Mirna Macur *

PRIVATISATION AND THE QUALITY OF HEALTH-CARE SERVICES

ABSTRACT

As social services have a special mission, privatisation of social services should not be approved if it is unable to assure the same or an increased quality of life. Quality of life, of course, does not depend solely on a greater number of services but also and especially on the higher quality of those services. Since higher quality is often one of the motives for the privatisation of health services and as it is also stated as a goal in national documents and health care programmes, the author evaluates the privatisation of health services and its impact on the quality of the health services. She finds users as the most important stakeholders in this evaluation since they experience the entire process of a health service and its outcome. Evaluation is *limited to the primary health level of the services of the general physician and dentist.*

Key words: quality, health service, user evaluation, privatisation of social services, satisfaction

Introduction: why evaluate privatisation through the quality of social services?

Privatisation can be evaluated from many different perspectives Ð the most common criteria are efficiency and effectiveness. I decided to use quality as a criterion for two reasons. Quality is an established criterion not only in relation to products and market services but also in regard to social services; and secondly, quality of health services is one of the goals of the health policy stated in various documents and national programmes.

Introducing a mixed economy of care may affect the quality of health services. World Bank experts enumerate the following positive aspects of privatisation (Torres, Mathur 1996):

* Mirna Macur is a Research Fellow at the Institute of Social Sciences (Centre for Evaluation and Strategic Studies) - Faculty of Social Sciences, University of Ljubljana. The basic idea of this paper was presented at the 14th World Congress of Sociology, Montreal 26. 7. - 1. 8. 1998.

- private financing can help reduce the burden on the government budget and by releasing scarce public funds, improve the efficiency of intra-sectoral allocation;
- private sector can go a long way towards achieving the objective of enhanced access and better quality of service delivery in private as well as in public institutions;
- private management is more responsive to the market and caters to the demands of the consumers;
- private management pays greater attention to cost efficiency and long-term sustainability.

As seen here, the quality of health services is one objective of privatisation of health care. However, the privatisation of health care services does not only include positive effects. As WHO experts (Saltman, Figueras 1997) state, the application of market-style mechanisms to the health sector is loaded with dilemmas. The most frequently mentioned dilemma is that market mechanisms necessarily create conditions in which the vulnerable population (the less well-off in particular) do not receive equal access to quality services.

As there should be no unrestricted market activity in the provision of a social benefit such as health care, a continuous evaluation of privatisation through research is necessary. Nevertheless, the privatisation of social services as well as health services should not be approved if it cannot assure the same or an increased quality of life. Quality of life, however, does not depend solely on a greater number of services but also and especially on the higher quality of those services (Rus 1997).

The purpose of this article is to ascertain whether the introduction of privatisation into the health care system has any effect on the quality of health services. To this purpose, primary health care in Slovenia is taken as a case study.

What is quality?

The term quality was first used in relation to industrial products. The term was extended to other areas of human life as well (e.g. quality of various services, objective and subjective aspects of the quality of life). Today quality is the most important objective of various types of human activity. Although the importance of quality is undeniable, usually there is no consensus about its meaning. “It is put to different uses, to serve different purposes Ð and its meaning changes accordingly” (Pfeffer, Coote 1991:1). The reason most likely relates to the different dimensions of quality, depending on the type of product or service.

Product quality differs from *service quality* because services include the provider-user relationship. Service can be defined as a product whose production and consumption is the very same process. In general, this means that the consumer experiences not only the product and his/her own consumption of the product, but the production and the producer as a person, too. Therefore, authors define different dimensions for the quality of a product and for the quality of a service. Bergman and Klefsjö, for example, define the following dimensions of quality for a product:

- performance (suited to the customers on the intended market segment);
- reliability (a measure of how often trouble occurs and how serious these problems are);
- maintainability (how easy it is to detect, localise and take care of a problem);
- safety;

and also serviceability, environmental sensitivity, aesthetics, faultless and durability can be added.

On the contrary dimensions of quality for a service are:

- tangibility;
- reliability;
- responsiveness;
- courtesy;
- communication;

and also assurance, access and empathy (Bergman, Klefsjö 1994).

From the latter we can see that service quality is quality of a provider-user relationship. However, it is important to draw a distinction between market services and public or welfare services. Although they both tend to satisfy the user, in market services the desire to satisfy is the means to a commercial end. Welfare services, on the other hand, have a more complex function: to serve the interests of the community as a whole, and to meet the needs of individuals within the community. The pursuit of quality in welfare services must be compatible within these objectives.

C. Pollitt (1997) describes two dominant approaches to quality:

- the "*professional approach*" is characteristic for public services - it is mainly concerned with "producer quality", where the services are supposed to be technically of a high standard in terms of prevailing professional aspirations;
- the "*business approach*" to quality is common in private sector manufacturing and services - it is concerned with "consumer" or "user quality", where the services should satisfy consumer requirements and expectations (and which, by so doing, increase the probability that the consumer will remain loyal).

This description of quality is sometimes considered to be a universal definition of quality,[1] but it does not suffice to define the quality of social services. Therefore, some authors define a third approach to the quality of welfare services: "the *consumerist approach*" (Pfeffer, Coote 1991) or "the *empowerment perspective"* (Dowling 1997). These two approaches stress the importance of user participation. Individuals should be empowered:

- as customers (in provider-customer relationship) and
- as citizens (the public should have an active influence on the planning and delivery of services).

Although both aspects of participation are important, we will concentrate only on customer participation, as participation in decision making calls for a different type of analysis. The latter is often merely a requirement that is not being implemented, also not in health care.

Quality of health services

The term quality is becoming more and more important in welfare services and in the health sector in particular. The quality of health care was postulated as one of the main objectives of the World Health Organisation. In Priority research for all (WHO 1988) it is stated that all Member States should have built effective mechanisms for ensuring quality of patient care within their care systems.

Although health care providers and administrators are increasingly concerned about the quality of care, there is not one meaning unique to the term. The current meaning of quality of care "concentrates almost exclusively on the technical aspect of treatment. It ignores such important issues as over-treatment, iatrogenic disease, the alienation of patients and their families, the unwanted extension of life, and the emotional and financial costs of illness" (WHO 1988: 84).

When we discuss the quality of health services we should always ask ourselves whose quality and who defines quality. It is possible to say that the main concern of providers has been the quality of care, whereas users are predominantly interested in the impact of care on the quality of life. We believe that in health care two views on quality dominate (see Table 1).

Table 1
Two contrasting (dominant) views on quality in health care

Approach to quality	Expert approach	Users approach
Main concern	Quality of care	Quality of life
Dominant question	Does care meet professional standards?	Does care benefit the person who receives it?
Evaluating quality	Medical audit	Consultation, evaluation of process and outcome
The most relevant criteria	Quality[2] Effectiveness	Appropriateness Effectiveness (recovery)

For a long time within the health care sector an expert approach prevailed along with which the users received what others (experts, i.e. doctors) thought was best for them. Expert opinion "prescribes levels - standards - of acceptability" (Pfeiffer, Coote 1991: 5). Service users, of course, are not supposed to have said concerning the service. In health care, physicians traditionally have had clinical freedom - the unique autonomy to decide what is best for each patient. Behind this concept, there is the understanding that physician is guided by the needs of the user. However, experts can exploit their autonomy by putting pet theories (good or bad) into practice and spending money without being accountable for it. "A professional ethics of a service can help create a narrow, self-serving monopoly /.../ and may also lead to serious organisational distortion, /.../

fragmentation, fierce internal loyalties and a general lack of external vision" (Pfeiffer, Coote 1991: 8). Where experts set standards, the results are also monitored. When goods and services fail to satisfy these standards providers are punished with a loss of contract or job, or by incurring a financial or other penalty. The dominant type of evaluation of health practices is the medical audit. Audits are "the systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcomes for the patients" (Drewett 1997:192). As a result of scientific procedure, audits are sometimes referred to as health technology. This type of evaluation excludes service users, because "in health care in particular, lay knowledge is viewed as inferior to professional accounts: the former is relegated to the status of personal and subjective, while the latter is elevated to the ranks of expert" (Drewett 1997:194). Unfortunately, clinical audits are largely one-off events and are poorly disseminated; therefore, they do not have a heavy influence on service development.

What looks like quality service to an expert may look rather different from the user's point of view. Even if a service is of high quality, service users are interested primarily in the benefit they receive from the service. Health service is supposed to address their needs, therefore appropriateness[3] is an important criterion of quality. With respect to health care services, recovery is the most important goal to users - that is the effectiveness of a health service. Patients are the most important evaluators of the effectiveness of health care.

Among the listed components of a system (Phillips et al. 1994: 20):

- "procedure (in accordance with formalised rules and regulations),
- process (a series of actions and interactions),
- input (resources invested in specified official activities),
- output (a measurable product attributable to an input or combination of inputs),
- outcome (a final state which may or may not be the intended effect of specified inputs, outputs or processes)",

those of greatest concern to the users are likely to be process and outcome. It seems that outcome is the most important criterion for evaluating health services from the users' perspective, because results of treatment (recovery, survival etc.) are those that matter most. Outcomes, however, are sometimes difficult to measure. It is much easier and often more informative to measure the process, although it is not easy to correlate the process with the outcomes; especially if there is no clear evidence indicating whether or not poor outcomes are due to the treatment.

Quality of the health care system as a whole depends on the *structure and resources, process and activities* and *outcome or effect* (Roemer, Montoya-Aguilar 1988). According to the focus of the research we include different stakeholders that measure quality. Users, for example, cannot evaluate the structure, "treatment facilities, including factors such as the quality of staff, the availability of appropriate technology and the standards of accommodation" (WHO 1996: 208). They can, however, measure the process and outcome of treatment. Providers of health care can also measure process, but in a different way. To them, the technical aspects of the process are important. From

the users' point of view the most important aspect of process is the patientÐdoctor relationship, whether the patient can speak about his/her health problems, whether he/she feels that he/she has been listened to or properly treated etc.

Although there are different approaches to the quality of health services and different ways of measuring it, WHO tried to set a unique concept for the quality of health services. According to WHO the concept of high quality care must be extended to cover the following vital elements of the primary health care approach:

- "the effectiveness, safety, efficiency and adequacy of care designed to meet people's needs,
- the acceptability to the user of the services delivered,
- the provision to users of information, their chances for participation, and their satisfaction in service and
- the protection of service users from unnecessary subjection to expensive, unpleasant, invasive and potentially hazardous equipment, procedures or drugs" (WHO 1988: 58).

Measuring the quality of health services in Slovenia

The data

Quality of health services was analysed only with respect to primary health care at the general physician and dentist level. For the analysis I selected three groups of users for each physician:

- users of public health services,
- users of services of the concession holder and
- users who pay directly for services (usually with private physicians).

After the field research I calculated the precise groups according to the payment of the health service (direct payment or health insurance) and the location of the physician (in a public or private health care centre). Among users of the general physician there were 233 users of the public general physician, 92 users of the concession holder and 3 users who paid directly for the service. The last group was too small to be included in the analysis.

Among users of the dentist there were 65 users of the public dentist, 40 users of the concession holder and 85 users who paid directly for the service.
First I will present the results for the general physician and then for dentist. Results are presented separately in groups.

The questionnaire

In users' evaluation of health services we explored:

- perceived changes in health services (both public and private) after adoption of the

new health legislation (Law on Health Activities) in 1992 and satisfaction with the health service;
- perceived changes in the level of health protection;
- user behaviour pattern when dissatisfied with the service and
- user aspirations with reference to health services.

Users were asked questions from all these groups, with the exception of the first category of questions which referred to a general physician or a dentist or both, depending on which physician the respondent had visited in the last year.

I will first present the characteristics of our sample, then the level of satisfaction with the three types of physician and the perceived changes in health care service. We limited our analysis to two broad questions that would provide the most information on the impact of privatisation on the quality of services.

The satisfaction scale is most often employed in user evaluation surveys and in measuring the quality of the services. In this article I also analyse answers to the question whether health service is better, the same or worse than it was before 1992, when a privatisation reform was initiated. Then I will compare the answers from users of the public physician, the concession holder and the private physician.

Earlier we argued that users can evaluate the process and results of health services, whereas input, output and procedure are usually evaluated by other stakeholders. Both questions address the dimensions that are connected with the process or outcome of health service. Process is measured in various ways: waiting lists, preventing contact in the waiting room between healthy and ill patients, the nurse relationship with patients, information provided by the nurses, the administrator relationship with patients, information provided by the administrators, the physician's sensitivity and attention to their health problems, respect for their privacy and dignity, and speed of treatment.

The outcome is perhaps the most important, yet the most difficult component to evaluate. In the literature it is stressed that outcome is highly dependent on the process, yet the relationship is hard to prove. In the research we measured the outcome as an effectiveness of the treatment. For both physicians there were also two indirect questions relating to the results of the treatment: "Did your general physician or dentist do all that he/she could for you?" and "Did the treatment process at the general physician or dentist meet your expectations?"

Review of the sample

Before I present the results we should first have a look at the sample we are analysing. There are three groups of the respondents at the dentist and two at the general physician. The sample, of course, is not representative so we need to present the results for each group separately.

Table 2
Characteristics of the interviewed population

		general	general physician	dentist physician	dentist	dentist
		public	concession holder	public	concession holder	private
sex	male	35.3%	35.9%	32.3%	45.0%	30.6%
	female	64.7%	64.1%	67.7%	55.0%	69.4%
education	up to primary school	17.3%	16.3%	10.8%	12.5%	3.5%
	finished secondary school	65.4%	68.5%	73.8%	60.0%	62.4%
	finished faculty. MA or PhD	17.3%	15.2%	15.4%	27.5%	34.1%
work status	employed	38.4%	47.8%	33.8%	57.5%	55.3%
	self-employed. farmer	7.3%	4.3%	10.8%	5.0%	18.8%
	unemployed. student	15.5%	17.4%	33.8%	20.0%	10.6%
	retired	38.8%	30.4%	21.5%	17.5%	15.3%
size of the municipality of residence	municipality with up to 2,000 inhabitants	35.1%	25.0%	36.5%	32.5%	22.4%
	municipality with 2,000 - 10.000 inhabitants	18.6%	31.5%	17.5%	17.5%	18.8%
	municipality with 10,000- 50,000 inhabitants	19.0%	25.0%	14.3%	30.0%	22.4%
	municipality with more than 50,000 inhabitants	27.3%	18.5%	31.7%	20.0%	36.5%
housing status	living with parents or relatives	18.2%	15.2%	36.9%	15.0%	12.9%
	owner of apartment or house	75.8%	77.2%	55.4%	65.0%	83.5%
	tenant	6.1%	7.6%	7.7%	20.0%	3.5%
social strata (subjective estimation)	lower	21.4%	23.8%	6.7%	18.9%	14.5%
	middle	70.4%	68.8%	78.3%	73.0%	67.1%
	upper	8.3%	7.5%	15.0%	8.1%	18.4%
How much responsibility do you take for your own health?	very much	18.5%	20.7%	23.1%	12.5%	15.5%
	some responsibility	63.4%	67.4%	56.9%	52.5%	77.4%
	not much. almost none	18.1%	12.0%	20.0%	35.0%	7.1%
Your health condition?	excellent	6.9%	10.9%	12.3%	20.0%	9.4%
	very good	19.8%	20.7%	27.7%	27.5%	29.4%
	good	62.5%	64.1%	56.9%	50.0%	57.6%
	bad	10.8%	4.3%	3.1%	2.5%	3.5%

The sex structure shows that women visit the physician more often than men. Sex structure in groups does not show a significant difference with respect to the type of general physician but it does with respect to the type of dentist. At the dentist conces-

sion holder, on the average there were more men than women, contrary to the category of self-paying patients (at private dentists) where there were more women than men.

In both groups patients at the general physician have a similar education structure. Those with lower education visit the private dentist less often than the public dentist or the concession holder. On the contrary, patients with higher education on average pay directly for the services more often and visit the concession holder more often than the public dentist.

The working status of the people who visit the general physician differs in groups, but not to the extent it does in the groups of the dentist. Generally, retired people visit the general physician more often than the dentist. Among patients at the general physician, retired people more often visit the public physician than the concession holder, but with employed people it is quite the opposite. The structure of the patients that visit the dentist differs according to groups: students and the unemployed visit the public dentist more often than concession holder, and they seldom pay directly. On the contrary, the employed do not visit the public dentist as often as the concession holder, and the concession holder as often as the private dentist. The highest percentage of patients at the private dentist is found in the category of the self-employed and farmers, most likely because in this strata there are more self-employed than farmers (in the sample there are 36 per cent self-employed and 10 per cent farmers).

The are some differences in the structure of the patients in groups according to the size of the municipality of residence, which is probably due to the percentage of concession holders and private physicians in different areas. Among the patients at the general physician, it is the public physician who is most often visited in the smallest and the largest Slovenian municipalities. Patients in medium-sized municipalities visit the concession holder more often. Among the dentist's patients in the smallest municipalities, visitors to the public dentist and the concession holder are more frequent than visitors to the private dentist. In medium-sized municipalities (from 10,000 to 50,000 inhabitants) patients are also frequent at the dentist concession holder. It is interesting that, in the largest Slovenian municipalities, patients of public and private dentists prevail.

We also controlled whether housing status differs among groups. In the transition period in Slovenia most flats have become privately owned and only a few people rent flats - mostly the young, who have not yet solved their housing problem. Accordingly, at the public dentist there are more patients that live with their parents or relatives and fewer patients who live in their own flat. Those who rent flats visit the concession holder more than the private dentist, on the contrary the ones that live in their own flat pay directly for the services more often than others. At the general physician there are no differences in housing status between the two groups.

We can observe the interesting structure of the various social strata. It is a subjective evaluation and we can observe no difference in the structure of the visitors to the general physician. In the data we note that people from the lower social strata visit a general physician more often than the dentist and those belonging to the upper social strata visit the dentist more often than the general physician. Among the dentist's patients those belonging to the lower social strata visit the concession holder more often than

the public dentist, on the contrary those in upper strata more often visit the public dentist than the concession holder. Of course they also visit the private dentist more often than those belonging to the middle or lower social strata.

Answers to the question, "How much responsibility do you take for your own health?", posed by the general physician, are similar; on average they take some responsibility for their health but not to a great extent. Among patients at the dentist, the percentage of those who take some responsibility for their own health is the highest. The greatest percentage of those who take little or no care visit the dentist concession holder. Among the patients paying directly for the services there is the smallest percentage of those who do not care for their own health and the highest percentage of those who do - but not of those, who do so to a great extent.

The last question is a subjective evaluation of their own health. Among patients of the general physician there are fewer respondents who answered "excellent" and more respondents who answered "good" than among patients of the dentist. Among the dentist's patients the answers do not differ much. The percentage of those in poor health is the same in all three groups. Interestingly, at the dentist concession holder there are more patients who think their health is excellent; a similar group of patients is rare at the private dentist. These data might mean that patients of the private dentist are not the ones who can easily afford it, rather the ones in greater need of health services, and perhaps cannot always receive them at the public dentist. This assumption is based on the fact that the percentage of people in the lower social strata who pay directly for services is higher than expected.

Results

General Physician

There are many items in the questionnaire, which refer to visits to the general physician, but for this article we have selected only the most interesting ones. Changes in the health care system (after the adoption of the Law on Health Activities in 1992) users first experienced with the possibility to freely choose their own physician. Of course this does not apply to all specialists but to the physicians at the primary health care level (general physician, dentist, gynaecologist, oculist). Among the respondents that visited a general physician 27 per cent of then have used the opportunity to choose a general physician. Most of them (73 per cent) remained with their old physician or visited the first one available. If we compare the percentages in both groups we can conclude that visitors to the concession holder chose a new physician more often than visitors to the public physician, but not predominantly. That means that changes in general physician groups are largely due to the change in status of a provider, but not to the users' free choice.

Table 3
At the general physician

		general physician	general physician
		public	concession holder
Did you assert the right to freely choose your own general physician?	I went to the first available g.p. or I stayed with the same g.p.	76.7%	66.3%
	I chose a new / my own g.p.	23.3%	33.7%
Do they consider seriousness of your health problems when making an appointment with the general physician?	totally	55.0%	68.5%
	partly	23.4%	7.6%
	not much. never	3.9%	3.3%
	they don't make appointments	17.7%	20.7%
When making an appointment with the general physician do they consider which times are convenient for you?	always	33.6%	48.9%
	often	23.6%	16.3%
	sometimes	8.3%	6.5%
	never	6.1%	1.1%
	they don't appoint in hours	28.4%	27.2%
How is the admission process at your general physican carried out ?	I am admitted exactly when I am appointed	15.5%	25.0%
	I have to wait a little bit before I am admitted	73.7%	70.7%
	they ignore the waiting list	7.3%	3.3%
	other	3.4%	1.1%
Did your general physician do everything he/she could for you?	totaly	55.0%	65.2%
	pretty much	32.0%	22.8%
	partly	11.3%	7.6%
	not much. not at all	1.7%	4.3%
Did the handling of your problem meet your expectations?	totally	41.6%	56.5%
	pretty much	41.6%	30.4%
	partly	13.9%	9.8%
	not much. not at all	3.0%	3.3%

Two questions follow in Table 3 which refer to patient appointments. We were interested in to what extent the seriousness of a patient's health problems and the times convenient for the patient are considered when making an appointment with the general physician. For the most part, the seriousness of the patient's health problem is considered, but more at the concession holder than at the public general physician (significantly different percentage in the answer, "totally", in two groups). The time of the appointment is also flexible according to the patient availability, but again, more at the concession holder than at the public general physician. At the concession holder almost half of the respondents answered "always", whereas at public physician only one-third. In the data we can note that more than one-quarter of the respondents in both groups replied that they do not appoint in hours at the general physician.

We were also interested in the admission process at the general physician. It is obvious that most of the time patients have to wait for some time before they are admitted. Patients at the concession holder are more often admitted precisely at the appointed hour than patients at the public general physician. Ignoring the waiting lists occurs more often at the public general physician than at the concession holder.

The last two questions in Table 3 refer to the overall evaluation of the general physician. Answers to the question, "Did the general physician do everything he/she could for you?" are favourable with 87 per cent of the respondents. The difference in both groups refers to the percentage of the answer, "totally", which occurs more frequently at the concession holder, and "pretty much", which occurs more frequently at the public general physician. At the concession holder we note more extreme answers than at the public general physician. Maybe the reason for this distribution is not only the quality of the service but also the different expectations of the users of the concession holder than of those of the public general physician (for the latter the answers "partly" and "not much and not at all" are more frequent).

Answers to the question "Did the handling of your problem meet your expectations?" are also favourable. Again we can see that the difference between the types of general physician is in favour of the concession holder.

As the answers to the satisfaction question were on a 5-point scale (except the first general question which is on a 10-point scale), we decided to present the results using means and standard deviations. Satisfaction with the general physician is high and is similar for both types of physicians. When measuring satisfaction in different areas of health service we also observe a high level of satisfaction in most areas. The levels of satisfaction are the highest with respect to the nurse's relationship with patients, to physician sensitivity and readiness to listen to the patient's problems, with respect to the patient's privacy and dignity, and to the speed and success of the treatment. Such answers suggest that the high level of satisfaction with the general physician mostly depends on the quality of the doctor-patient relationship and on the doctor's success. Users are least satisfied with the prevention of contact between the healthy and sick patients in the waiting room.

From standard deviations we can see that differences in the answers in each dimension and group are not significant. Answers vary the most in regard to waiting lists and prevention of contact between healthy and sick patients in the waiting room. Standard deviation of general evaluation of the general physician is 1.7 and 1.9 and it is not high, as it is measured on a 10-point scale.

Table 4
User satisfaction with health services at the general physician

How satisfied are you with:		general physician public	general physician concession holder
your g.p. in general (from 1-"very dissatisfied" to 10 -"very satisfied")?	Mean Std Deviation	8.3 1.7	8.5 1.9
a) the waiting lists?	Mean Std Deviation	3.5 1.1	4.0 1.0
b) the prevention of contact between healthy and ill patients in the waiting room?	Mean Std Deviation	2.9 1.0	3.3 1.0
c) the equipment in the health centre?	Mean Std Deviation	3.8 0.8	4.2 0.8
d) nurse's relationship with you?	Mean Std Deviation	4.0 0.8	4.4 0.7
e) administration's relationship with you?	Mean Std Deviation	3.9 0.8	4.3 0.7
f) information provided by the nurses?	Mean Std Deviation	3.9 0.7	4.2 0.7
g) information provided by the adminstration?	Mean Std Deviation	3.8 0.8	4.1 0.7
h) the physician's sensitivity?	Mean Std Deviation	4.4 0.7	4.5 0.7
i) the physician's readiness to listen to your health problems?	Mean Std Deviation	4.3 0.8	4.4 0.8
j) the respect for your privacy and dignity?	Mean Std Deviation	4.3 0.7	4.4 0.7
k) the speed of your treatment?	Mean Std Deviation	4.0 0.9	4.3 0.7
l) success of the treatment?	Mean Std Deviation	4.0 0.8	4.3 0.7

Legend: the first question measures satisfaction with health service in general; the scale of answers is from 1 (very dissatisfied) to 10 (very satisfied). Satisfaction with different dimensions of health service is measured on a 5-point scale: from 1 (very dissatisfied) to 5 (very satisfied).

Significant differences in the level of satisfaction between groups[4] can be seen for the following dimensions of health service: waiting lists, prevention of contact between healthy and sick patients in the waiting room, health centre equipment, the nurse's relationship with patients, the administration's relationship with patients, the information received from nurses and administration, speed and success of the treatment. In all these areas the level of satisfaction is higher with the concession holder than with the public general physician. It is interesting that the levels of satisfaction primarily differ in areas that are unrelated to the doctor-patient relationship, which is the most important determinant of quality in health service. However, the level of satisfaction with the success of the treatment which measures the outcome is also high and should therefore be kept in mind.

Respondents were asked whether these components of health service improved or worsened after the changes in the health system in 1992. Possible answers were:

1. much worse
2. worse
3. the same
4. better
5. much better.

We have noted that all the answers are between 3 and 4, meaning that the health services of the general physician have improved. Differences among the mean within each dimension are small, standard deviations are also small (lesser than 1.0), which means that responses for each dimension and each group are similar. When we compare the two groups we can see a significant difference in the improvement of the health service in following areas: waiting lists, nurse's and administration's relationships with patients. Improvement of health service in these areas is higher at the concession holder; the same applies for differences in mean less than 0.3.

Table 5
Evaluation of the changes in the services of the general physician after the adoption of the Law on Health Activities in 1992

		general physician	general physician
		public	concession holder
a) waiting lists	Mean Std Deviation	3.3 0.8	3.6 0.9
b) the prevention of contact between healthy and ill patients in the waiting room	Mean Std Deviation	3.1 0.4	3.2 0.6
c) equipment in a health centre	Mean Std Deviation	3.6 0.7	3.8 0.7
d) nurse's relationship with you	Mean Std Deviation	3.4 0.6	3.7 0.8
e) administration's relationship with you	Mean Std Deviation	3.3 0.6	3.6 0.7
f) information provided by the nurses	Mean Std Deviation	3.4 0.6	3.6 0.8
g) information provided by the administration	Mean Std Deviation	3.3 0.6	3.5 0.7
h) physician's sensitivity	Mean Std Deviation	3.5 0.8	3.6 0.8
i) physician's readiness to listen to the health problems	Mean Std Deviation	3.5 0.7	3.7 0.8
j) respect for privacy and dignity	Mean Std Deviation	3.4 0.6	3.6 0.7
k) speed of the treatment	Mean Std Deviation	3.4 0.7	3.5 0.7
l) success of the treatment	Mean Std Deviation	3.5 0.7	3.6 0.7

Dentist

For dental health care I analysed all three categories of users: in the sample we have 65 users of the public general physician, 40 users of the concession holder and 85 users that pay for services directly.

Table 6
At the dentist

		dentist	dentist	dentist
		public	concession holder	private
Did you assert the right to freely choose your own dentist?	I went to the first available d. or I stayed with the same d.	70.8%	42.5%	34.1%
	I chose a new /my own d.	29.2%	57.5%	65.9%
When making an appointment with your d. do they consider the seriousness of your health problems?	totally	66.2%	82.5%	88.1%
	partly	24.6%	12.5%	6.0%
	not much & they don't make appointments	9.2%	5.0%	6.0%
When making an appointment with the dentist do they consider which times are convenient for you ?	always	53.1%	72.5%	81.2%
	often	31.3%	10.0%	11.8%
	sometimes	7.8%	10.0%	4.7%
	never & they don't make appointments	7.8%	7.5%	2.4%
How is the admission process at your dentist carried out?	I am admitted exactly when I am appointed	21.9%	40.0%	52.9%
	I have to wait a little bit before I am admitted	70.3%	57.5%	45.9%
	they ignore waiting lists. other	7.8%	2.5%	1.2%
Did your dentist do everything he/she could for you?	totally	55.4%	60.0%	73.8%
	pretty much	35.4%	30.0%	21.4%
	partly	6.2%	7.5%	3.6%
	not much & not at all	3.1%	2.5%	1.2%
Did the handling of your problem meet your expectations?	totally	50.8%	59.0%	69.4%
	pretty much	38.5%	33.3%	21.2%
	partly	9.2%	2.6%	8.2%
	not much & not at all	1.5%	5.1%	1.2%
Do you have the same dentist as before the changes in health system?	yes	56.9%	37.5%	38.1%
	no	43.1%	62.5%	61.9%

In Table 6 I selected some of the general questions for the dentist as in Table 3 for the general physician. On the average, users of dental services changed their physician more often than users of the general physician. Most users of the public dentist remained with their dentist and only 29 per cent of them chose a new dentist. More patients of the concession holder chose a new dentist, a practice which is common for users who pay for their services directly - 66 per cent of them chose a new dentist.

Answers to whether patient appointments depended on the seriousness of their health problems are very favourable; the seriousness of health problems is considered very much at the private dentist (88 per cent), somewhat less at the concession holder (82.5 per cent) and even less at the public dentist (66.2 per cent). When asked whether consideration of times convenient for the patient play a role in making an appointment: the percentage of those who answered "totally" at the public dentist was 53 per cent, at the concession holder 72.5 per cent and at the private dentist 81.5 per cent.

In the admission process at the dentist the most common practice is that patients must wait for a bit before they are admitted. Surprisingly many expressed the sentiment, "I am admitted exactly at the time at which I am appointed"; most of these we see at the private dentist (53 per cent), 40 per cent at the concession holder and only 22 per cent at public dentist.

The following two questions present an overall evaluation of the dentist. When questioned as to whether the dentist did all he/she could for you, most respondents answered "totally": 55.4 per cent at public dentist, 60 per cent at the concession holder and 73.8 per cent at the private dentist. To the question of whether the handling of the problems met the expectations we discovered that most answered "totally" at the private dentist: at the public dentist this was the answer of 50.8 per cent of the respondents, at the concession holder 59 per cent and at the private dentist 69.4 per cent.

We also asked the respondents whether they were using the same dentist they had before the adoption of the Law on Health Activities in 1992. Changing dentists was a more common practice than changing general physicians. 43 per cent of the users of a public dentist changed their dentist, compared to approximately 62 per cent of the users of the concession holder and the private dentist.

The level of overall satisfaction with dental health services is very high. Users are slightly more satisfied with the concession holder and the private dentist than with the public dentist. Standard deviations are relatively small, which means that groups are relatively homogeneous.

Table 7
User satisfaction with health services at the dentist

How satisfied are you with		dentist public	dentist concession holder	dentist private
your dentist in general? (from 1 - "very dissatisfied" to 10 - "very satisfied")	Mean Std Deviation	8.7 1.4	9.0 1.6	8.9 1.5
a) the waiting lists?	Mean Std Deviation	3.7 1.2	4.1 1.0	4.3 0.8
b) equipment in the centre?	Mean Std Deviation	3.9 0.7	4.3 0.8	4.5 0.6
c) the nurse's relationship with you?	Mean Std Deviation	4.2 0.8	4.3 0.8	4.5 0.6
d) information provided by the nurses?	Mean Std Deviation	3.9 0.7	4.2 0.8	4.3 0.8
e) the dentist's sensitivity?	Mean Std Deviation	4.4 0.6	4.7 0.5	4.7 0.5
f) the dentist's attention to your health problems?	Mean Std Deviation	4.3 0.7	4.4 0.7	4.6 0.6
g) the respect for your privacy and dignity?	Mean Std Deviation	4.2 0.7	4.4 0.6	4.6 0.6
h) the quality of the health service at your dentist?	Mean Std Deviation	4.2 0.8	4.4 0.8	4.6 0.7

Legend: the first question measures satisfaction with health service in general; the scale of answers is from 1 (very dissatisfied) to 10 (very satisfied). Satisfaction with different dimensions of health service is measured on a 5-point scale: from 1 (very dissatisfied) to 5 (very satisfied).

Satisfaction with different dimensions of health service is relatively high: most replies are between 4 (satisfied) and 5 (very satisfied). In general the lowest satisfaction level is in reference to waiting lists and information delivered by nurses. It is interesting that the level of satisfaction in each area is higher for the concession holder than for the public dentist and for the private dentist higher than or the same as that for the concession holder. With such results we can conclude that the services of the private dentist are of a higher quality than those of the concession holder and the services of the concession holder of higher quality than those of the public dentist. Standard deviations

are small, which proves the homogeneity of user groups. The only discrepancies refer to waiting lists at the public dentist and the concession holder. It seems that privatisation does not successfully answer the problem of waiting lists.

Table 8
Evaluation of the changes in dental health services after the adoption of the Law on Health Activities in 1992

		dentist public	dentist concession holder	dentist private
a) the waiting lists?	Mean Std Deviation	3.2 1.0	3.8 0.8	4.0 0.9
b) equipment in the centre?	Mean Std Deviation	3.6 0.7	3.9 0.7	3.9 0.8
c) the nurse's relationship with you?	Mean Std Deviation	3.3 0.6	3.5 0.8	3.6 0.8
d) information provided by the nurses?	Mean Std Deviation	3.3 0.5	3.5 0.7	3.5 0.8
e) the dentist's sensitivity?	Mean Std Deviation	3.4 0.8	3.8 0.8	3.7 0.8
f) the dentist's attention to your health problems?	Mean Std Deviation	3.4 0.7	3.7 0.9	3.7 0.8
g) the respect for your privacy and dignity?	Mean Std Deviation	3.4 0.7	3.6 0.8	3.6 0.8
h) the quality of the health service at your dentist?	Mean Std Deviation	3.6 0.8	3.6 0.7	3.9 0.8

Legend: Respondents were asked whether these components of health service improved or worsened after the changes in the health system in 1992. Possible answers were: 1 - much worse; 2 - worse; 3 - the same; 4 - better and 5 - much better.

Users compared today's dental health services with those in existence before the adoption of the Health Activities Act and whether they had improved or worsened. All responses are between 3 (stayed the same) and 4 (improved). The slightest improvement refers to the waiting lists at the public dentist (mean 3.2); the most significant improvement also relates to waiting lists, but at the private dentist. In most areas the concession holder and the private dentist made greater improvements than the public dentist. The only area with a different tendency is the quality of services at the dentist;

it improved the most at the private dentist (3.9), whereas improvement in quality at the public dentist and the concession holder remained the same (3.6).

Concluding remarks

In this article I assessed the impact of privatisation on the quality of health services at the primary health level: at the general physician and the dentist.

Privatisation of heath services presents three categories of users of the general physician and the dentist, so the results were presented in groups. At the general physician, users who pay directly for the service are rare, so we analysed only two groups. On the average all users are satisfied with the health services at the general physician. Between the two groups of users those at the concession holder are more satisfied with the services of their general physician than users at the public general physician.

Users evaluated that for the most part, health services at the general physician have improved since the changes in the health system. Services improved more at the concession holder than at the public general physician but, with reference to the physician-patient relationship, improvement in services of concession holder and public physician is similar.

At the dentist we could compare all three groups of users. The level of satisfaction with the dental services was very high; the average falling between satisfied and very satisfied. However, it is very interesting that the level of satisfaction in all areas (except for dentist sensitivity) is higher for the private dentist than for the concession holder; and for concession holder, higher than for the public dentist. Such results suggest that privatisation in health care does influence the quality of health services.

Today, dental health services with all three types of providers are better than they were before the changes in the health system were initiated. The level of improvement is higher for the concession holder and the private dentist than for the public dentist. It is interesting that there are no differences in the level of improvement between the concession holder and the private dentist, except in the quality of health services. According to users, improvement in the quality of health services was the same for the public dentist and the concession holder and higher for the private dentist.

NOTES

1. The quality of a product (article or service) is its ability to satisfy the needs and expectations of the customers" (Bergman, Klefsjö 1994:16).
2. Quality as a scientific - technical quality: the level of application to care of the currently available medical knowledge and technology (Vuori 1982 :VII)
3. Appropriateness - relevance to need (Phillips at al. 1994 :19).
4. I selected only dimension with mean difference 0.3 and more.

REFERENCES

Bergman, B., and B. Klefsjö. 1994. *Quality: From Customer Needs to Customer Satisfaction*. London: McGraw Hill Book Company.

Dowling**,** M. 1997. "Measuring Quality in Personal Social Services?" Pp. 95-108 in *Developing Quality in Personal Social Services: Concepts, Cases and Comments* edited by A. Evers, R. Haverinen, K. Leichsenring and G. Wistow. Vienna: Ashgate, European Centre.

Drewett A. 1997. "Evaluation and Consultation: Learning the Lessons of User Involvement". *Evaluation* 3, (2): 189-204.

Pfeffer N.**,** and A. Coote. 1991. *Is Quality Good for You?* London: Institute for Public Policy Research..

Phillips C., C. Palfrey, and P. Thomas 1994. *Evaluating Health and Social Care*. London: The Macmillian Press LTD.

Pollitt, C. 1997. "Business and Professional Approaches to Quality Improvement: A Comparison of Their Suitability for the Personal Social Services". Pp. 25-48 in *Developing Quality in Personal Social Services: Concepts, Cases and Comments* edited by A. Evers, R. Haverinen, K. Leichsenring and, G. Wistow. Vienna: Ashgate, European Centre.

Roemer M. I., and C. Montoya-Aguilar. 1988. *Quality Assessment and Assurance in Primary Health Care*. Geneva: WHO Offset Publication (105).

Rus, V. 1997. "Privatisation of Social services" (Privatizacija družbenih dejavnosti). *Neprofitni management*, 1, (1): 1.

Saltman, R. B., and J. Figueras. 1997. *European Health Care Reform: Analysis of Current Strategies*. Copenhagen: WHO Regional Office for Europe (72).

Torres G., and S. Mathur. 1996. *Third Wave of Privatisation*. Washington: The World Bank.

WHO. 1988. *Priority Research for Health for All*. Copenhagen: WHO Regional Office (3).

WHO. 1996. *European Health Care Reforms: Analysis of Current Strategies*. Copenhagen: WHO regional Office For Europe.

Vuori, H. V. 1982. *Quality Assurance of Health Services*. Copenhagen: WHO Regional Office for Europe.