



Coordination practice

MINIMUM NETWORK OF PROVIDING IN-PATIENT HEALTH CARE IN SLOVAKIA

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The coordination practice deals with the issue of the physical access of patients to health services. In the Slovak system where most of the health-care providers are privately owned establishments and most of the health-care finances are in the hands of a network of competing (at least formally) public and private health insurance companies, the guarantee of physical access can be achieved only by high-quality coordination activities of state bodies on all levels. The Slovak solution to the issue of minimum physical access is to a large extent based on an interesting coordination tool – “the minimum network of providers”. This study investigates how such a minimum network is defined from the central level and how its existence is achieved on the level of self-governing regions in Slovakia. The results provide several important policy lessons with regard to the policy-making and implementation capacity of the Slovak government, complexity of coordinating pluralistic service-delivery system and pros and cons of intervention in the short-term perspective.



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Preface

This coordination practice is a result of research within COCOPS Work Package 5: The Governance of Social Cohesion: Innovative Coordination Practices in Public Management.

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The COCOPS project (Coordinating for Cohesion in the Public Sector of the Future) seeks to comparatively and quantitatively assess the impact of New Public Management style reforms in European countries, drawing on a team of European public administration scholars from 11 universities in 10 countries.

The specific objectives of Work Package 5 are:

- To search and identify emerging coordination practices and related steering instruments in public management in European public sectors.
- To compile a case study catalogue of such coordination practices with direct utility to public managers and the research community.
- To analyse the functioning of such coordination practices and to assess their value in countering public sector fragmentation and delivering public value.

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1. THE COORDINATION LANDSCAPE

Main country characteristics: SLOVAKIA

General political-administrative structure

The history of Slovakia as an independent country is relatively short. The Slovak Republic was established on 1 January 1993 as a result of the friendly break-up of former Czechoslovakia, following the major changes after the 1989 “Velvet Revolution”.

The Slovak Constitution was ratified on 1 September 1992 and became fully effective on 1 January 1993. The representative head of the executive branch is the President elected by direct popular vote for a five-year term. The executive head of the government is the Prime Minister. The Cabinet is appointed by the President on the recommendation of the Prime Minister. The legislative branch is represented by the unicameral National Council of the Slovak Republic with 150 seats. Its members are elected on the basis of proportional representation for four-year terms. The judicial branch is represented by the Supreme Court and the Constitutional Court.

Two tiers of self-government exist in Slovakia – municipalities and self-governing regions. In 2010 there were 2883 municipalities (including 138 cities) in Slovakia and eight self-governing regions – Bratislava, Trnava, Nitra, Trenčín, Žilina, Banská Bystrica, Prešov and Košice. The legal status of the city of Košice and of the capital, Bratislava, was regulated by special laws. Territorial fragmentation is a problem on both levels of self-government. On the one hand, the number of municipalities is extremely high and has increased continuously since 1989. On the other hand, municipalities are very small – 68% of municipalities were below 1000 inhabitants in 2011.

From the formal point of view the central administration has not changed much since 1990. The system of central state bodies was inherited from the Czechoslovak Republic and has not changed significantly. Most changes undertaken have been related to the accession to the EU and the need to establish required agencies (mainly regulatory) and offices. Even the splitting of Czechoslovakia in 1993 did not have a significant impact on the central administrative structure due to the fact that from 1968 on Czechoslovakia functioned on federal principles.

The central administration is coordinated by the Office of Government and consists of 13 ministries and 28 other central bodies of which 16 may be classified as independent or semi-independent agencies, responsible for regulation in a given area (for example Postal Regulatory Office). In some branches of administration, the ministry is responsible for all aspects of governing the sector, in others some regulatory activities are delegated to the agencies, for example in the transport and telecommunications sector.

During the entire period of independence the focus of administrative

	<p>reform has been on the regional and local levels. The changes on the subnational level have been frequent and significant. The core issues have been the organisation of deconcentrated state administration and the responsibilities of self-governments. The independent local self-government was established in Slovakia in 1989.</p> <p>Starting in 1996, Slovakia implemented a second wave of reforming the local administration. The reform was characterised by the parallel themes of a radical change of the territorial structures of state administration and the abolishment of specialised deconcentrated administrative offices. The result was the establishment of a uniform two-tier system of offices of general state administration with a broad range of tasks and responsibilities.</p> <p>After the general elections in 1998, the new liberal Slovak government initiated further decentralisation. Because of the requirements of the EU accession processes, the reform aimed to create and operationalise the regional self-government authorities. The later phases of this reform wave (after the 2002 elections) focused on decentralisation done by a massive transfer of competencies from the state to local and regional self-governments and a radical change of the local state-administration system. The realisation of the 2000-2005 decentralisation and fiscal-decentralisation measures created the current public-administration system in Slovakia, where local and regional self-governments deliver a large proportion of the public services. Although some responsibilities were transferred from the central government to the regions and municipalities, the core central structures remained unchanged in this case, as well.</p>
<p>Coordination discourse</p>	<p>The transformation from a centralised system ruled by one political party to the democratic system after 1989 was related to a significant increase in the importance of coordination activities and capacities of the state. During the early phase of transformation, the core area for coordination was the welfare system. The state decided to deliver the core welfare services (pensions, unemployment and health benefits) predominantly via independent public or semi-private bodies. The most radical change was connected to the health-care delivery system.</p> <p>The accession to the EU brought with it the need to create new coordinative mechanisms and to respond to the requirements of <i>Acquis</i>. The switch from direct provision to regulation was especially visible in the utility sector and public services. In most sectors the system of public-, private- and civil-sector mix has been established as the result of privatisation and de-monopolisation, with the state being responsible for its functioning – water, electricity, gas, transport, postal services, telecommunication services, personal social services etc.</p> <p>The public-administration system established before 2005 is still in existence without major changes today. Current public-administration changes focus on savings achieved by cuts of certain types of expenditures.</p>

	<p>The improved effectiveness and efficiency of performance of the public sector are not part of the mainstream discussions. Such a situation means that modern approaches to improving administrative performance are not discussed and implemented in the country as a rule.</p> <p>However, certain trends to switch from pluralistic schemes back to direct management have been visible since 2011. They are related to the return of the left-wing government and to the fact that citizens' trust in liberal ideologies and policies has almost fully disappeared. The most visible case is health care, where the policy to nationalise health-insurance companies was officially announced by the government in autumn 2012.</p>
Policy area	<p>The objective of pre-1989 Czechoslovakia was to provide a comprehensive system of health care for all members of society. Under the old system both services and medicines were free to the patients. Everyone was able to get appropriate health care at a relatively high international medical standard. However, until 1987, there was no individual choice of a practitioner.</p> <p>The processes of reforming the Slovak health-care system started immediately after the Velvet Revolution in 1989. Important changes were introduced to the system – especially privatisation and the shift in financing the health care from general taxation to the social health insurance. At the same time, the focus was also on maintaining universal access and assuring the “basic package” to all citizens regardless of their ability to pay.</p> <p>From the point of view of its administration, the Slovak health-care system can be described as decentralised. Due to the mixed ownership, the delivery and financing systems are administered and regulated at all levels of government. The Ministry of Health is responsible for health-policy development and implementation. It defines the network of health establishments, coordinates central health-care programmes and establishes academic hospitals and other specialised units. It is also responsible for training the medical staff and for the categorisation of medicines.</p> <p>The second central body is the Health Care Surveillance Authority, which was established in 2004. The main tasks of the Authority are to supervise the provision of health care and public health insurance as well as arbitration on the following levels of relationships:</p> <ul style="list-style-type: none"> - Health-insurance company ↔ provider - Ministry of Health ↔ provider - Ministry of Health ↔ health-insurance company <p>Regional governments are responsible for local hospitals and for the maintenance of a minimum network of health-care providers in the region – including licensing of all local and regional providers such as general practitioners, group practices, specialised ambulances and dental-care</p>

establishments. Municipalities have limited responsibilities concerning the local network of providers.

The privatisation of health care began in the mid-1990s, mainly in outpatient care and pharmacies, and was almost completed by 2012, except for the hospital level.

On the in-patient level the categorisation of hospitals has not changed during independence and remains as follows:

- Hospitals of the 1st type, providing basic in-patient care on the local level (normally located in cities up to 20,000 inhabitants, with few wards).
- Hospitals of the 2nd type, providing middle-level care on the sub-regional level (normally in cities with 20-40,000 inhabitants).
- Hospitals of the 3rd type, providing highly specialised care for almost all diseases and in most cases also serving teaching purposes (large cities).
- Specialised hospitals focusing only on specific diseases.

By 2003 all regional hospitals (hospitals of the 1st and 2nd types) had been transferred to regional self-governments or converted into non-profit bodies. The ministry remained responsible for 3rd-type hospitals and specialised hospitals.

With regard to the financing of the health care, Slovakia switched to the so-called "Bismarck" system of social health insurance in 1992, replacing the old general taxation-based financing. However, together with the Czech Republic, it decided to introduce a competitive social health-insurance system with the main goal to provide universal and equal access to high-quality health services to all its citizens.

Since 1993, most health funds have been transferred to the network of health insurance companies that collect the majority of their revenues via compulsory social health-insurance premiums. The health-insurance scheme for a large group of persons without regular income – a group representing about 3.5 million from a total of 5.5 million inhabitants – is financed from the state budget. Health-insurance premiums are redistributed among insurance companies on the basis of the structure of the insured.

Soon after the start of this pluralistic system 13 health-insurance companies were established. However, most of them left the market because of mergers or bankruptcies. In 2012 only 3 health-insurance companies operated in Slovakia – one fully public (General Health Insurance Company VsZP with about 70% of the insured) and two fully private health-insurance companies (Dôvera and Union).

The current status of health-insurance companies is the result of the radical shift to marketisation of the health-care system since 2005. The law on health-insurance companies transformed all of them into shareholder

	<p>companies. Formally, all insurance companies are independent from the state, and their activities are monitored by the independent regulator. In reality, almost full independence is true for the private companies, but not for the public one. Private insurance companies can make and use profits, provided that all their obligations are fulfilled. The state limits their administrative costs by percentage from total costs but cannot interfere with their managerial decisions.</p>
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2. COORDINATION PRACTICE: Minimum network of providing in-patient health care	
2.1. Substance	
Country	Slovakia
Area	Health care
Main characteristics of the practice	<p>The main principle of the Slovak health-care system is a universal and equal access regardless of the ability to pay and regardless of the place of living of the patient. The coordination practice deals with the issue of the physical access of patients to the health services. In the system where most of the health-care providers are privately owned establishments and most of the health-care finances are in the hands of a network of competing (at least formally) public and private health-insurance companies, the guarantee of physical access can be achieved only by high-quality coordination activities of state bodies on all levels.</p> <p>The Slovak solution to the issue of minimum physical access is to a large extent based on an interesting coordination tool – “the minimum network of providers” – access to the emergency care is regulated by the law on emergency service stipulating that every citizen has the right to rapid emergency service within a maximum of 15 minutes. The implementation of this “minimum network of providers” has two dimensions:</p> <p>a) the legal definition of a “minimum network”;</p> <p>b) the real establishment of a “minimum network”.</p> <p>Concerning the legal definition, the Health Care Act defines the “minimum network” as follows – “a minimum number of publicly accessible providers on the territory of a regional self-government set by the number and structure of providers necessary to effectively guarantee accessible, continual and permanent professional health care, reflecting number of inhabitants, geographical and demographical specifics of the region, mortality and morbidity indicators in the territory, migration and state security”.</p> <p>This definition of a “minimum network” is really complex, and it is not easy to convert it into real practice. The coordination practice discusses</p>

	different policy-making and policy-implementation aspects of the “minimum network” with focus on the regional level in Slovakia.
Background and initiation of the practice	<p>The principle of “minimum network” as a legal obligation is an interesting health-policy issue, both because of its contents and its implementation aspects. The establishment of the “minimum network” was largely a result of the last major health care reforms in Slovakia enacted in 2005. The new package of “semi-liberal” laws included also the issue of physical access to the health services. The law on emergency service stipulated that every citizen had the right to rapid emergency service within a maximum of 15 minutes. The law on health insurance not only transformed the health-insurance companies into shareholder companies, but also established new rights and duties for them in order to allow them to function as real regulators of the health-care system. Among many other issues, health-insurance companies became formally co-responsible for securing the minimum network of health facilities.</p> <p>The law on health care and health-related services and the law on the scope and financing of health care defined the state’s main responsibilities in relation to the “minimum network” as follows, concerning the in-patient care:</p> <p>a) the central government was responsible for establishing and keeping the minimum network of hospitals of the 3rd type;</p> <p>b) self-governing regions were responsible for the minimum network of hospitals of the 1st and 2nd types.</p> <p>However, the new legal norms did not define any tools or instruments for the implementation of this broad definition of the “minimum network” into practice and did not provide any guidelines concerning this policy.</p>
Time frame	<p>On the basis of the set of health-care laws from 2004 the Ministry of Health and all the self-governing regions became the main bodies responsible for assuring the minimum network of providers. During the initial years of health-care reform not much happened, because of unclear legislation and political changes in the government. The “minimum network” was not a priority at the beginning.</p> <p>The original focus of this practice was to assure physical access. However, in the process of implementation, the goals of the practice changed and the focus moved to the lack of resources and the too high number of hospital beds in Slovakia (app. 900 beds per 100,000 inhabitants, two times more compared to the developed countries’ figures). The government decided that the “minimum network” equalled the real network and started to implement this principle also in practice. In late 2007, the Ministry of Health published the first concrete data defining the “minimum network” for in-patient care for all types of hospitals (proposed structure of wards and numbers of beds for each of them). However, the ministry never revealed how its data had been calculated.</p>

	<p>From 2008 on the Ministry and the self-governing regions have negotiated with the health-insurance companies in order to motivate them to change their reimbursement patterns towards not financing the “redundant capacities”. Both the Ministry and the regions have also been expected to set some transparent rules for building the “minimum network”.</p> <p>New central data on the “minimum in-patient network” were published by the ministry in 2011, further tightening the expected structure. The process of optimising the in-patient capacities is still on-going but the first results are already visible.</p>
<p>2.2. Structure and actors</p>	
<p>Basic features</p>	<p>With the 2005 reform, the Ministry of Health became responsible for guaranteeing the “minimum network” of hospitals of the 3rd type serving the most complicated cases. This task was relatively simple from a technical point of view – because of the existing system of hospitals there was no need to establish new hospitals. Because the system existed already, their task was just to choose which hospitals to include to the minimum network.</p> <p>In addition, the Ministry of Health was also expected to provide implementation guidelines for the regions in order to help them to convert the broad legal definition of the “minimum network” into practice. It did not deliver any guidelines, besides detailed data from 2007 that addressed the minimum network as the existing network. The latter made the situation very complicated on the regional level. The focus of the issue switched from creating and implementing regional health-care policies to the goal of decreasing the number of existing hospitals in the region in a way prescribed by the Ministry. As at the start of the reforms in 2005 the main goal of the minimum network was to secure a certain minimum level of equality of access to the health-care system consisting of dominantly privately owned providers, the overcapacity was not an issue. Before the financial crisis, the role of the regional governments was just to assure that the “minimum existed”. After the financial crisis it became necessary to cut the excessive numbers of beds on all levels of hospitals in Slovakia. On the hospital level, the semi-official rule that the “minimum network” equalled the real network started to be applied and the “minimum network” principle became the tool to optimise the number and allocation of beds.</p>
<p>Main tools</p>	<p>The tools available for assuring the minimum network of providers have been very different for the Ministry compared to the regions. Especially so after 2007 when the Ministry published its data on the existing network.</p> <p>The Ministry of Health is coordinating the hospitals of the 3rd type and nominates the directors of all such hospitals. In performing the function, it has both horizontal and vertical tools to use.</p> <p>The ministry has some informal vertical power also in relation to the public-</p>

	<p>health insurance company VsZP, but needs to combine it with horizontal coordination tools. With regard to the private insurance companies, only horizontal tools can be used.</p> <p>However, self-governing regions have hardly any vertical tools to assure the minimum network. Most of the hospitals in their territory are fully independent private bodies (in 2008, 22 hospitals were owned by the regions and 83 hospitals were private). Furthermore, there is no direct link between the regions and the health-insurance companies.</p> <p>The regions were expected to establish their own policies for assuring the minimum network, but did not have any direct tools to implement it. Therefore, it is no surprise that not much happened until 2007 when the ministry published the full set of data about the expected structure of hospitals, their wards and beds, both for the national and the regional levels.</p>
Main actors	<p>The core actors engaged in the practice are the following:</p> <p>At the national level:</p> <ul style="list-style-type: none"> - the Ministry of Health, responsible for the minimum network; - public hospitals of the 3rd category; - public health-insurance company VsZP; - private health-insurance companies Dôvera and Union. <p>At the regional level:</p> <ul style="list-style-type: none"> - regional self-governments, responsible for the “minimum network”; - public hospitals established by self-governing regions; - private hospitals in the region, for-profit and not-for-profit; - public health-insurance company VsZP; - private health-insurance companies Dôvera and Union. <p>The self-governing regions are the owners of only few hospitals in their area, and all other lines of coordination are horizontal for them, except for the opportunity to ask the ministry to act on behalf of them in relation to the health-insurance companies.</p> <p>An important actor for both levels is the central government that has the right to direct the ministry and to adopt regulations for the health-insurance market. However, because the health-insurance companies are independent and two of them private, such regulations have to be in line with the EU legal framework.</p> <p>The last actor is the Health Care Surveillance Authority, responsible for the oversight of the system but not directly involved in the issue of “minimum network”.</p>

2.3. Impacts and effects

On the central level, the Ministry of Health established the minimum network of the hospitals of the 3rd type mainly on the basis of the number of inhabitants. This network is relatively well balanced. Although in theory also other factors should have been included into the model for setting the minimum network of the top-level hospitals, in practice the existing structure was respected.

With regard to the regional level, the Banská Bystrica region can be brought as an example. The advisors proposed the region to use two core criteria for setting the “minimum network” – the average yearly number of hospitalisations in the region and the physical access (travel time by public transport). The underlying criterion for the “minimum network” was the level of hospitalisations in different districts of the region. Experts also calculated the level of physical access by two criteria – the percentage of citizens able to access their hospital within 60 and 120 minutes and the average travel time per citizen.

The core problem was that the network modelled according to these criteria differed significantly from the existing network of hospitals. As a result, the areas with more hospitals would have had to abolish one or two hospitals. However, the regional assembly never took a formal vote on the proposed “minimum network”, because of both political and technical reasons. In the initial years, the fact that there were more hospitals than in the proposed “minimum network” was not perceived as a problem. Nevertheless, since 2008 the situation changed due to the strong pressure from the central government. Publishing of all expected parameters of the regional “minimum network” by the ministry clarified the political consequences of any decision about future regional networks and also helped to negotiate with the health-insurance companies.

As a result, the “minimum network” became more of a central request than a decentralised objective to be achieved by the regions. The ministry also used its indirect vertical lines towards the public insurance company, and it agreed to reflect the proposal for the “minimum network” in its reimbursement system. As later on also the private companies adopted the same approach, the “redundant” regional hospitals lost most of their revenues. Without sufficient revenues smaller hospitals have started to stop operating by closing down or merging with the dominant hospital in the area. Consequently, the current “minimum network” of hospitals has become more and more close to the “optimum network”.

As indicated above, optimisation of the hospital network did not reduce the access to the health-care services significantly – except for one area, citizens can reach in-patient care within 60 minutes by public transport. Inhabitants of the smaller cities were not very happy about losing their small hospitals, but no major protests followed. The latter may be related

	<p>to the fact that the hospitals were mostly closed because of bankruptcy (“private-sector failure”) and not administrative decisions (“public-sector failure”). From the expert point of view this change had short-term positive effects – it reduced the too high number of hospital beds and supported a better quality of care because of higher specialisation in larger hospitals. Side effects of this change were almost marginal, since professional staff from the closed hospitals was able to find new positions within the existing network (replacing retired or emigrated employees).</p>
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<p>2.4. Lessons learned and policy recommendations</p>	
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	<p>It is still too early to conclude this case as the structure of hospitals is still in the process of change. However, for the first lesson, it is clear that it is difficult to achieve expected results if:</p> <ul style="list-style-type: none"> - the legal definition of the problem at hand is too broad, proclamative and difficult to operationalise; - there are no implementation guidelines; - the regional governments have too limited vertical powers to implement the scheme and they are expected to set their own rules. <p>If the risk of difficult political “fights” on the regional level is too high and the deputies are expected to make decisions that will go against the interests of their electorate and the lobby groups in the area, the decisive political action will be postponed as long as possible.</p> <p>Second, certain originally interesting and potentially positive ideas can be adapted considerably in the implementation process and used to achieve fully different goals than those intended in the beginning. The original intention of establishing the minimum network of in-patient care was to assure physical access to health care for everybody. In reality, the idea was turned by the Ministry into decreasing the number of hospital beds.</p> <p>Third, a potential lesson relates also to the future consequences of the minimum network. Equalling the “minimum hospital network” to the real network creates certain access risks. Under such conditions, existing providers represent a highly monopolistic structure. This may influence their behaviour but also raises a very important question – what if some of them close down? Decreasing the number of hospitals may be easier than establishing the missing capacities. If there is no supply of potential new operators willing to access the health-care market, regional self-governments will hardly find resources to establish new capacities on their own. The risk of long-term absence of capacities is high, especially in the Slovak conditions, where the reimbursement rates from health-insurance companies hardly cover the real costs of the hospitals.</p> <p>Fourth, the case provides policy lessons on the pros and cons of providing public services through private providers. The ownership mix can be a</p>
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	<p>source of competition leading to an improved quality of services. For certain aspects (especially for the quality of non-medical services, like accommodation or food) privately owned hospitals perform better. Private or non-profit ownership also means more constrained budgets and the need to improve financial management systems. However, there are also several risks related to such a mix of ownership. As the case indicates, high-quality coordination and regulation are necessary for assuring the balance of public and private interest. Private hospitals may go bankrupt or limit the scope of their activities (for example, to provide only “lucrative” health services) – if this happens in areas where there are no substituting capacities, access can be endangered.</p> <p>In conclusion, the “minimum network” of providing in-patient health care is a really interesting health-policy instrument. Formally it looks like a very positive attempt to guarantee equal access to the high-quality health-care services. In reality, several implementation problems have resulted in important risks indicated in the above text.</p>
2.5. Further information	
<p>Data and references</p>	<p>The information and data in this case are mostly based on the author’s long-term research focusing on the health policies in Slovakia and in CEE regions, published in the form of books and articles in English (see references). A considerable amount of information on the main problems of the health-care reforms in Slovakia can be found in the yearly evaluations of Slovakian development by the Institute of Public Affairs in Slovakia (www.ivo.sk).</p> <p>Hrčková, M. and H. Kuvíková. 2011. “Optimalizácia primárneho subsystému poskytovania nemocničných služieb v Banskobystrickom samosprávnom kraji.” <i>Region Direct</i> 4(1), 24-53.</p> <p>Nemec, J. 2005. “Health Care.” In M. Butona, M. Kollar and G. Meseznikov (ed.). <i>Slovakia 2004</i>. Bratislava: IVO.</p> <p>Nemec, J. and E. Ginter. 2004. “Health Care.” In M. Kollar and G. Meseznikov (ed.). <i>Slovakia 2003</i>. Bratislava: IVO.</p> <p>Nemec, J. and N. Kolisnichenko. 2006. “Market-Based Health Care Reforms in CEE: Lesson after Ten Years of Change.” <i>International Review of Administrative Sciences</i> 72(1), 11-26.</p> <p>Nemec, J. and C. Lawson. 2005. “Health Policy in Slovakia and the Outcomes of Health Care Reforms 1989-2003.” <i>Journal of Comparative Policy Analysis</i> 7(1), 35-47.</p> <p>Rosenbaum, A., J. Nemec and K. Tolo. 2004. <i>Health Care Delivery Systems: Opportunities for Public Management Education in CEE</i>. Bratislava: NISPAcee.</p>

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