

Increasing Quality and Economic Efficacy of Health Institutions in Public and Private Sectors in Slovenia

MILAN PUKSIC, DARKO GORICANEC*

Pharmacies of Maribor

Minarikova 6, 2000 Maribor

*Faculty of Chemistry and Chemical Engineering,

University of Maribor

Smetanova 17, 2000 Maribor,

SLOVENIA

Abstract: The direct and indirect users of public financial resources face demanding tasks rising from demands for better quality and economic efficacy. Rationalisations and improvements of business processes, not only in healthcare, are the core of modern economy. Many papers describing those issues were published. Our paper presents the most important facts concerning quality and economic efficacy of public and private institutes providing health care. Both forms of institutes represent public health service with all their benefits and deficiencies.

Key-Words: quality, economic efficacy, rationalisation, quality management, health institutes

1 Introduction

All modern societies have enforced their efforts in ensuring high quality of public services in the last decades, pointing to services that have a high impact on the quality of life. These services include public health service as an activity that protects health and provides all levels of health care. Health is one of the most sensitive issues influencing our lives, resulting in demands for quality and efficacy of health service. A new philosophy of health care quality and new, more effective ways of its implementation in health care are evident in the organisation and performance of health services. Management of health institutes with full inclusion of all human resources plays the most important role in that philosophy.

The permanent following and implementation of modern theoretical findings and practical experience in quality of health service from highly developed environments to others is a key for successful development of all public services.

2 Philosophy and principles of quality in health service

Lack of information about recent developments in quality management and improvement of health service is one of the most important reasons for misunderstandings in planning and performing high

quality services in hospitals, health care centres and pharmacies. This results in partial quality management of health services (e.g. only quality of medical services or only financial issues or only supervision of one of the services is emphasised) without consideration to all other important quality factors (e.g. the satisfaction of users of health services). The quality management in the past was focused mainly on the quality of medical services and management [1]. It was based on the traditional comprehension of the exceptional and prestigious status of the medical profession and professionals without any possible influence of health care users. Modern approaches to the quality management in health care, described in this paper, include the above mentioned traditional ways and upgrade them with the significance of quality health service for the user. All relevant issues in health service should be equally covered with quality management.

Definition of the term 'quality of health service' is a complex procedure. Health service is a public service which differs greatly from other public services due to the following characteristics:

- unlimited demands for health services and limited financial resources,
- sensitive users of health services (clients) with a limited influence on the quality,
- presence of highly trained professionals,
- enormous influence on quality of life, and

- satisfaction of complex needs: expectations and demands of users (patients), demands of payers (health insurance companies, public financial resources), professional standards, and moral (ethical) standards.

Quality of health service is defined as 'fully meeting the needs of those who need the service most, at the lowest cost to the organisation, within limits and directives set by higher authorities and purchasers [2]. This definition emphasises three basic dimensions of quality:

- Client Quality,
- Professional Quality, and
- Management Quality.

These dimensions of quality are demanded from three interest groups, involved in the health care system: users, professionals (providers of services) and management. A full cooperation between these groups is a fundamental issue for a successful quality improvement of health services [3].

Harvey and Green have described the quality of health service as a transformational quality and emphasised the necessity of systematic monitoring of the responsiveness of all users of health services to the quality of services. Their idea is based on the proper understanding of demands for quality, expressed by different groups of users (patients and other direct users, their relatives and other indirect users) and on implementation of their demands in the process of quality management.

Joss and Kogan have also defined quality of health service as did Ovretveit [2] as three basic dimensions:

- Technical Quality,
- Systemic Quality, and
- Generic Quality.

Thorough comparison of both definitions shows that the term 'technical quality' denotes 'professional quality', 'systemic quality' includes all elements of 'management quality' and 'generic quality' is actually 'client quality'. However, the important difference between both definitions is in the description of users' impact on the quality of health services. Joss and Kogan's 'generic quality' principle allows users to exert influence not only on the outcome of health services, but also on their planning and performance.

A simple or more understandable description of total quality, in accordance with the definitions is as follows: Total quality (TQ) of a healthcare system is defined as an optimal provision of healthcare services accompanied with the lowest possible costs for the organisation and constant attention to

professional standards and ethical issues [5]. The term 'optimal provision' means provision of the best possible health care services to all users with the aid of professional judgement of their needs with full consideration for professional standards and ethical issues. The term 'lowest possible costs for the organisation' describes the lowest costs of one organisation calculated per unit of work in comparison with other providers of health care.

Different definitions of the term 'quality' create a slight problem in the implementation of quality in health care. However, we have to know precisely, what the term 'quality' means, in order to evaluate, measure, provide or improve it. That is a complex question which could be answered only by considering the needs and expectations of the three interest groups present (users, professionals and management) in the health system. Their needs and expectations are different and often in a conflict. The proper definition of quality in the health system has to take into consideration all specific characteristics of health services, interdependence of those services and client or user satisfaction as the final indicator.

2.1 Principles of Total Quality Management (TQM)

One of the most important issues covered in numerous publications is the development of new and more successful ways of quality improvement with the simultaneous decrease of non-quality costs. There are many more or less successful ways of improving quality present in practice. Joss and Kogan [4] have stated that the majority of mentioned programs fall into the scope of Total Quality Management (TQM). TQM is an integrated system of continuous quality improvement aimed at meeting external and internal customers. TQM has practically been proved to be the most successful system of a continuous quality improvement in health service in developed states in Europe and in the USA.

Ovretveit [2] defines TQM as a 'systematic and scientific approach to organisational improvement based on the training and stimulation of employees for the consistent use of quality methods in improving the quality of work processes, relations and results. Joss and Kogan [4] have described TQM as an integrative program of organisational changes, designed to enhance the culture of continuous improvement of quality and based on the definition of characteristics of quality as demanded from different groups of health care users. The concept of

TQM is also often described as the most successful way to realise a culture of continuous improvement of quality of all organisational processes (e.g. organisation, human resources, information), and not only the quality of medical services.

One of the crucial parts of the TQM philosophy is a complete dedication to quality and long-term accordance of all members of the organisation for a successful improvement of all systems and processes, clinical and non-clinical. The leading idea is continual improvement of quality of all systems and processes included in the health service.

Joss and Kogan [4] have described the process of TQM implementation in hospitals or other health care institutes in the following steps:

- First step: before-TQM diagnosis: ascertainment and resolving different views of quality
- Second step: changes to organisational structure. TQM supports the structure, which:
 - removes barriers between different functions and groups in the organisation,
 - enables and improves collaboration between managers and other professionals,
 - develops a multifunctional and multidisciplinary approach to the constant improvement of quality; and
- Third step: education and training of all employees for a more successful improvement of quality.

The execution of the first step demands thorough information about the existing system of quality based on the views of users (clients), professionals and management, plans for organisational changes and resources for the quality improvement. The second step encompasses the structural changes in the organisation in accordance with the basic principles of viability of organisation systems [5]. The third step includes learning processes about the philosophy and principles of quality, and methods and tools for the implementation of quality into all processes. This step also provides motivation for quality and enhances innovation of processes and systems.

It is difficult to expect the formation of the above mentioned processes and activities without proper incentives and the proper functioning of those processes without adequate resources. The TQM theory states that the implementation of structures and processes for the improvement of quality, assurance of suitable resources and expedient use of those resources lie in the jurisdiction of management. Managers on every management level in health

institutes and also in the entire health system are the main factors in ensuring suitable conditions for quality improvement. Those conditions are, for example, goals and strategies of quality which enable management and collaborators to consistently improve the quality of their work and consequently, the quality of health services. It is obvious that all important elements of the process of continual improvement of health care quality can not be included in this paper. It would be necessary to present modern managerial approaches to quality improvement, formation of quality standards, significance and methods of quality measurement, cases of business excellence and other activities for quality improvement in health care organisations and institutes.

We cannot avoid deep thoughts when considering the term, meaning and ways of quality improvement without resolving a complex question. This question refers to the proper time to commence with the systematic change of unsuitable behaviour which obstructs us from reaching our goals. A comparison with our own lives is obvious at that point. Did we always function properly and use all opportunities? Did we always make the correct decisions? The consequences could be irreparable. There is only one proper way of thinking and response: time for change is now, not in the unpredictable period in the future. Continuation of non-quality behaviour reflects in negative results in our personal and business lives.

2.2 Availability of private funds and motivation of private investors

The policies of developed countries are directed at the transfer of production of public benefits and services from the public to the private sector in order to enhance private investments. Private investors may aid the public sector to improve in improving the performance of public services. The role of private investors though may be questionable. Do they have adequate financial resources to support the public service? Many private investors only wish to invest with work, becoming a concessionary to perform one of more public services (health care professionals moving from public health institutes and becoming state concessionaries). On the other hand, those who want to invest their financial resources in the public service face a disheartening fact: public service is non-profitable. Investments in

public service are therefore less attractive and unpredictable.

2.3 Higher unemployment

Private providers of public services bear personal responsibility for business success. They tend to reach positive financial outcomes or otherwise face bankruptcy.

A purchaser of public services in Slovenia is the Health Insurance Institute of Slovenia. The Institute conducts its business as a public institute, bound by statute to provide compulsory health insurance. In the field of compulsory health insurance, the Institute's principal task is to provide effective collection (mobilisation) and distribution (allocation) of public funds, in order to ensure insured persons quality rights arising from the described funds. It establishes a contract with the private provider of health service which defines the extent of services and corresponding financial agreement. Private providers do not have a lot of manoeuvring space to increase financial gain from that source. Therefore, they tend to minimise costs. Health care is a branch with high work input and the working force presents the principal cost, which could be reduced. Many private providers of health care tend to perform the health care program with the minimal possible number of personnel. A certain number of health care professionals may become unemployed. The state tends to retain a certain level of health care services and therefore, defines the minimum requirements and conditions regarding human resources to provide health service.

2.4 Low competitiveness

Privatisation of public services is often connected with such terms as market, competition, competitors. Competition between public and private providers of health service should improve the quality, efficiency and decrease the costs of providing required services. Those expectations are exaggerated. The level of competition is lowest in the public sector and some services, including health service, function in conditions close to monopolistic.

How can providers of health care services become competitive? What should be the main subject of competitiveness? Companies compete on the market with products that are not offered by other manufacturers, have better properties, high quality and a lower price. How can this

competitiveness be successfully transferred to the providers of health services, e.g. physicians? All specialists in one medical branch in the entire public health system offer similar services for the same price, defined by the contract with the public purchaser (health insurance company). Even the quality of the services may be similar with regard to whether the providers were educated and trained in the same way and at the same institutions.

It couldn't be otherwise. The 'market' for public health services is organised and strictly regulated by the state. The state should fulfil the public needs of health services and enable equal accessibility of public health services on the predefined level to all residents. There is only so called 'public competition' on the fictive market of health services. Public funds are equally dispersed to the providers of health services and defined by contracts [6-9]. The competitiveness may only be apparent in the promises of certain providers to perform better service for the same amount of money, but it rarely occurs. Providers may only be competitive in the additional, non-medical services: kindness of the personnel, quality of hospital housing, patient counselling, etc.). Private providers may thus have a huge advantage.

2.5 Prices of public services

Private providers of health care services perform a non-profitable public service, however they tend to maximise their incomes in comparison with their colleagues in public institutes [10]. Private providers implement constant pressure on the public purchaser and demand higher prices for their services or higher payments for certain elements of the service cost (cost of work, materials, equipment). They may increase their incomes with the provision of payable services (from private patients), but face the limitations of human psycho-physical abilities. Overload of personnel may result in mistakes with severe consequences.

Private providers tend to form influential professional associations in order to a gain stronger negotiating position towards public purchasers and health insurance companies. Their influence and persistence often results in higher prices for health care services [11].

2.6 Establishing business relations

The biggest problem accompanying the private provision of public services is the establishment of business relations between private providers and public purchasers. The motives of both sides are entirely different. The public sector tends to offer equal health services to the entire population in accordance to the accepted standards (financial and quality) and constitutional or legal rights [6]. The main goal is a righteous dispersion of a public good (health care). The private provider, on the other hand tends to have maximal financial success and a resulting profit. He wants to be independent and swift in his business decisions and development. It is necessary to point out the importance of a good relationship between public purchasers and private providers of health care which may reduce the costs of public health care programs.

3 Provision of health service

Health service may be provided by the state as a public service (public health service) directly or indirectly, through public health institutes. The state may transmit the public service to the private providers (concessionary public health service). This results in both public and private providers of health services in a public health system [12].

The development of private health services (concessionary!) depends on the answer to the basic developmental question: Which health services should be transmitted to private providers? Generally, all services are open to the private initiative. The health policy makers should decide who provides better and more beneficial health care funded from public resources [13]. Their decision should base on such factors as efficacy, cost limitation, equal accessibility to users, user satisfaction and relationships between purchasers and providers. Two other measures may include the professional independence of the provider and low priority of the service (e.g. non-emergency transport of patients). The professional independence of the provider, meaning the provision of a wide range of medical services in one place, is definitely a benefit.

Concessionary public health service has certain disadvantages and certain benefits. The determination of a benefit or non-benefit depends on the standpoint of the observer.

Benefits of private providers of public health services may be the following:

- private investment in the material resources of the public health system,
- more providers result in a wider choice of general practitioners (so called 'personal physicians' in Slovenia),
- higher work productivity, short waiting period for certain medical services,
- higher level of total quality as seen by the client (kindness, short waiting period, patient counselling),
- competition between providers,
- high financial and business independence (better work organisation, efficient use of resources, lower costs),
- stimulating salary, and
- responsibility for their own financial success.

Deficiencies of private providers may be as follows:

- stimulation of curative procedures (before preventive services),
- poor access to the health services and worse supervision of the service quality due to geographic region (Slovenia),
- combining of public and privately financed services (use of public resources for private purposes, not defined in a contract with the public purchaser),
- different financial goals from the public purchaser,
- poor responsiveness to the needs of public health system (e.g. no cooperation with public providers when night and emergency services have to be performed),
- limitation of accessibility to users (e.g. rejection of patients demanding expensive and long-term treatment, different approaches to patients),
- performance of unnecessary treatments financed from public resources, and
- illegal service fees (e.g. supplementary payment demanded from the patient).

Private providers of health care are an important factor in the public health system despite their deficiencies. The health policy of Slovenia will be aimed at the consistent improvement of their benefits and reducing their deficiencies. Otherwise, the privatisation of the public health service may become unsuccessful and unnecessary.

4 Conclusions

Quality and development of health care services is constantly improving. The use of incremental and breakthrough quality management techniques to constantly improve processes, products, or services provided to internal and external customer and thus achieve higher levels of customer satisfaction. On the other hand, needs for those services are increasing due to the ageing of the population. Financial resources to cover the health system's costs are more or less limited. All possible steps towards higher quality and rationalisation of health services have to be considered and correctly implemented. Privatisation of a public health service may be one possible step in combination with a thorough consideration of all benefits and deficiencies.

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