomy includes everything from independent decision-making on working hours, income and organisation of work to autonomy in choosing colleagues. In addition to greater autonomy, private practitioners also highlighted higher income, better access to modern technologies and higher quality materials. The prevalent negative factors on the side of public health care institutions, the so-called 'push' factors, include negative relations between employees, conflicts with superiors, disagreement with the management policy of institutions and poor organisation of work. Thus both financial and professional motives lead doctors to choose private practice. It is worth noting that the research was carried out before the doctors' strike in 1998 which led to an agreement on the gradual increasing of doctors' salaries, which probably lowers the relative deprivation of doctors in the public sector in comparison to doctors in the private sector. Nevertheless the question of working autonomy represent that important aspect of work which at this moment still argues in favour of private practice. Similar findings have been found in a recent study in the USA, by Warren et al. (1998). They show that changes in only some aspects of doctors' autonomy affect their satisfaction: so long as physicians retain control over their work schedule and are paid what they want to be paid, they do not care whether they must sign managed care contracts to get patients or whether they own or rent their own offices or equipment. But they also found it more satisfying to work under such institutional arrangements within managed care which offer more clinical autonomy and entrepreneurial autonomy.

We also asked doctors about their actual and desired professional status, in order to determine whether doctors differ in their professional aspirations according to the sector in which they are employed (or would like to be employed). We measure professional status by the obtaining of the status of mentor, the publication of articles in professional journals, and the obtaining of the status of assistant or higher. Analysis of these three modalities shows us that there is a relatively good hierarchical ordering among them and that 'mentorship' represents the lowest level of professional status and 'assistant status and higher' the highest level.

Do differences occur among the three categories of doctors (private sector, 'would be' private sector, and public sector) with regard to the achieved and desired professional status? There are significant differences between the group of doctors in public health care institutions who wish to become private practitioners and those who are not considering this. The first group contains the largest share of those who have obtained the status of mentor and have achieved assistant status or higher (see Table 4). One third of doctors (34%) expressed professional aspirations in the sense of achieving one or more of the goals listed above: mentorship, publication and assistant status or higher. The differences between the groups are not highly statistically significant, although the share of those who stated at least one professional goal again falls linearly from private practitioners (40%) to doctors in the public sector considering a move to private practice (33%) and doctors in the public sector not considering such a move (28%).

A similar story is told by the figures on participation at professional seminars and meetings. On average doctors attended 4 seminars or meetings in 1997. Among private practitioners this average is highest (4.7). Doctors considering moving from the public sector to the private attended an average of 3.5 seminars/meetings, while doctors not considering private practice attended an average of 3.3 seminars/meetings.

We also looked at the activity of various categories of doctor in professional associations. Private practitioners are on average members of the highest number of professional organisations (1.98), while doctors employed in the public sector not considering a move to private practice have the lowest rate of membership (1.27). Private practitioners are also most active in associations (2.17), while doctors not considering leaving the public sector are least active (1.36). Activity was measured by the question: *'How frequently do you take part in the work of medical associations or the chamber of medicine'*, on a scale from 1 'almost never, I just pay the membership fee' to 5 'very frequently'.

Doctors considering leaving the public sector are more active in medical associations than their colleagues not considering private practice. They are also most active in volunteer organisations in the area of health, both with regard to membership and the functions they take on in these societies. This means that at this moment it is the professionally more vital section of doctors employed by public health care institutions that is considering a transition to the private sector. The consequences of this differentiation of doctors may have a long-term effect on the system of public health care. Even if health policy decides that the public and private sectors should be balanced in terms of the services they offer, this balance can be upset by the process of self-selection of doctors for one sector or the other.

Work-related value orientations

What work means to the respondents was measured with the help of six questions which offered them statements such as: *'Work gives you a social position'* or *'If you work society benefits from you'*. We asked the respondents to choose for us the two of the six statements they most agreed with. Work represents an intrinsic quality and a route to income and material security for most doctors in both the public and private sectors (see Table 4). Although there are no major differences among respondents in this respect, two differences nevertheless stand out. First, private practitioners see their work as a means of achieving a social position more than doctors employed in public health care institutions do (22% as opposed to 7%). This is undoubtedly related to their greater financial power and the status of the private practitioner in comparison to doctors in the public sector who have the status of public servants and who enjoy a lower income. A larger proportion of doctors employed in the public sector chose statements saying that work is a socially-useful activity and an interesting social experience.

Second, the financial aspect of work, or the income which the individual earns through his work, is slightly more present in the conception of work held by doctors in the public sector who are considering a move to the private sector (76%) than among those who are not considering such a move (63%). This last group see work as a socially-useful activity to a greater extent. The transition to the private sector therefore implies certain changes in understanding of the importance of work, which is shown by the fact that among doctors who have already set up private practices or are seriously thinking about doing so, the financial and status-related aspects of work are pushed more into the foreground than among those who want to remain in public institutions.

Social and cultural capital

Social and cultural capital are factors which have an important influence on major decisions in the life of an individual. This applies especially to the decision to move into private practice, which requires a relatively large initial investment and a change in the working and professional environment. Cultural capital refers to the life style and the value system acquired by the individual in his primary social environment. Social capital refers to the contacts, some stronger, some weaker, which ease the individual's path to his goals, either through advice and necessary information or through financial assistance. In our research we measured social and cultural capital in a very simple way by looking at the business and management tradition in the doctor's family. We asked respondents: *'Has anyone in your family or among your close relatives ever carried out a management function in a company or run his/her own business or company?'*

Table 5
Social capital

	Private sector	Public sector (total)	Public sector (wishing to move to private sector)	Public sector (not wishing to move to private sector)
Social capital				
managerial tradition in the family	60	64	64	64
entrepreneurial tradition in the family	36	35	47	27
medical tradition in the family	36	38	29	43

The existence of a management tradition in the family does not affect the doctor's decision to move into private practice (see Table 5). The differences among doctors employed in private and public health with regard to management tradition in the family are not statistically significant. This also applies to business tradition, if we compare the public sector as a whole with the private sector. If however we look separately at the two categories of employees within the public sector we see that those who are considering a move into the private sector have a statistically significantly higher business tradition in their family (47%) than those not considering private practice (26%). The entrepreneurial life style, or the acceptance of business risks, is more readily accepted by those who are familiar with it thanks to their own strong ties within their circle of relatives than by those who do not have this experience. On the other hand, social capital, which extends into the circle of doctors and other professions within health care, discourages the individual from the transition to the private sector and encourages him to remain in the public sector and follow the values of that sector, such as equality of access to quality health care and work for the good of society.

Conclusion

The results of the research conducted among doctors employed in primary health care in the Ljubljana area can be summarised in the following way:

In the development of private practice it is possible to distinguish two periods which differ both in terms of the motivational basis of doctors for a transition to the private sector, and in terms of doctors' attitudes towards the various organisational forms of private practice. In the first period of development of the private sector, the decision to become a private practitioner was decisively influenced by structural opportunities and the assessment of business risk. As a result, certain categories of doctors were over-represented in the private sector in comparison to the public sector (dentists, middle-aged and male doctors). In the second period individual and work-related factors such as satisfaction with the working situation, professional aspirations, value orientations and social capital come to be expressed. This confirms our hypothesis that privatisation,

or the spontaneous transfer from the public sector to the private sector, is a reflection of professional dynamics, though much more so in the second period of privatisation than in the first.

One third of doctors today employed in the public sector express interest in opening a private practice. These are doctors who are noticeably dissatisfied with their current working situation and who represent the professionally more active section of the medical community. If these doctors were allowed to cross over into the private sector, the public and private sectors would be balanced in terms of the number of doctors. If, however, we take into account the age structure and level of professional activity of doctors in the two sectors, the private sector would be in a better position, since it would include a larger share of professionally more active doctors of the most productive age group, who are today abandoning the public sector. These doctors note a worsening of relations among all groups of employees in recent years, especially between the management of institutions and doctors. The management of institutions is clearly a considerable problem at this point. A crucial element of the reform of the health system in Slovenia is, therefore, the reformulation of the relationship between public institutions and the state in the sense of increasing administrative autonomy, the reorganisation of institutions to allow greater employee participation in decision-making processes, and greater professional autonomy for doctors, with a simultaneous allowance made for spontaneous privatisation and the transition of doctors from the public sector to the private sector and vice versa.

While private practitioners are in favour of individual private practices and the renting or purchasing of premises on the private property market, doctors who are today considering a move into private practice prefer group practices and the renting of premises within health centres. They favour the reorganisation of medical activity in the form of smaller working and professional groups, in which they would have more working autonomy and autonomy in choosing their colleagues. It is clear that doctors currently opting for privatisation are not only considering the need for an unblocking of the process of privatisation, but also the simultaneous transformation of public institutions. This is also reflected in their preferences with regard to the privatisation of public institutions.

The most acceptable form of privatisation for most doctors is a 'weak' form which includes the privatisation of activities but not of infrastructure. Doctors feel that health care institutions should remain in state (municipal) ownership and that doctors should rent premises within them as private practitioners. Such a form of privatisation would transform health centres into organisational networks combining individual private practices.

The challenge of a primary health care structure is, therefore, to harmonise the two sectors and to establish comparable business conditions, which would make both sectors competitive. Clearly competition between the public and private sectors has already had certain results, since the quality of services in recent years has increased in both sectors (see the article by M. Macur in this collection of papers). However, as some point out, under the current business and management conditions in the public sector,

notable for 'nationalisation' in the sense of increasing centralisation and a reduction in the autonomy of public institutions, the public sector cannot continue to compete with the private sector, either in the business sense or from the point of view of the quality of services. It is understandable that in a situation where the development of the private sector means a loss for the public sector, the latter should try to block, slow down and limit the development of the former. But the public sector, despite all the positive qualities it today represents, can hardly be expected to be competitive in the present form to the private sector, especially when the reform of the public sector which calls for even less autonomy for public institutions is carried through. In the long run, the solution has to be sought in the incorporation into the public sector of elements of private sector, for example, public institutions signing contracts with private providers to use their premises and equipment, or the transformation of public institutions into non-for-profit institutions operating within the "third sector" (e.g. neither state nor for-profit sector), with both the increased employee autonomy and increased autonomy of management with regard to the state.

NOTES

1. These numbers include only those private physicians who work on contract with Health Insurance Institute of Slovenia (hereinafter: HIIS). According to our survey, about 20% of all private practitioners do not have contract with HIIS. Thus, the overall percentage of private doctors is somewhat larger than the numbers reported above.
2. In defining the sector of employment we only took into account the doctor's basic employment in the private or public sector, since information on the overlapping of employment contracts in the two sectors is too unreliable. The doctors surveyed were not prepared to talk about work commitments in addition to their basic employment, though in fact there is less of this at the primary care level than at the secondary and tertiary levels. A further limitation is that in the private sector we only look at the owners of private practices (those doctors employed by private practitioners are excluded from the analysis), and in the private sector only at those employees who do not have a management function (the directors of public health care institutions are excluded).

REFERENCES

- Abbot, A. 1988. *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago press.
- Barr, J. K., and M. K. Steinberg. 1983. "Participation in Organisation Decision-Making: Physicians in HMOs." *Journal of Community Health* 8: 160-73.
- Baker, L. C., and J. C. Cantor. 1993. "Physician Satisfaction under Managed Care." *Health Affairs* 12: 258-70.
- Chuck, J., T. Nesbitt, J. Kwan, and S. Kam. 1993. "Is Being a Doctor Still Fun?" *Western Journal of Medicine* 159: 665-69.

- Comparative Tables on Health Care Reform in Phare Countries. 1998. In *Recent Reforms in the Organization, Financing, and Delivery of Health Care in Central and Eastern Europe in the Light of Accession to the European Union*. Brussels: Proceedings of the Conference.
- Dahl, R. 1971. *Poliarchy: Participation and Opposition*. New Haven: Yale University Press.
- Dore, R. 1983. "Goodwill and the Spirit of Market Capitalism." *British Journal of Sociology* 34: 459-82.
- Freidson, E. 1986. *Medical Work in America: Essays on Health Care*. New Haven: Yale University Press.
- Freidson, E. 1994. *Professionalism Reborn: Theory, Prophecy and Policy*. Chicago: University of Chicago Press.
- Hafferty, F. W., and D. Light. 1995. "Professional Dynamics and the Changing Nature of Professional Work." *Journal of Health and Social Behavior*, (Extra Issue) 132-53.
- Halpern, S. 1988. *American Pediatrics: The Social Dynamics of Professionalism, 1880-1980*. Berkeley: University of California Press.
- Halpern, S. 1992. "Dynamics of Professional Control: Internal Coalitions and Cross-Professional Boundaries." *American Journal of Sociology* 4: 994-1021.
- Hassenteufel, P. 1996. "The Medical Profession and Health Insurance Policies: A Franco-German Comparison." *Journal of European Public Policy* 3: 461-480.
- Haug, M. 1988. "A Re-examination of the Hypothesis of Physician Deprofessionalization." *The Milbank Quarterly* 66:48-56.
- Haug, M., and B. Lavin. 1981. "Practitioner or Patient - Who's in Charge." *Journal of Health and Social Behavior* 22:212-29.
- Health Insurance Institute of Slovenia. 1998. Annual Report 1994-1998. HIIS: Ljubljana.
- Hirschman, A. O. 1970. *Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States*. Cambridge: Harvard University Press.
- Kogovšek-Vidmar, T. 1999. "Privatizacija javnih lekarniških zavodov." In *Zbornik 6. Strokovnega srečanja ekonomistov in poslovnih delavcev v zdravstvu*, Zveza ekonomistov Slovenije, Društvo ekonomistov v zdravstvu, Terme Čatež, Brežice.
- Lammers, J. C. 1992. "Work Autonomy, Organisational Autonomy, and Physicians' Job Satisfaction." *Current Research on Occupations and Professions* 7: 157-75.
- Lichtenstein, R. 1984. "The Job Satisfaction and Retention of Physicians in Organized Settings: a Literature Review." *Medical Care* 41: 139-79.
- Linn, L. S., R. H. Brook, V. A. Clark, A. R. Davis, A. Fink, and J. Kosecoff. 1985. "Physician and Patient Satisfaction as Factors Related to the Organisation of Internal Medicine Group Practices." *Medical Care* 23: 1171-79.
- McKinlay, J. B. 1988. "Introduction." *The Milbank Quarterly* 66:1-9.
- McKinlay, J. B., and J. Arches. 1985. "Towards the Proletarianization of Physicians." *International Journal of Health Services* 15:161-95.
- McKinlay, J. B., and J. D. Stoeckle. 1989. "Corporatization and the Social Transformation of Doctoring." *International Journal of Health Services* 18:191-205.
- Mick, S. S., S. Sussman, L. Anderson-Selling, C. Del Nero, R. Glazer, E. Hirsch, and D. S. Rowe. 1983. "Physician Turnover in Eight New England Prepaid Group Practices: An Analysis." *Medical Care* 21: 323-37.
- Perrow, C. 1993. "Small Firm Networks". Pp. 277-402 in *Explorations in Economic Sociology* edited by R. Swedberg. New York: Russell Sage Foundation.
- Podolny, J. M., and K. L. Page. 1998. "Network Forms of Organisation." *Annual Review of Sociology* 24: 57-76.
- Skolnik, N., D. R. Smith, and J. Diamond. 1993. "Professional Satisfaction and Dissatisfaction of Family Physicians." *The Journal of Family Practice* 37: 257-63.

- Warren, M. G., R. Weitz, and S. Kulis. 1998. "Physician Satisfaction in a Changing Health Care Environment: The Impact of Challenges to Professional Autonomy, Authority, and Dominance." *Journal of Health and Social Behavior* 39:356-67.
- Židanik, A., and M. Košir. 1999. "Zasebna dejavnost v osnovnem zdravstvu" (Private Practice in Primary Health Care). In *Zbornik 6. Strokovnega srečanja ekonomistov in poslovodnih delavcev v zdravstvu*, Zveza ekonomistov Slovenije, Društvo ekonomistov v zdravstvu, Terme Čatež, Brežice.