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PUBLIC-PRIVATE MIX OF THE PRIMARY HEALTH-CARE PROVIDERS IN LJUBLJANA 1992-1998: SYSTEM AND LABOUR MARKET CONCERNS

ABSTRACT

The article deals theoretically and empirically with pluralisation (privatisation) of providers of medical services. First, a broader socio-economic framework for policy interpretation of a health system reform is briefly sketched. Then, internal professional tensions of public health quasi-markets, with a few illustrations for transition countries, are elaborated. The empirical part focuses on the recent pluralisation of primary health care in Ljubljana, the capital of Slovenia. The basic labour market comparisons between physicians working in private practices and in public institutions are presented and discussed. It is aimed at exposing some developmental differences in recent public-private arrangements. The findings reveal an increasing awareness among all physicians of some basic malfunctions within the public institutions and of a better quality of health services, delivered by physicians in the private sector. However, they also demonstrate quite a blurring providers' view on the sources of the system's (in)efficiency. Physicians prefer to emphasise the administrative & organisational disadvantages of the public sector, but in terms of professional liability, still avoid directly addressing the well-known internal professional tensions in medical markets, which also were strong push-factors for them.

Keywords: primary health care, physicians, Slovenia, privatisation, concession, labour market, public-private mix

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Introduction

The medical profession is one of the strongest professions in Slovenia. Its professional roots extend to the old surgery and midwives' organisations and schools, approaching the average efficiency level of a health care supply already within the Habsburgh Monarchy (Pintar 1950). The basic elements of a new public health care system were established a little before (school medicine) and mainly after World War I, along with a private medical practice (Pirc 1938). Curative infrastructure and services prevailed, with some initial forms of health insurance systems, designed mainly for industrial and craft workers. Preventive services and insurance schemes for other large groups of the active population (craftsmen, small farmers and farm workers) were missing. After World War II. a rapid development of the socialised medical system within the socialist system enabled the population to easily access all kinds of professional health care services, but private practice was no longer allowed. In a few decades, an extensive three-level health care system was organised, with the primary level embracing regionally dispersed units to protect inhabitants from basic health risks. The secondary and tertiary level included specialists, hospitals and more demanding services. The whole system looked impressive, with equal access to services as a major baseline. However, an extensive and bureaucratic development of the whole health system was becoming an obstacle, making it increasingly expensive and moreover, quite non-responsive concerning doctor-patient relations. This resulted in a system which was hardly manageable, from both an organisational and financial aspect. The primary health care level, loosing its original prominence in comparison to the specialists and hospital activities in the period of the mid seventies to the nineties (Health Insurance Institute of Slovenia 1998), was also slowly becoming a female domain. Alas, all kinds of professional tensions appeared in both the horizontal and vertical health occupational scales.

In 1992 the basic regulation for a reformed health system, with a public Health Insurance Institute as its system backbone was introduced (Bismarck model), together with the partnerial negotiations among health care actors.[1] Also, private practices which aim to complement the public primary health level by new private providers, was allowed once again - even though the regulation for its implementation had not been fully elaborated. The extent of the permissible (concessioned) private practices was, and still is, restricted by the available public financial sources. However, some new hybrid private practices (firms) extend over the desired limits, constituting a small but increasingly privatised sector for health services.

The initial stages of more plural forms of health care providers in Slovenia are important for further development, but are not fully investigated and reported. We will try to describe in more explicit detail a local process of providers' pluralisation up to the present, using a recent survey taken on physicians, working in public health institutions and in private practices in Ljubljana (Rus et al. 1998). Special attention will be paid to their labour market position, their professional and other differentiation,

their working conditions, and to some underlying factors which are currently making the whole medical system, and especially its manpower, highly mobile in Slovenia.

The public-private mix of providers in Ljubljana does not represent an overall picture of the rate of pluralisation in Slovenia, since in Ljubljana it is happening at a higher growth rate. On the other hand, it is known that contemporary general performances of the reformed health care system of Slovenia are internationally recognised as rather efficient, even in comparison to some advanced industrialised countries (Schneider 1998). Moreover, the expertise of physicians is well acknowledged elsewhere and therefore, we may speculate about the high professional quality of medical services in Slovenia. Given this situation, the interesting questions connected to the privatisation process are the comparative ones: the system's push-and-pull factors concerning structural opportunities for private practices, aspirations of both kinds of physicians as well as equity concerns which link private practice with increasing co-payments of patients.

A deeper empirical insight can probably bring us closer to some general knowledge on the health pluralisation processes, at least for transition countries. But first we must start with a short introduction into the recent system and the professional considerations of a reformed health care system as such. Our aim is to develop an appropriate framework by which the entire contemporary plural dynamics of health care delivery in Ljubljana (Slovenia) will result in a less exceptional, more general and thus a more meaningful endeavour.

Health-care privatisation in transition economies: system concerns

A very general liberal framework of the privatisation of a welfare state can recently be found in Spulber (1997). He sees privatisation as the opposite to nationalisation, i.e. as an instrument for redefining the scope and functions of the state. It includes, "not only a changing of certain property rights and shifting the boundary between the public and the private sectors, but also at downsising the state and recasting its agenda" (Spulber 1997: 160). In this sense, Spulber is in favour of a more liberal understanding of privatisation of a (Western) Welfare state, by which Saunders and Harris (1990) pointed out, mainly empowers providers and investors, but does not substantially affect users. Spulber, in general, admits that the tools of modern privatisation, starting in the late 1970s in the Western world, still can not be theoretically combined in a unified goal of privatisation. Basic contradictions of the whole privatisation endeavour, especially in regard to the not-yet-answered dilemma on expansion or contraction of a future Welfare state, thus remain open, at least in Western countries.

Spulber, in his parallel debate on transition countries, immediately dispels all his above-mentioned theoretical doubts about non-coherent privatisation goals. These countries, he simply addresses elsewhere, as the former "command-and-control regimes"

or "Russia and its former satellites" (Spulber 1997: 185). However, this is a rather typical view for a vehement liberal. He goes on to say, that full privatisation is necessary here, and "the total reversal is not even thinkable" (Spulber 1997: 186). For him, only in East Germany the breakdown of the large state-owned conglomerates has been carried out fully, effectively and at a rapid pace, albeit with enormous resources. In most other transition countries, the scope of privatisation, especially readjustment of social protection, has not yet been fully answered.

Thus, his comments on health care delivery in transition economies are over-simplified in terms of the former, overcentralised systems which are said to be highly inefficient providing low-quality service (nonetheless easily accessible), loosely combined curative and preventive functions, characterised by a lack of cost accounting, etc. He hardly sees any possible improvements, as, for example, the cost containment will obviously lower standards, deteriorate preventive services, increase copayment, and decrease access to hospitals. In general, the prospective of transition countries looks bad, as the ending of state monopoly can increase free choice, but future higher developed standards of health care will be available "only for those who can afford to pay" (Spulber 1997: 184).

Obviously, Spulber follows mainly efficiency and individual freedom, assigning developmental relevance as a challenge of only a few Western states, and lessening the meaning of experiences of developing countries to a minimum. By this approach, he artificially dichotomise the world, which is by far more gradually structured, and advocates marketisation of social protection in transition countries by no deeper sense or sociological feeling. Knowing that in a global contemporary world the differences are otherwise present, but always mutually conditioned, more modest conclusions and recommendations on an individual freedom primacy would be much more appropriate.

A more polytomous approach to the differences between health care systems may be found long before today's tensions in Mechanic (1975). He stated a convergence hypothesis on basic similarities of health systems across (industrialised) countries. At that time, health systems were seen by him as to be responding to technological development and to a variety of exogenous factors. It is known, that a hard version of the convergence idea usually overestimates underlying economic reasoning,[2] and neglects some other decisive issues, shaping social and polity factors. Surprisingly, after two decades, the main message of Mechanic's hypothesis, albeit modified, probably still holds: health systems and especially their problems are now becoming more and more similar.

A recently published a more elaborate version of the convergence approach (Mechanic, Rochefort 1996), is now organised around revisited primary elements of the old convergence approach. To the authors, national health systems are still moving toward a convergence in response to certain common scientific, technological, economic, and epidemiological imperatives. But this convergence is no longer seen as being similar in organisational forms, but mainly in similar causes and issues of a deeper change, as many historical, social, and situational factors affect the particularities of any medical

system, "and no exact form of organisation is inevitable" for all countries (Mechanic, Rochefort 1996: 242).

The improved understanding of convergence implies, that certain underlying macro processes narrow health system options, compared with those theoretically possible, as the processes lie beyond the control of a particular national health care actor. Similar conclusions on scientific medicine as a cause for change were reached by the OECD (1994) Anderson (1989) and Kirkman-Liff (1994) on common health system reform steps confronting all health care managers, etc. Thus, Mechanic and Rochefort (1996) suggest dealing with common sources (factors) and consequences of the convergence phenomenon.

Among the underlying factors, affecting convergence, Mechanic outlines the following sources of change: dynamic medical knowledge and technology, the effects of medical demands on national economies and its health service development, changing demography, changing patterns of disease (Frenk 1993; Wilkinson 1994),[3] in addition to rising public expectations and mass communication. A special variable, strongly influencing the organisation of national medical care systems, are also politics, government and the state within a country; evidently, these factors basically filter health policy decisions and shape a particular service delivery structure (Walt 1994).

Consequences of convergence, valid in nearly all nations, can be seen in (at least) six areas: controlling costs and increasing efficiency and effectiveness of health services; initiatives to promote health and health-related behaviour; inequalities in health outcome and in access to medical care; strengthening of primary health care systems; patient satisfaction and participation (choice, voice, organisation of services); an ever increasing linkage between health and other social services (taking care of ageing, chronic disease).

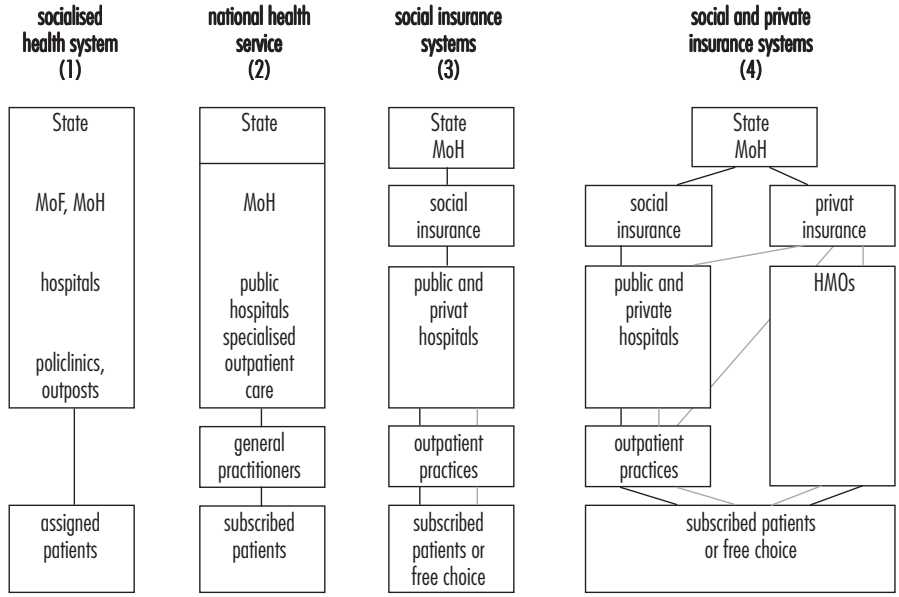
One specific topic, quite commonly elaborated on within countries but often neglected along with the health reform steps, deals with the importance of competition among a variety of health occupations for defining and controlling the division of labour. This aspect includes the impact of the controversial social status of doctors and "the waning of their professional dominance" (Mechanic, Rochefort 1996: 263) in their national (internal) markets, and consequentially on the current integration problems in the international labour markets. Perhaps these professional factors are even more important for transition countries, where the suggested structural reforms often fail if these endogenous factors are not taken into account.

The currently acceptable convergence approach strongly diminishes an impatient liberal notion on unbridgeable differences of health systems between and among the states. The experiences of Western countries show, that sources of change and their consequences are similar although the organisational capacities and partner forms might differ a lot. In this line, there is also a recent economic and policy comment, made by Schneider, on the nature of health care reforms in transition economies.

Schneider (1998) first tries to explain general health care sector features from an EU integration aspect. This sector consists of the particularities of health care markets, including the transfer of goods and services, labour and capital, insurance markets, specific conditions and regulations. The author states that all the health care systems in

the Community,[4] as well as those in other neighbouring transition countries, can be described as a mixture of all three basic types of vertical integration (Semashkov model, Beveridge model, Bismarck model). Thus, all countries now move to some more common, improved form because of the global market pressure (chart 1).

Chart 1
Health Care systems by vertical integration



Source: Schneider (1998)

Two of the previous general forms of health care systems in Western countries, "national health services" (Beveridge) and "social insurance systems" (Bismarck), are approaching a new mix, called "social and private insurance systems" (Chart 1, *b* and *c* approaching *d*). A newly arising mix of the two old models demands strong regulation to safeguard quality, efficiency and equity, leading to sound accountability and self-regulation or participation of all policy actors, especially providers. Socialist countries developed a third model in past (*a* in Chart 1), called a 'socialised health system' which was very integrated and hierarchically structured, highly complex, but also muddled and with no clear communication links among stakeholders. The financial background was merely a black hole. The basic concern of the CEE countries today is in the question of how to pass as quickly as possible from the former "socialised health system" (the picture on Chart 1, farthest to the left), shaped by a very strong vertical integration, to a better solution (with *b* or *c* as a first, and approaching *d* as a final step), which is more

adjusted to a large, future EU market integration. It "does not mean to copy them, but to upgrade them with market elements" (Schneider 1998: 7).

In contrast to Spulber, who nearly omitted the problem of an expanding state in transition countries as a valid question, Schneider (1998: 8) explains this basic policy feature of any actual health care reform very clearly for both, developed and transition countries, saying that "the scope of regulation increases with the decline of vertical integration". This increase is thus urgent, while a system moves from an older form to a new one. It means, more and not less regulation is needed in a more market relaxed circumstance, with different actors taking over the functions of state regulations. The price for more autonomous actors in new settings is larger public regulation. This is in accordance with Luhman's known general message on social system progression (Luhman 1981): a system can reduce a higher social complexity only by improved co-ordination and communication among social actors, based on sound inter-relations and trust.[5]

For Schneider, the main problem of health reform in the CEE countries is substantial investment in infrastructure, which is needed to upgrade the system, and the question of how to raise the doctor-patient relations and other health system and health care standards to the EU level. Also, pluralisation of providers, with private general practitioners mainly being a part of the public health care networks (concessions), seems inevitable in this respect. But the privatisation of primary health care based on contracts of providers with public health insurance funds (or state agencies) is, for CEE countries, "only at the beginning, while in EU countries about 50% of health care is delivered by private institutions". As the health system and health care standards of CEE countries are usually far below EU standards, it can hardly be expected that the gaps between EU and CEEC standards could be closed in a mid-term - without external support - "except for Slovenia" (Schneider 1998: 14).

Obviously, the performance of the Slovenian health care sector, at least its quality and efficiency aspects, is much closer to the EU standards than to any of the CEE countries.[6] But even in Slovenia, and for the medical profession in particular, "it seems to be difficult to learn that it is worthwhile to invest in building up new management structures /.../ as a management culture and special training centres for health insurance administration as in EU countries do not exist" (Schneider 1998: 12). This means, that establishing more adjusted health arrangements, i.e. public/private mix of health insurance, providers and suppliers, and the opening of various new opportunities, will especially divide medical professionals into different interest groups and coalitions: supporters and opponents of inevitable changes.

Bifurcated medical labour markets: legitimating capacity of new institutions

Doctors have come to dominate the medical division of labour throughout the world during the twentieth century (Mechanic, Rochefort 1996), due in large part to the concentration of medicine in hospitals (Friedson 1970). Other health workers outnumber doctors, but the medical profession has legitimised its authority successfully by different mechanisms, especially by defining and controlling how sickness is to be managed. However, several factors in recent times have eroded doctors' authority.

Among these general-eroding factors are perhaps just two essential ones: changing nature of medical services and universal concern with health care costs. Medical care is slowly moving out of hospitals and doctors on the primary health care level, especially, have a lot to do with competing occupations, while defining their distinctiveness in comparison to them. This is quite known competition over jurisdiction (Abbott 1988). These underlying processes are increasingly dividing medicine as a profession (medicine as an institution or meta-organisation) from (the power, authority, and autonomy of) its individual practitioners (Mechanic 1991). While the profession is becoming stronger, individual practitioners are becoming threatened, as, for example, is the case with general practitioners, who have to protect their domain on many sides. Increasing hierarchy, using all kinds of planning instruments, and having limited sources available for them, lessens chances of a successful meeting of both sides of hierarchy. So, quarrels might cover and even destroy the ethical mission of the medical profession. It is not rare, under such turbulent settings that medicine as a profession is more and more highly politically fragmented[7] (Mintzberg 1989), "with competition among specialities, types of medical functions, and organisational alignments. Doctors are increasingly challenged /.../ by professionals from their own ranks /.../ Medical authority may continue in a larger sense, but doctors on the front line are becoming more constrained in what they do and how they do it" (Mechanic, Rochefort 1996: 263).

In a sociological critique of the institutionalisation of medical ethics, Zussman (1997) concentrated primarily on professional regulating procedures in doctor-patient relationship which sharply moved doctors' autonomy away from justice in their medical service delivery.[8] As changes in disease patterns have altered the conception of illness, patients expect to be treated by doctors as being ill even while they perform their usual daily activities and they do not achieve a desired quality of life. This means, that the professional doctrine of health and illness is under a constant, even mounting pressure. Such tensions in every day medical practice are experienced mostly by doctors on the primary heath care level and there is no easy way to turn back once a system initially fails in this - over-institutionalised - respect.

Therefore, a more relaxed and more individually responsive system is becoming an explicit demand not only amongst the general public (patients, customers, purchasers), but also within professional circles, especially among general practitioners, who are working on the front line. Thus professional internal concerns are closely approaching

the already mentioned general concerns, coping with the current health reform puzzle on a private/public mix (Saltman 1992): what about health as a public/private good, how to delimit collective/individual decisions on financing and provision of health, and how efficiently to demarcate public/private providers within a national health system?

Such questions are of high importance, especially for doctors and their professional associations in transition countries. They are in the middle of health privatisation endeavours. While the above problems, arising mainly from professional hierarchy and their known malfunctions, seem somehow endogenous factors of change, in transition countries they may become an intrinsic factor of change. In nearly all transition countries we are witnessing with a surprising fact which is already detectable[9] among certain occupations, but not yet convincingly explained: the stronger a profession as such in the former public (socialist) sub-system, the more intensive the individual processes of its (post-socialist) renewal, reformation and even privatisation.[10] This contradiction, deriving probably from a deeper incongruency between organisational goals and individual desires, has interesting consequences for any current reform step, especially for pluralisation and privatisation attempts. It produces much stronger political behaviour of yesterday's state professionals on otherwise highly regulated professional labour markets, as one would have expected.[11] It might be, for example, that a lot of human energy and reform ideas were concentrated, but also rudely blocked, just within the most developed areas of the formal public sectors.

To date, the reasons behind this have not been clearly explained. Among them, the decreasing capabilities of institutions of producing public goods deserve special attention. At times, contracts between (firms and) institutions and corporate authorities in central planning agencies were used to create many of the requisite public goods. When the various capacities of those authorities to reward (firms and) institutions for their public oriented behaviour were destructed, then the socialist institutions that enabled people (within them) to create public goods were also destroyed, "but not replaced by other institutions more appropriate to a new order, i.e. capitalism" (Stinchcombe 1997: 5).

A commonly used view, that the newly introduced legislation itself will soon correct initial bad system performances, is too simple for the above problems.[12] Just new organisational forms and regulation can not replace the immediate lack of appropriate rewarding, as the former more likely widen than lessen the gaps between institutions and their staff. Formality is never enough for legitimacy, without some conviction that the formality is just a more abstract form of the substance, rather than just a formal reading of the writing. Stinchcombe (1997: 8) believes that, "we have recently underestimated the degree to which people accept institutions, because they think the institutions have the right answer, because institutions embody a value that the people also accept. Formal procedure is not good enough; it must hold a value as to be a legitimator (for example, the using of reason and good sense). Its legitimating capacity follows from its being a value." Perhaps a majority of public/private transition flows derives from less known internal professional and human tensions in the former, planned economies[13] . A new regulated transition path did not cause them, but probably only triggered them to show up in a fuller range. The intensity and attractiveness of the

privatisation process we have been witnessed in transition countries until now have not been well predicted by the reform actors from this aspect. Therefore, its future size is hardly to be precisely regulated, once put in to work. If the process is open, things just happen. But if it is limited, it may continue endlessly: black professional markets and white-strike behaviour in formal workplaces are only two more explicit forms.

Among such new legitimising factors, which aim to introduce new values among professionals, in addition to new regulation procedures and institutions, are also reformed health care systems in transition countries. New values, which still are not settled among population and professionals, continue old income and risk solidarity, and try to embrace a new orientation towards markets, yielding to a more transparent account of performances. They can be capsulated into just three points: (1) the whole public health care system should be limited to the level of public funds available; (2) a public, professional medical aid in the domain of equity is approaching the ever reduced standards of the urgent medical aid, and is supported by the public insurance scheme based on solidarity; (3) all other system performances should serve mainly for different improvements in efficiency and quality concerns of the system.

These three points are not a priory consistent. They suppose a more stratified society and a consensus, one that needs a permanent consolidation of tensions about desired quality assurance, social cohesion. Their aimed convergence demands elaborated policy actions, with a lot of discussion among different actors on their acceptability and feasibility. It seems, at least at the current moment, that the pluralisation and privatisation of providers at the primary health care level might serve to all of them simultaneously. However, the question of how contradictions between a variety of goals of different actors are to be relaxed within a particular country, is still open.

Survey on privatisation processes among health providers in Ljubljana

To investigate how Slovenian pluralisation and privatisation dynamics of primary health care depends on individual differences between the physicians and not only on the objective opportunities offered by a reform regulation, a pilot survey study among the physicians (mainly general practitioners) in Ljubljana was done. Ljubljana experienced a very intensive pluralisation and, to a less extent, a true privatisation, of primary health care during recent years. Survey results can offer a significant contribution to a deeper understanding of this pluralisation in Ljubljana, and, with some caution concerning the generalisation of the results, in Slovenia, too.

In the continuation, after describing the process of establishment of a private practice in Ljubljana and its accountability, we empirically compare and shortly discuss the following professional aspects of private and public physicians in Ljubljana: number of patients, waiting time (lists) for medical services, working time of physicians, on-job conflict solving, quality and supervision of health care services, general working

arrangements of physicians, preferences for rationing system performances, and equity issues, concerning differentiated remedy supplies.

By pointing to the significant differences between the two groups of physicians we not only intend to extract the distances in some respects, but also to emphasise the similarities in other respects. By this, we want to prove that the process of pluralisation and privatisation of medical services' delivery in Slovenia is currently somewhere in the middle of its long-term implementation. Some further changes in re-structuring of the primary-level of the public health-care system can already, at this point, be anticipated.

Establishing a private practice in Ljubljana during 1992 - 1998

In the survey, we deal with physicians, who work in public institutions and only with those private physicians who have concessions for their publicly financed but privately arranged professional work in Ljubljana. In table below (Table 1) we present some basic socio-economic characteristics, concerning the initial phases of establishing their private practices during 1992-1998.

In 1998, the rate of private medical professionals who were working in Ljubljana without a signed contract with the Health Insurance Institute of Slovenia (hereinafter: HIIS) was about 37% of general paractitioners (hereinafter: GPs), 7% of dentists, and 5% of specialists. Also, we can see that collecting of the required documents lasted on average a year for GPs, about twice as long for specialists, and a year and a half for dentists. The standard deviation is quite high for all of them, the highest for specialists.

Nearly all private physicians (above 90%) had some financial means to invest into their new working arrangements. Expectably, the investments were the least dispersed (were probably lower and were more family based) among general practitioners, as their expert work needs less technical equipment. The risk of investment is probably quite high (or quite low?!) among all groups, if we take into account a big share of private physicians (from 30 to 50 percent), declaring a nearly unknown period for a return on their investments.

Business investment are probably more prominent among specialists, where, on average, the return period for the borrowed money is the shortest (modus is about 5 years for general practitioners, and about 1 year for dentists and specialists): specialists' services take less time, but the prices can be quite high.

Table 1
Basic characteristics of the process of establishing a private health care practice in Ljubljana

(variables 33,35,38)	Statistics & answer categories	general practitioners	dentists	other specialists
Duration time, *in months*, from starting activities, through submission of application until approval of a private practice	Mean	11.6	17.0	24.9
	ST deviation	11.6	13.9	21.1
	Minimum	2.0	2.0	6.0
	Maximum	47.0	59.0	77.0
	Mode	7.0	6.0	6.0
Investment into private practice	yes, investment	90%	95%	93%
	no, no investment	10%	5%	7%
Structure of investment for a private practice (combination of different sources is supposed)	yes, own sources	79%	90%	86%
	no, no own sources	21%	10%	14%
	yes, family sources	32%	43%	29%
	no, no family sources	68%	57%	71%
	yes, bank sources	21%	40%	57%
	no, no bank sources	79%	60%	43%
	yes, other sources	5%	12%	36%
	no, no other sources	95%	88%	64%
Average return time of borrowed amount for investments, in years	Mean	9.9	5.1	5.5
	ST Deviation	5.8	3.1	3.7
	Minimum	5.0	1.0	1.0
	Maximum	20.0	10.0	10.0
	Mode	5.0	1.0	1.0
When will your investment be returned to you via your business (practice)?	precise knowledge	10%	17%	13%
	only rough knowledge	60%	44%	38%
	no good idea on this	30%	39%	49%

Accountability of the current private practice

In plural settings, more and more financial flows are dependent on transactions of delivery of medical services. This is a precondition for the desired, cost-containment efforts, valid especially in a private health practice. It means, that a control of costs, including the setting of appropriate (profit) prices, is a long-term and even crucial orientation for a viable practice. However, at the beginning, these efforts among private physicians in Ljubljana seem still quite modest, probably because their current business scores are positive anyway (Table 2).

Private physicians at least follow the standard price level of the HIIS, developed for the public sector and valid also for them as of 1996. But on average, their prices for services are higher. We can guess, that market pressure (larger investments) is stronger with dentists and specialists, and lower for GPs. Such a background clearly reveals why a modern, public-private mix creates mainly quasi-markets: a majority of health services are still publicly financed (via insurance companies and taxes) and only the delivery of services is a private endeavour.

Table 2
Prices and their accountability in a private health sector

(variables 37,39,40)	Answer categories:	general practitioners	dentists	other specialists
Can you say that you currently have a positive business score?	no, I have not it yet	15.0%	7.3%	7.1%
	yes, I have it already	80.0%	90.2%	92.9%
	I do not know exactly	5.0%	2.4%	-
Do you have at your disposal the whole price calculation of your health care services?	yes, whole	40.0%	73.2%	85.7%
	no, only partial	15.0%	22.0%	-
	no, not at all	45.0%	4.8%	14.3%
What are the prices of your services in comparison to the (standard) prices of the HIIS?	lower, on average	16.7%	2.6%	8.3%
	nearly the same	33.3%	35.9%	16.7%
	higher, on average	50.0%	61.5%	66.7%

Comparative results on private-public mix in Ljubljana

Further results of the survey will be organised and presented in a comparative way. The aim is to confront some facts, attitudes, opinions and aspirations of physicians from both sides, public institutions and private practice in Ljubljana. The results concern labour market issues in a broader sense and comparisons tend to find differences.

Number of patients, waiting time, working time:

By the transition of working in a public health institution to a private practice, a physician also bids farewell to the “normal” working schedule and duties of a public health service professional. The change is significant, probably in favour of a private practice (Table 3).

Table 3
Number of patients, waiting lists, working stress, satisfaction with work-time

(variables 8, 9,10,11,12,13,14)	Statistics	physicians in private practice	physicians in public institutions
Total number of patients in 1998	Mean STD deviation	1706 798	1419 700
Patients' mobility in 1997 (share of total file, in %)	Leavers Newcomers	42.3% 25.8%	16.5% 5.3%
Average waiting period for patients, in days	Mean STD deviation	20.6 36.7	15.9 24.6
Average number of patients/day	Mean STD deviation	24.5 13.2	31.1 13.5
Working hours/week	Mean STD deviation	49.0 14.2	42.9 7.4
Share of work time for medical (doctor-patient) care (in %)	Mean STD deviation	80.4% 14.9%	83.9% 11.8%
Satisfaction with work-schedule	basically yes depends basically not	84.0% 14.7% 1.3%	62.1% 28.7% 9.2%

Average figures at a first glance show the opposite: a larger amount of patients, a longer working day, a longer patient waiting time are all associated with private practices. Also, higher fluctuations of patients here uncover the fact that, in private practice, a lot of services are in the nature of first visit to a physician, which can be time consuming. The average share of working time, devoted to patients, is similar in both sectors (about 80%). However, the daily workload is lower in a private practice (24 patients in comparison to 31 patients, respectively). This suggests that organisation of a private practice is probably better.[14]

One of the reasons for such a general score might be that, among private physicians, the dentists prevail, and a lot of services are not urgent - but larger differences among private physicians also suggest that reasons are complex. They are symptomatically reduced to a single, very important factor of differentiation: about 84% of private physicians are satisfied with their work time, in comparison to only 62% of physicians in public institutions; nearly 10% of the latter are basically dissatisfied. This significant sectoral difference might come from a trivial source: that in the public sector the time schedule is compulsory, while in a private practice it is more variable.

On-job problem solving:

Problems and conflicts are normally included in every social situation. However, comparisons of the characters of daily problem solving can demonstrate how differently similar problems can be addressed when the organisational contexts differ among themselves (table 4).

Table 4
Problem-solving in private practices and public health organisations

(variables 22,24)	Answer categories	physicians in private practice	physicians in public institutions
Does he/she warn collaborators about their mistakes?	no, nearly never yes, seldom - often	9.0% 91.0%	19.5% 80.5%
Does he/she raise a conflict, if necessary?	no, nearly never yes, seldom - often	71.6% 28.4%	60.9% 39.1%

Based on the results of two rather modest questions about problem solving situations within an organisation, we might infer that the contamination of atmosphere with potentially conflicting interests is higher in public than in private institutions, but the rate of open conflicts is higher in a private practice. Thus, a higher possibility of an active relaxation of conflict is an important advantage of a private arrangement, in comparison to a public one.

Quality and supervision of health:

Quality assurance is one of the major concerns, while introducing plural forms of health care delivery. One would expect that physicians of each sector, public and private, will discriminate in favour of their own sector. Surprisingly, we found that physicians in public institutions hardly support the superior quality of their own sector (table 5a). While all private physicians definitely claim that their own sector is better in comparison to the public sector in this respect (56%), only a weak minority (about 14%) of physicians from public health institutions claim the same, in favour of their own sector.

This distrust among physicians working in public institutions as to the quality of their own services must be explained further. Probably physicians from public institutions use here a tacit distinction of what constitutes quality, which they otherwise do not like very much: between a professional and a laicist (not-professional) aspect of the quality of services. There is no reason that they would have any doubt about the equal professional skills of physicians, working in both sectors, especially considering that acknowledged expertise can be more easily found in public institutions. Rather, they probably feel that all other, more laicist aspects of quality of services (approved as an

intrinsic part of a health service also by the World Health Organisation) can hardly be better within the public institutions in comparison to those in private practices.

Table 5a
Quality of health services

(variables 15,20,21)	Answer categories & statistics	physicians in private practice	physicians in public institutions
What can you say about the quality of health care services, comparing public and private sector?	both sectors are equal	20,0%	28,7%
	it depends	22,7%	48,3%
	private is better	56,0%	8,0%
	public is better	-	13,8%
	'refusals'	-	1,2%
	I do not know	1,3%	-
Can people improve the general health level also by themselves, by their own activities?	yes, very much	22,7%	29,9%
	yes, quite a lot	34,7%	32,2%
	middle	17,3%	20,7%
	no, maybe a little	18,7%	13,8%
	no, very little	5,3%	2,3%
		1,3%	1,1%
How many patients come to you needlessly (weekly)?	Mean	7,7	13,6
	ST Deviations	10,1	15,4

A more patient-oriented sensitivity among private practitioners, supporting the above ideas, can also be seen from the results from the other two questions in table 5a. Trust in patients' initiative to take responsibility for their own health, is a little lower among 'public' practitioners. On the other hand, the estimation of the average weekly number of patients coming needlessly to public medical examinations is twice as large as with private practitioners (Table 5b)?

Both, physicians in private practice and in public institutions, assume that only internal and, to a lesser extent, external supervision is effective forms of additional control of their health care services. Also, we can see from the lower average marks (mean, abbr. as M) and from their narrower dispersion (standard deviations, abbr. as STD), that physicians in public institutions are more dedicated to internal and also to external professional supervision, in comparison to those in private practice. This might mean that professionals in private practice already allow a basic doubt to exist on the exclusiveness of strict professional control, as they are already more sensitive to a patient's burdens and to other (environmental) influences.

Table 5b
Supervision of health care services, ranks of desired forms of supervision

(variables 16,17)	Answer categories & ranked responses	physicians in private practice	physicians in public institutions
Is there a need for a larger (better) supervision of medical services?	no yes refusals	45,3% 54,7% -	41,4% 57,5% 1,1%
Evaluate the following forms of supervision: Scale: 1-very effective, 2-effective, 3-middle, 4-little effect, 5-not-effective		rank M (STD) *effective forms:*	rank M (STD) *effective forms:*
	internal supervision external supervision	1 2,7 (2,2) 2 3,0 (2,2)	1 1,8 (1,5) 2 2,5 (1,4)
		not-effective forms:	*not-effective forms:*
	individual complaints users' associations users' vouchers	3 4,0 (2,2) 4 4,1 (2,4) 5 4,1 (2,3)	3 3,8 (1,5) 4 3,8 (1,5) 5 4,1 (1,9)

Cross-sector comparison of public-private workingarrangements:

Highly regulated professions in socialist settings (seen as monopsony regulation or rent-seeking mechanisms for the upper professional actors) probably, slowly but deeply, harmed the sensitive human and social dimensions of the public manpower systems. By these social dimensions we mean simple things like questions related to professional prestige, working conditions, recruitment and promotion practice, differential payment, career perspectives, professional and social ties like trust, loyalty and commitment, etc. In replacement, supposing there was a way out of these tensions and given the non-market situation, there were also all kinds of substitutional rewards for additional and exceptional work: promotions, education, professional and academic career, advancements, etc. With the emergence of competitive private practices all these substitutes have become less attractive, even questionable (Table 6). Above all, why not just earn money as the most general and complex reward?
Physicians in private practice are quite sure that by making the transition, they have gained the following solid advantages in comparison to others, who remained "behind" (in the public sector): a higher work autonomy, a higher income, and better medical and technical equipment. Physicians in public institutions totally agree with them: they feel that they are worse off in comparison to private practitioners in exactly these respects. Also, educational possibilities are no longer seen as a unique way to promotion as also higher income and autonomy appear. Rather, educational efforts are now viewed as being badly rewarded.

Table 6
Cross-sector comparison of public-private working dis/advantages

Are you better or worse off, concerning the following items, in comparison to physicians working in the other sector (private/public)?

Scale:
1 - much worse off
2 - worse
3 - nearly the same
4 - better off
5 - much better off

item	M (STD)
better off in comparison to private sector:	
consultation with colleagues	3,7 (1,2)
educational possibilities	3,4 (1,6)
nearly on the same:	
responsibility	3,1 (0,9)
work loading	3,0 (1,1)
worse off in comparison to private s.:	
equipment	2,9 (1,7)
autonomy	2,8 (1,1)
income	2,4 (1,8)
consultation with colleagues	3,5 (1,0)
worse off in comparison to public s.:	
work load	2,7 (1,1)
responsibility	2,5 (1,2)

Higher workload and responsibility, which private physicians complain about, is the only price for their public-private transitions. But these two features can also fall among the desired aspirations, as they resemble prestige. So, a funny cross-sector message appears: the only things which Public physicians think as being equal among both sectors (responsibility and workload), are on the other hand the only things which 'private' physicians feel as their basic sacrifice for a successfull transition. This might simply mean, that by a public-private transition a public physician can only gain something - or, the other way round, he/she can loose nothing! From this combination of subjective impressions of phythough physicians, one can understand easily why the attractiveness of the current private labour market arrangements in Ljubljana are put so high among all the physicians.

In the eyes of public physicians, the only single favourable condition, which remains still associated with public health institutions, are the consultations amongst colleagues. It means, public physicians think they have larger possibilities for stimulating and immediate professional discussion in comparison to private physicians. These thiny professional links probably still hold together a large part of the Slovenian public health care sector at the primary level. As they provide an ethically highly needed exchange of skills and knowledge among physicians, they can undoubtedly be considered as the crucial system ties.

Preferences for rationing system performances:

The ranking of factors, which are important for an improvement of the whole health care system performances, yield to similar results among both groups of physicians (table 7).

Table 7
Health care system rationalisation, ranking of factors by importance

(variables 18, 19, 28)	Answer categories & ranked responses	physicians in private practice		physicians in public institutions	
Is there a need for health care system rationing?	strongly agree		20,0%		13,8%
	agree		30,7%		28,7%
	only partially agree		28,0%		44,8%
	disagree		21,3%		12,6%
Where should we start to achieve more rational performances of the health care system?	*with:*	rank	M (STD)	rank	M(STD)
	administration	1	2,5 (2,2)	1	1,9 (1,7)
	work organisation	2	2,9 (2,1)	2	2,8 (1,6)
Scale:	superfluous services	3	3,8 (2,1)	3	3,7 (2,0)
1 - most important	fewer patients visits	4	4,5 (2,1)	4	4,3 (1,8)
...	patients copayment	5	4,7 (2,1)	5	4,6 (1,7)
6 - least important	remedies & equipm.	6	5,3 (1,9)	6	5,3 (1,6)

The root of blame - in the physicians' eyes - for bad system performance is obviously on the administration in public health institutions; this general criticism is immediately followed by a similar one - an inefficient work organisation.

Superfluous medical services are a professional concern and are somewhere in between the factors, ordered by importance. Fewer patient visits and patient copayments will not mend matters substantially. The queue ends up with the least important factors, medical equipment and remedies which for both physicians, public and private ones, are good as they are. Also, it is apparent, that opinions are more coherent among physicians working within public health institutions, in comparison to those working in private practice.

Remedy supplies, effects of remedies from "positive" list, equity issue:

We concluded that from the point of view of physicians, neglecting here their sectoral membership, the question on remedies are the least important among all possible reasons and factors which could contribute to better system performances. Theory and a large part of the socio-economic empirical literature on health-markets assert just the opposite: how the coalitions among pharmaceutical firms and physicians are controlled is highly policy relevant. It is not the quality issue here, which could be in danger (all remedies are basically of high quality), but rather the system aims of efficiency and, indirectly, equity (justice).

This hesitant understanding of the role of the pharmacy in medical service delivery

is also presented in the structure of physicians' responses (table 7), who are more than regularly visited by all kinds of pharmaceutical agents. The differences between public and private physicians are also meaningful.

Table 8
Supply of remedies, effectiveness of remedies from the 'positive list', equity issue

29,30,31		physicians in private practice	physicians in public institutions
Visiting frequency of pharmaceutical agents	daily	-	5,7%
	weekly	13,3%	9,2%
	a few times a month	29,3%	34,5%
	monthly	24,0%	13,8%
	yearly	25,3%	27,6%
	never	8,0%	9,2%
Are remedies from the 'positive' list (paid to pharmacies by HIIS, for insured persons) sufficiently effective?	in a majority of cases	77,3%	80,5%
	in a minority of cases	6,7%	6,9%
	it is hard to say	14,7%	12,6%
	I do not know	1,3%	-
Is it right (justified), if we detect an increase of rich people among the self-paid patients?	it is not right	40,0%	31,0%
	it is OK, that rich	17,3%	10,3%
	people can afford	-	-
	such a service	-	-
	it is hard to say	40,0%	11,5%
	I do not know	2,7%	47,1%

Pharmaceutical agents visit physicians working in public institutions more frequently than private practitioners, what is reasonable from a market point of view. The former deal basically with nice "white" medical prescriptions, which are directly connected with hardly resistant public insurance funds[15] . However, some doubt exists (about 20%), that the slowly shortened positive list of remedies, by which the professional commission tries to reduce the system costs for publicly financed remedies, discriminate between more or less effective remedies in a professional sense, are nearly equally distributed among both, "public" and "private" physicians. And finally, the perception of an increasing injustice in public-private health care delivery is higher among private practitioners. Did not we expect the opposite?

Remedies, as a topics which physicians avoid exposing as a matter of a health-care reform (table 7), therefore inevitably capture all three crucial system aspects of health care reform (table 8): efficiency, quality, and equity (justice). The above results are again a small, but solid confirmation of the basic sociological finding on policy-oriented behaviour of professionals: any professional rhetoric, spread permanently among ethics,

individual interest and public behaviour, is hardly spoken clearly, and tend to crumble into pieces, for its intrinsic contradictions.

Conclusion

We started with the recognition that medicine in Slovenia, and probably elsewhere, is among the strongest professions. However, we were modestly, but significantly able to support a hypothesis that the stronger a profession is in a respect to the system, the weaker its public oriented behaviour is. Probably, public oriented behaviour is a more human than system concern; it is more a value than a goal. Therefore, it has behavioural and not simply legal connotations. Because the former (socialist) public health care system slowly failed in nearly all, a system, professional, and also human respect, some system reforms, especially pluralisation, privatisation and insurance improvements, are now stabilising the more apparent failures. The first results are promising: the system efficiency (Health Insurance Institute) and the quality of service delivery (Phasicians' Chamber) are under better control and supervision than before (Schneider 1998).

But, we also concluded that the process of pluralisation of providers is somewhere in the middle of its anticipated expansion. The medical manpower system in public institutions is slowly shrinking; private practice is slowly enlarging. However, it is surprising that the expansion of private practices happened only within larger cities, where an easy access to primary physicians was/is available anyhow. It can mean, that the privatisation process in Slovenia up to now does not follow more common arguments, which are: the importance of guaranteeing equal access to services in rural areas and the value of personal accountability between physician and patient.

The degree of internal stability (Saltman 1992) seems higher in 'private' arrangements than in public ones: both, public and private physicians admire a lot of advantages of private practices. It seems as if human and professional aspects of medicine in the Slovenian public health care institutions are currently connected mainly by thin ethical links, which are based on higher possibilities to consult colleagues in the case of emergency in comparison to private physicians. This is a small bridge for a fair transition, but a very important one. We should not under-estimate it, as it also concerns justice. Our findings suggest further that efforts to redesign the delivery of primary health care services in Slovenia are still in an experimental phase. Private sector providers on quasi-independent medical markets are not yet fully regulated. After this short evaluation, based on Ljubljana situation, let us then conclude with a hypothesis.

We have seen that the private providers of medical services in Ljubljana seem still highly sensitive to the issue of justice. If they proceed further with strengthening this awareness for social responsibility, the pluralisation (public finances, private delivery of medical services) - and whatever form it takes in the future - may result in even stronger privatisation (private-public finances, private delivery) of primary health care, but it will hardly harm a basic, open (easy) access of the public to a physician. However, if they proceed further with a weakening of this awareness, then a crude form of privatisation (private finance, private delivery) is nearly inevitable and the fresh public-

private mix of service delivery in Slovenia might collapse very soon.

In other words, as always and anywhere, the viability of further health system reforms in Slovenia depends basically on the awareness among the physicians, and among all other actors of the health care system as well, of the crucial point of the health reform, which concerns the issue of justice: how to establish and maintain a proper balance between both, health as a public and health as a private good?

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NOTES

1. The basic purpose of the partnerial negotiations is to ensure accountable definition of the upper limits of public funds for the implementation of health care programs" (Health Insurance Instiute of Slovenia 1998: 17).
2. Review article of 144 studies on comparative and international health care research, published in leading journals between 1970 and 1985, was written by Van Atteveld et al. (1987). They found little coherence in methods and results and the dominance of a quantitative economic approach.
3. It includes three fundamental transformations: (1) decline in importance of the infectious diseases and the prevalence of chronic degenrative conditions, injuries, and behavioral disorders; (2) changing age prevalence of illness, with preponderance of mortality among the older cohorts; (3) altering of the conceptions of illness and patients expectations (Mechanic, Rochefort 1996).
4. From the viewpoint of Euroepan economic integration, the common basis of the health care systems in 15 Western countries are: "a common European value on income solidarity and the limitation of power of market forces within the health sector" (Schneider 1998:6).
5. This finding has a strong policy message, concerning the implementation of an adequate information system: a new situation needs less information, but they should be more structured and commonly agreed upon among the more autonomous actors - the latter are becoming partners instead of competitors, and so forth.
6. There are various approaches to estimate an average performance of a health care system. however, it seems important that in Slovenia actors rejected the planning style alloaction budget model rather early and tended toward a contract payment system - in both, public health institutions and private practices. This shift probably encouraged a more innovative behaviour of actors, at least some of them.
7. Political behaviour is a basic feature of any (strong) profession, claims Mintzberg (1989). It happens because the professional autonomy of various, rather weakly hierarchically ordered

actors always tends to gain additional influence by crossing weak organisational borders of a profession. So, the inter-sectoral coalition formation, which is basically the political behaviour, is a very typical way of handling problems and conflicts for the actors in this kind of organisations.

8. As with lawyers, also medical professional doctrine on doctor-patient communications should favoure rules that use the reason and good sense of doctors, rather than formal rituals of correctness (Stinchcombe 1997:8-9).
9. The arguments for this statement can be found in empirically detected signs of a danger restructuring of the inner circles of a state legitimating power: spontaneous outsourcing of coercive power, large privatisation of legal professions, fiscal disorder, caused by increased but uncontrolled public funds, etc. More on this see: B. Zalar (1998): "(Il)legitimacy of Privatization of the State Enforcement Apparatus". Pp. 37-56 in *Zasebno varovanje in detektivska dejavnost* (Private Security and Investigation Activities) edited by A. Anžič. Ljubljana: Visoka policijsko-varnostna šola.
10. And the opposite is true, as well: the weaker a profession in the former times, the stronger its current striving after improving its position within the public sector.
11. More on a general dynamics on expanded "occupational labour markets" within the former socialist countries see: A. Kramberger (1999): *Poklici, trga dela in politika (Occupations, Labour Market and Politics).* Ljubljana: Znanstvena knjižnica *(submitted for publishing).*
12. Highly regulated professions loose more and more control by introducing always new correctives and regulation on the whole occupational territory: education (tracking), exams, licences, concessions, recruitment, selection, promotion, retirement, replacement, etc.
13. One only has to recall the unexepctedly long and rigorouse doctors' strike in 1998 and some recent furious discussions (yet unresolved) on attempts to improve collective arrangements between various health occupations in Slovenia. Discussions between doctors and actors of other occupations are full of mutual ignorance, accusations, mis-understandings and occupational non-solidarity.
14. It is interesting that economic theory for profit reasons expects a higher number of patients per day for a private practice, which also includes less time spent on a single patient in comparison to public institutions.
15. On the other hand, "green" medical prescriptions can be used life-long by all the licenced physicians, especially in a case when they deliver a medical service and a remedy to the patients without insurance contracts.

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