THE OWNERSHIP FORM OF HOSPITALS FROM THE VIEWPOINTS OF ECONOMIC THEORY AND SLOVAK PRACTICE

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Introduction

The issue of the ownership form of hospitals frequently crops up in political discussions in Slovakia and surrounding countries. Health Minister Zajac`s 2004 reform (Pažitný [30]) was strongly based on the assumption that private ownership is the best solution. The Law on Health Care Providers, Medical Staff and Professional Organizations in the Health Service Sector (Nr. 578/2004) decreed that all state providers should be transformed into private companies. The current Slovak government is trying to reverse this step, despite proposing a range of ownership forms in its programmatic statement. As it must respect the rule of law, its attempts are indirect, such as the decisions on the minimum network of providers, and promoting state-owned academic hospitals.

In the Czech Republic the differentiation of political interests is even more visible. The Social democrats have tried several times to stop any hospital privatisation. In 2005 they passed an amendment to the Law on Public Health (Nr. 5/2005) to stop privatisation. The Council of Regions successfully appealed this amendment at the Constitutional Court, and the privatisation continued, supported by the then prime minister Topolanek`s government.

The New Public Management theories from the end of the last century advocated privatisation. But more recent governance and public-private-civil sector mix and cooperation approaches suggest reasons for a range of ownership models (Pollit and Bouckaert, [31]). For example in the UK most hospitals are public, but in the Netherlands they are private.

The goal of our paper is to examine the issue of the ownership of hospitals from both theoretical and practical Slovak perspectives. Our main research questions are as follows:

1. How does economic theory deal with hospital ownership?
2. What is the actual Slovak situation? Is there any evidence that would favour public or private ownership?

The answers to these questions provide the basis for deciding whether the hospital ownership issue is an important reform question, or whether it is better described as a convenient ground for party political fights to attract voters - like the issue of co-payments?

The basis for the theoretical analysis is modern neoclassical public economics represented for example by Samuelson [32], Stiglitz [43] and Musgrave [24], and by local authors Malý [22], Ochrana [26], [27], [28] and others. But we briefly also note other points of view. The second part of the article is empirical, and examines the effects of different forms of hospital ownership using available Slovak public source data. Standard qualitative and quantitative research methods are employed.

1. Current Neoclassical Economics and the Ownership in the Public Sector Issue

Ownership issues in the public sector have long been discussed. There are several distinct views: e.g. a middle ground neoclassical strand, a liberal view, and also left wing approaches. The core questions are the importance of ownership form, privatisation, and performance comparisons across organisations with different ownership forms.

Most "Anglo-Saxon" authors do not present public ownership as the main feature of the public sector, but to compare performance across organisational forms define the public sector by func-

tions (Stiglitz [43], Bailey [2], Cullis and Jones [6], Brown and Jackson [4], Apgar and Brown [1], Musgrave [24]). Also international statistics define a public sector activity as one with more than 50 % public financing, rather than by asset ownership.

The issue of the relations between the ownership form of an organisation and its service delivery performance has been widely investigated (Cullis and Jones [5], Knapp and Missiakoulis [18], Kay and Thompson [16], Stiglitz [34], Dawer and Christensen [9], Weisbrod [43], Yarrow and Jasinski [42]). Their studies supply no simple answer. For example Cullis and Jones ([5], p. 169) argue that the level of competitiveness, not ownership, is the most important determinant of performance.

Cullis and Jones ([5], [6]) are crucial for understanding privatisation theories in the public sector. According to them, privatisation can only be assessed by complex analyses that fully reflect all the conditions that determine the performance of public sector economic bodies. Changing public monopolies into private ones will not in itself deliver improved outcomes. Privatisation is therefore not a goal in itself, but could be justified to improve performance. They advocate a wider definition whereby any change in public sector delivery form, for example in ownership or financing, that raises efficiency and effectiveness, can be understood as privatisation. The most important implication of this is that any decision on changing public service delivery arrangements should be based on a careful case by case evaluation of concrete socio-economic conditions, and not on subjective ideas and preferences.

Cullis and Jones, and other authors such as Osborne and Gaebler [29], laid the base for the current approach of "middle stream" public economics which employs concepts such as "public governance" and "public-private-civil sector mix, partnerships, competition and cooperation". We ourselves follow this approach. The basic concepts of such an approach are set out in Table 1, and derive from answers to the two core questions.

1. How do we produce public/collective services?
2. How do we pay for them?

As noted, there is no ubiquitously valid answer to these questions: only specific answers in particular conditions.

In addition the above authors make an important distinction between the terms private hospital and privatisation of hospitals. Privatisation that just involves a change in ownership may simply involve a switch from public to private production of public goods, if they are delivered by a public service delivery arrangement. If such a change does not involve a switch to full private financing and deregulation, the service still remains public.

The issue of ownership is also dealt with by liberal and "left wing" theories. But currently all such strands of thought have only marginal influence. For example the very limited popularity of proposals to privatise via ownership change reflects the circumscribed success of the New Public Management (NPM) approach. Current analyses (Pollit and Bouckaert [31], Lane [21], Coobes [7], Cooper [8]) clearly show some positive achievements for the approach. But the extensive achievements expected from New Public Management based changes were not fulfilled. Drechsler and Cattel [10, p. 95] go even further – their evaluation for our region is simply, "Adieu NPM".

In conclusion we need to stress the role of public choice theory, which may help explain why issues of only marginal influence may become so important to society.Public choice theories were presented by authors like Buchanan, Arrow and many others from the second half of the last century. They represent important steps towards an economic explanation of the nature and failures of political processes. With some simplification we may summarise the main assumptions of public

Tab. 1: Production and financing of public - collective services

Resources		Production
- private - mixed - public	**Public - collective services**	- private - pluralistic - public

Source: authors, drawing on Bailey [2] and on Cullis and Jones [5].

choice theory as follows (see e.g. Mueller, 1979). All important expenditure decisions (including health care reform) are decided by collective voting, which is significantly imperfect. Politicians and bureaucrats are predominantly rent seekers, and protect their own, not the public interest. Their main strategies are re-election (politicians) or increased budget (bureaucrats). To be re-elected, politicians may make popular, but economically unnecessary (Pareto non-optimal) decisions to attract extra voters. In such a world political decisions can be entirely different from domestically desired actions.

To sum up: theoretical considerations suggest that -

a/ The question of ownership of hospitals is not a core problem for current (neoclassical) public service delivery theories.

b/ The main determinant of the performance of public organisations is the level of competitiveness and not ownership. However, simultaneously the literature stresses that the level of competition in the hospital sector will always be very limited (Bjorkman [3]).

c/ Concrete decisions on ownership need to reflect specific conditions. Changes are appropriate only in situations where benefits from change clearly overweight the costs of such change.

d/ Public choice theory helps to explain why some "marginal" economic questions may become issues of top political importance.

2. Ownership Forms of Hospitals in Slovakia and the Analysis of Main Aspects of Their Performance

In this second part of our article we try to answer the question of the optimum ownership form of Slovak hospitals using actual performance data. But from the start, be aware that there is little available relevant data.

2.1 Current Situation

The 2004 health care reform and subsequent actions created a really interesting hospital ownership structure (Table 2).

In 2007 there were 89 public hospitals and 83 "other" hospitals. State hospitals are those where the "owner – establishing body" is a state body, whereas public hospitals are these, where the "owner – establishing body" is a regional or local self-government. The other possible forms are private company or non-profit organisation. However, all hospitals in Slovakia, including private companies, are predominantly financed from public insurance. This means (see above text) that there are no hospitals that are both privately owned and funded. So our analysis will only use the terms public hospitals, including state and self-government hospitals (87) and non-state hospitals (83).

Tab. 2: Incidence of hospitals by ownership and region (2007)

Ownership	Western Slovakia			Central Slovakia		Eastern Slovakia		Brati--slava	Total
	TT	TN	NR	BB	ZA	PO	KE		
State – Ministry of Health establishments	4	3	6	13	6	8	11	10	61
State – other state bodies` establishments	0	1	0	0	1	2	0	2	6
Public – regional or local self-governments	4	4	2	2	5	3	1	1	22
"Other" (profit and non-profit companies)	4	8	6	14	5	21	11	14	83
Total	12	16	14	29	17	34	23	27	172

Source: Ministry of Health

Explanations: TT – Trnava, TN – Trencin, NR – Nitra, BB – Banska Bystrica, ZA – Zilina, PO – Presov, KE – Kosice regions

2.2 Measuring Hospital Performance

Health economics and health practice provides no perfect measure of health providers` performance (Figueras, Robinson, Jakubovski [12]). Here we employ the World Health Organisation`s methodology (WHO [43]), which evaluates health systems on the basis of fairness, effectiveness and health status (medical quality). Because of space and data limitations the main part of our later analysis focuses on effectiveness.

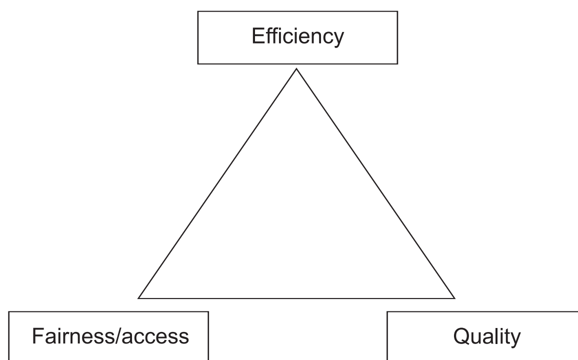
Important trade-offs between these three dimensions are shown in Figure 1. Given limited resources the trade-offs imply that almost any macro-level health sector decision represents some kind of a compromise between competing goals.

Productivity of labour in public and non-state Slovak hospitals

Using data directly obtained from hospitals willing to co-operate (from a planned random sample) we show labour productivity from the beginning of privatisation in 2005 to 2007. Labour productivity is measured as the ratio of total revenues from health service delivery (reimbursement plus direct payments) to number of employees. The anonymous, sometimes incomplete results for eight hospitals are summarised in Tables 3 and 4.

The results do not provide clear picture. Higher productivity is achieved by public hospitals, possibly from scale economies and better initial positions; but average productivity growth is greater for non-state hospitals (Table 5).

Fig. 1: "Magic triangle" of health care



Source: authors` construction

Efficiency – Economic Performance of Hospitals

It might be thought that because all Slovak hospitals are predominantly publically financed, assessing economic performance using public data will be a simple task. This is far from the case. So we had to use fragmented data published in the media and to undertake our own field research. This required us to narrow our focus to a comparison of productivity and financial results (debts). Our research sample is relatively small and selected from hospitals that were willing to co-operate. Because the number of hospitals in the different ownership forms is too small, standard statistical testing of sample validity is impossible. Hence all data have an illustrative and not a statistically representative character.

It is clear that we are unable to provide any definitive answers, not least because our sample is too small. However the productivity data gives little impression that it is determined more by ownership form rather than by the hospital managements` approaches.

From the point of view of management, non-state hospitals are in better situation, as they have more freedom (see also next section) to determine their cost and revenue structure – to influence the so-called "case-mix". In the conditions, where payments from insurance companies are not based on real economic figures, but only on rough estimates (see for example Maly [22] or Pazitny et al. [31]) some treatments are more "productive", some less effective. Small non-state health establishments with flexible and effective

Tab. 3: Labour productivity in public hospitals (H) 2005-2007

	H1			H2			H3			H4		
	2005	2006	2007	2005	2006	2007	2005	2006	2007	2005	2006	2007
Revenues [Sk]	127524	141785	174130	2720335	2736890	X	1084383	961038	X	689950	707179	X
PPEPP [persons]	224,2	228,1	241,3	4262,3	4260,1	X	1913,2	1874,1	X	1465,1	1450,2	X
PP [Sk/ person]	569,3	621,86	722,53	638,28	642,46	X	566,85	512,83	X	470,96	487,71	X
	H5			H6			H7			H8		
	2005	2006	2007	2005	2006	2007	2005	2006	2007	2005	2006	2007
Revenues [Sk]	815352	885586	1079808	611835	648981	X	393051	427606	596867	430012	451774	X
PPEPP [persons]	1619,1	1608,2	1595,2	1324,3	1330,1	X	1329,1	1308,2	1287,3	1189,1	1170,1	X
PP [Sk/ person]	503,61	550,74	677,00	462,11	487,96	X	295,75	326,91	463,77	361,66	386,13	X

Source: Authors` research

Explanations: PP: productivity of labour
PPEPP: average weighted number of employees

Tab. 4: Labour productivity in non-state hospitals (SN) 2005-2007

	SN1			SN2			SN3			SN4			SN5		
	2005	2006	2007	2005	2006	2007	2005	2006	2007	2005	2006	2007	2005	2006	2007
Revenues [Sk]	63902	72891	83029	63751	60000	X	54456	58716	64367	492138	524068	615095	136025	272043	X
PPEPP [persons]	223,3	180,3	181,1	158,2	158,3	X	179,3	166,1	152,2	912,3	918,2	926,2	664,3	692,1	X
PP [Sk/ person]	286,56	405	461,27	403,48	379,74	X	304,2	353,71	423,47	539,63	570,88	664,25	204,86	393,13	X

Source: Authors` research

Explanations: PP: productivity of labour
PPEPP: average weighted number of employees

management systems have the opportunity to react to these deficiencies and to select a profitable profile for their activities; large regional or teaching hospitals must treat the rest, regardless of the impact on their economic performance.

Hospital financial performance (debts)

We assess financial performance by its crucial dimension – debts. The Ministry denied us comprehensive data, so we show only partial media-provided statistics (Table 6).

Ministry of Health data clearly show the critical situation of state hospitals. At the end of 2007 this group owed creditors 5,842 bil. Sk (about 5 % of total health care expenditures in Slovakia in 2007), and their financial situation is continuing to deteriorate. The largest creditors are drug suppliers – 55.4 %. Other creditors include gas, energy and water suppliers – 8.4 %; works suppliers 5.9 %; and other suppliers 11.5 %. State hospitals also owe money to other hospitals and to insurance companies. They are also late in paying their

Tab. 5: Indices of labour productivity and labour costs 2005, 2006 and 2007

	Productivity			Labour costs		
	06/05	07/06	07/05	06/05	07/06	07/05
H1	1,09	1,16	1,27	1,19	1,28	1,52
H2	1,01	x	x	1,03	x	x
H3	0,90	x	x	1,12	x	x
H4	1,04	x	x	1,08	x	x
H5	1,09	1,23	1,34	1,12	1,19	1,32
H6	1,06	x	x	1,14	x	x
H7	1,26	1,42	1,57	1,14	1,30	1,47
H8	1,07	x	x	1,14	x	x
SN1	1,41	1,14	1,61	0,90	1,13	1,02
SN2	0,94	x	x	0,90	x	x
SN3	1,16	1,20	1,39	1,04	1,11	1,15
SN4	1,06	1,16	1,23	1,08	1,16	1,25
SN5	1,92	x	x	1,90	x	x

Source: Authors` research

Tab. 6: Cumulated external debt of hospitals (unpaid commitments) from 1.1.2005, mil. Sk)

	31.12.2005	30.6.2006	31.12. 2006	30.6. 2007	31.12.2007
State hospitals	2 033	2 887	4 435	5 155	5 842
Hospitals transformed into companies	x	15	14	21	6
Hospitals “owned” by self-governments	2 384*	2 342*	2 275*	2 094*	1 960
Non-profit hospitals	x	x	x	x	194
Deficit total	5 634	5 523	6 821	7 292	8 074

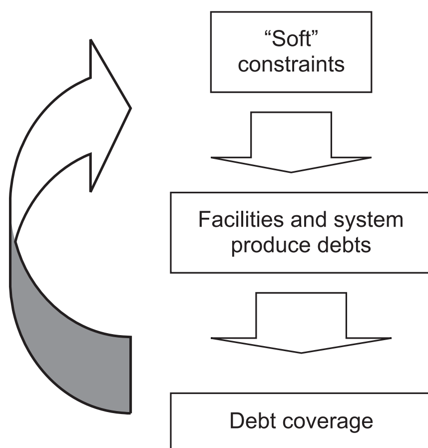
Source: Správa o vývoji dlhov v rezorte zdravotníctva k 31. 12. 2007

* including non-profit hospitals

social contributions – their unpaid commitments to the public monopoly responsible for the pension system – the Social Insurance Company - represented 15 % of their total debt (MZ SR [44]). Published data also exclude so-called “old debts”: debts transferred under the previous government from hospitals to the Veriteľ (Veritel was the Dzurinda government`s purpose-made public company responsible for managing then existing hospital debts). For example in December 2006 such debts were put at 468.5 million Sk.

Self-government hospitals are also in debt, but their trend, which shows a small nominal decrease, is much more positive. The best situation is in the non-state hospitals sector, which has balanced financial results.

Fig. 2: "Soft budgetary constraints"



Source: authors` construction

Debt data has been misused by some "experts" to promote privatisation. But we feel that the reason for the variations is not the ownership type, but the form of budgetary constraints (cap). State hospitals have so-called "soft budgetary constraints", incentivising them to create debts, as indicated in Figure 2.

Further evidence for such policies is the fact that the size and type of hospital significantly correlate with their financial performance. Every large academic hospital delivering universal and specialised services is indebted - Fakultná nemocnica s poliklinikou Bratislava, Fakultná nemocnica s poliklinikou Banská Bystrica, Fakultná nemocnica s poliklinikou Košice, Fakultná nemocnica s poliklinikou Prešov, Fakultná nemocnica Trnava. But small and specialised state hospitals are in good financial health - Fakultná nemocnica s poliklinikou Nové Zámky, Národný onkologický ústav Bratislava, Národné rehabilitačné centrum Kováčová, Inštitút nukleárnej a molekulárnej medicíny Košice, Detská fakultná nemocnica s poliklinikou Banská Bystrica.

2.3 Quality of Health Services

It is relatively difficult to measure the quality of hospital services. And unfortunately there is no systematic public data available on it. Here we will try to estimate the clinical and organisational quality of delivery of hospital services (Kuvíková, Murgaš, Nemec [20]) using selected implicit indicators: the structure of complaints submitted to the Health Care Surveillance Authority (www.udzs.sk) and quality rankings.

Tab. 7: Complaints received by the Health Care Surveillance Authority 2006 – 2008

	Complaints received	Authority decision		Number of complaints against academic hospitals
		Valid	Invalid	
2008	1431	148	613	901
2007	1226	146	530	720
2006	1263	209	535	664

Source: Health Care Surveillance Authority, 2009

A system of "soft budgetary constraints" can also be attractive to the state. It allows it to ask directly managed hospitals to deliver health services independent of finance. Most commentators think that the level of reimbursements for most diagnoses is below the existing treatment costs. An example was the situation in Banska Bystrica academic hospital in 2008. The hospital director introduced a "crisis regime" to cap debts. But the Minister of Health immediately asked him to cancel all his new internal regulations limiting the level of "free" patient services.

Patients´ complaints

Our original idea was a comprehensive evaluation of the purposes of complaints and of addressees of complaints submitted to the Health Care Surveillance Authority. We did not anticipate a problem because the full list of complaints and the Authority's opinions on them was originally publicly available. However, this practice has been discontinued and we had to ask the Authority for data. The response from the office responsible for regulating of the health system and its quality was a refusal to provide any com-

parative data. It claimed such data was not held in a form that allowed a comparative analysis (this situation suggests that the Office as the public (transparent) regulator is failing in its duty, and has fallen under political influence). We received only a limited sample of partial data (Table 7).

The data in the Table 7 indicate that a majority of complaints relate to the quality of care in academic hospitals. They also show that the Authority is not able to provide timely decisions. As academic hospitals provide about 40 % of all treatments and deal with the more complicated cases, where complaints are more likely, we feel the data does not clearly indicate quality variations by type of hospital.

Quality rankings

According to the current legislation (Law 581/ 2004 as amended), quality rankings of health establishments are compulsory, and health insurance companies are required to construct them as a basis for contract negotiations with providers. Under such regulation it may seem obvious that ranking systems provide effective quality benchmarks. But again we found a different reality.

Health insurance companies respect the law and construct rankings, but their attempts are uncoordinated and their criteria differ. Table 8 provides examples of such rankings. The first is from 2007 for the company Dôvera. Its main criteria are the general level of health service quality; the complexity of services and departments; personnel; equipment and the position of the hospital in its region. This approach focuses on capacities and availability of services; real clinical quality is not effectively incorporated. The second 2007 ranking is by the largest provider – the General Health Insurance Company. It was constructed using indicators on the management of chronic diabetes; the management of chronic pneumonia; non-planned readmissions of patients after day surgery; and patients` satisfaction surveys. The final ranking was constructed in 2008 by a consortium of insurance companies - Apollo, Dôvera and Union. It was based on patients´ satisfaction surveys, with twelve questions focusing on satisfaction with medical staff approaches and behaviour, satisfaction with care and its results, and satisfaction with support services (catering, accommodation and cleaning).

Tab. 8: Selected quality rankings

Order	Dôvera	VšZP	Apollo, Dôvera and Union
1.	FNsP Bratislava	Ľubovnianska nemocnica, n. o.	FNsP Milosrdní, s. r. o. Bratislava
2.	FN J.A. Reimana Prešov	Nemocnica Zdravie, s. r. o. Púchov	Nemocnica, a. s. Šaca – Košice
3.	FN L. Pasteura Košice	Nemocnica, s. r. o. Krompachy	Nemocnica Zdravie, s. r. o. Púchov
4.	NsP Žilina	NsP Dolný Kubín	Ľubovnianska nemocnica, n. o.
5.	FNsP Nové Zámky	Nemocnica Stropkov	Nemocnica, s. r. o. Bánovce
6.	FN Nitra	Nemocnica, s. r. o. Handlová	Nemocnica, n.o. Kežmarok
7.	MFN Martin	VšNsP. A. s. Levoča	Nemocničná a. s. Malacky
8.	FNsP F. D. Rooswelta BB	Nemocnica, n.o. Kežmarok	Nemocnica, s. r. o. Handlová
9.	FN Trnava	Nemocnica, a. s. Šaca - Košice	NsP Hnúšťa
10.	FN Trenčín	NsP Ilava	NsP Snina

Source: own compilation from web pages of selected health insurance companies

Table 8 shows that different quality indicators tell different stories. If service complexity is the main issue, academic hospitals are superior, but patients feel better in smaller, non state hospitals. The negative message for our inquiry is that these existing quality rankings cannot be used to produce a comprehensive comparative analysis of performance.

2.4 Access to Health Care / fairness

The argument that privatisation decreases universal access is, together with the argument that private hospitals channel public health care resources into private pockets, one of the most frequents objections to private hospital ownership. However, our independent economic analysis suggests the problem is absent from Slovakia.

We have noted that Slovakia introduced a universal social health insurance system, guaranteeing all citizens have non means tested access to a basic package of health services. Almost all hospital treatments are financed by a health insurance system that covers all citizens. In such a system access is unrelated to the hospitals` ownership forms. If the treatment is approved by an insurance company, it will be provided.

Discussions about access in relation to ownership are in reality discussions about the priorities of the respective government. Different governments may opt for different priorities from three main dimensions of the "Magic Triangle" (Figure 1). For example:

a/ Governments focusing on access should prefer state owned and controlled hospitals. Only in such environments can they ask or order hospitals to provide more services than are actually reimbursed. Access is guaranteed but efficiency is sacrificed (debts increase).

b/ Governments focusing on efficiency should prefer non-state hospitals. These hospitals are at least semi-independent and must operate in more transparent financial environment with hard budgetary constraints. Rational non-state hospitals will deliver all ordered and reimbursed services, but may refuse any additional financially unsound demands. Thus efficiency may be secured, but access is limited by lack of available public insurance resources.

In any case, we can show that access to hospital services in Slovakia is unrelated to the ownership form of hospitals, and so discussions on assess are based on political and not economic grounds.

Conclusions

Our limited data indicate that there is no conclusive evidence on which hospital ownership form would suit Slovak conditions. We were not able to find any causal link between the ownership form and hospital performance. Observable differences can be explained by more obviously relevant factors.

Indeed the question is predominantly political. We need to recognise that public sector economics encompasses many questions that have no definitive answers. But some politicians and economists that want a different answer for ideological reasons will disagree. And given this fact it is clear we need to discuss ownership questions to prevent important implementation failures.

What are main results from our study? First, we provide important theoretical arguments that the ownership form of hospitals is not the main determinant of their performance. We also propose that decisions about hospital privatisation should take account of the concrete environment of the policy. In general the public-private-civil sector mix seems to be the most appropriate policy response to the issue.

The fact that our search for practical comparisons almost failed is also very important. It indicates that the current priority is non-transparency, which creates space for economic and political manipulations. In spite of lack of data, we feel that quality, accessibility and efficiency of hospital care in Slovakia does not depend ownership forms.

Why then is the issue of ownership so frequently discussed? Public choice theory comprehensively explains why this topic is really politically important. If, as in the Slovak case, voters are not well informed, then different political actors and interest groups can use the issue of hospital ownership to label themselves in the socio-political space, and consequently to attract more voters. This is not surprise: for example Stiglitz [34] (p. 188 and 299) provides well known economic/public choice explanations:

- Politicians decide on the base of own interest.
  Their main strategy is re-election.
- In democracy decisions on public expenditures are compromise between interests of different groups and such decisions normally do not respect outcomes from economic analysis.

Because the issue of the ownership of hospitals is dominantly political one, practical answers of concrete governments to it would be based on

political priorities. In conditions of limited resources trade offs between three basic choices (quality, access and efficiency) are necessary. Social government are expected to prefer to sacrifice efficiency and to achieve this they need to create centrally managed non-transparent hospital system. Liberal governments are expected to prefer efficiency and sacrifice universality of access, or at least fairness – as the "best" alternative, rich will receive better services, but access for poor still may remain guaranteed.

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ABSTRACT

THE OWNERSHIP FORM OF HOSPITALS FROM THE VIEWPOINTS OF ECONOMIC THEORY AND SLOVAK PRACTICE

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The marketization of public services, among them health care service aims at a continuous increase in public expenditure efficiency, continual improvements in public services quality, the implementation of the professional management tools in the public sector and developing the plurality system of ownership forms in public service delivering – privatization in public services.

Redefinition of the roles of the state and private providers, privatization in health care became a central theme of recent health care reforms in Slovakia. The debate about the pros and cons of privatization in health care is very intensive, though mainly at the political level. Some opponents still regard privatization as a policy simply advocated to cut back the role of the public sector in health care. But advocates of privatization believe it can raise effectiveness and quality.

Our article analyses the problem of Slovak hospital ownership. It begins with a brief theoretical overview of the key aspects of privatisation: predominantly from the viewpoint of neoclassical public economics.

The analytical part was intended provide a comparative analysis of performance of different types of Slovak hospitals. But the lack of publicly available data limits the scope and depth of our analysis.

Despite these limitations our article argues that ownership form is not the main determinant of hospital performance. We base this argument on both theoretical grounds and on our empirical evidence from Slovakia. In the light of this argument, we propose that decisions about hospital privatisation and its form, in spite of their dominantly political character, should respect concrete conditions and the specific environment. A public-private-civil sector ownership mix seems to be the most appropriate current response for Slovakia.

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