

SERBIA AND MONTENEGRO

Health profile



Serbia and Montenegro were the two republics that comprised the Federal Republic of Yugoslavia (FRY) after the break up of the Yugoslav federation during the 1990s. In March 2003, the remnants of the federation were finally dissolved when the two republics agreed to enter a looser arrangement referred to as Serbia and Montenegro.¹ This arrangement, which provides for a federal assembly and president, and joint handling of defence and foreign affairs, will remain in existence for three years, after which it will be reviewed. The Republic of Serbia includes Central Serbia, Vojvodina and Kosovo.² In 1999 Kosovo came under UN administration under the terms of UN Security Council Resolution 1244.³

According to the 2002 census, the population of Serbia was 7.5 million⁴ and apart from its ethnic Serb majority, the country's population includes substantial minorities of Hungarians, Roma, Albanians and Bosniaks. In 2001 the population of Montenegro was estimated as 662,500.⁵

Before the conflicts of the 1990s, FRY was a developed middle-income country with fairly equitable distribution of income and good provision of education, health and public services. For much of the past decade, Serbia and Montenegro were subject to UN and international economic sanctions. In 1999, NATO conducted an 11-week air bombardment against the FRY that eventually forced the withdrawal of Yugoslav troops from Kosovo. This decade of sanctions, misrule, and corruption, and finally the NATO bombardment itself, has left Serbia and Montenegro with a

severely damaged infrastructure, economy and isolated from changes in other transition countries. Despite the downfall of the Milosevic regime in autumn 2000, and considerable efforts to reform the economy, this damage has not yet been fully repaired. Another legacy of war is the presence in Serbia and Montenegro of a large number of refugees and internally displaced persons, many of them ethnic Serbs from the former war zones of Croatia, Bosnia and Herzegovina or Kosovo.

Poverty

A Poverty Assessment was carried out by the Federal Government in 2002, based on the most recent census data (2002) and comprised a sample of around 7,000 households. In Montenegro, a random sample of around 800 households from the most recent listing of adult population was used in the survey. These assessments appear to indicate

that poverty is more the result of a decline in the whole population's income than of any sudden increase in inequality. One indication of this is the fact that the Gini coefficient (at 0.28 in 2000) had been relatively stable for the previous decade.⁶

Both Republican Governments published Interim Poverty Reduction Strategy Papers in 2002. Serbia has since developed a first draft of the 'Poverty Reduction Strategy Paper in the Republic of Serbia'.

The groups identified as being most vulnerable to poverty appear to be:⁷⁶

1. Uneducated population
2. Unemployed and dependent persons
3. Elderly people (65 years+) and children between 7 and 14 years of age
4. Households with five and more members
5. Elderly one and two member households, particularly in rural areas
6. Agricultural pensioners, particularly in rural areas
7. Rural areas of Southeast and Western Serbia/ South and North of Montenegro

The Strategies take a rights based approach to poverty, noting that poverty is not just defined in economic terms but also in access to basic education, health and social services. They predict that the number of people at risk of poverty will increase as unemployment rises in the wake of economic restructuring. Low earnings, pensions and social benefits, plus the ongoing adjustment of prices to market levels and the government's limited fiscal capacity may combine to push many more households below the poverty line.

Levels of poverty are especially acute among internally displaced persons (IDPs) and refugees, most of whom are inadequately housed. Only 18% of registered refugees and 7.6% of the internally displaced have their own accommodation. The displaced also have an even higher rate of unemployment than the local population. There are estimated to be around 45,000 refugees and IDP's living in Montenegro,⁹ and some 330,000 refugees and 240,000 IDP's living in Serbia.¹⁰ Around 20,000 refugees and 11,500 IDPs live in collective accommodation centres in Serbia.¹¹ Figures for both IDPs and refugees are likely to be overestimated and are under review in 2003.

There are no reliable data on the effect of social exclusion on poverty (for example, the disadvantages suffered by refugees, Roma and other minorities and disabled) although data is emerging from the Governments of Serbia and Montenegro poverty surveys.

Key Health Indicators

Several factors make it difficult to obtain reliable health data for Serbia and Montenegro. As a result of large-scale population movements following the Yugoslav wars and the Kosovo crisis, population figures for Serbia and Montenegro during the 1990s have been largely speculative. Another problem is that many figures relate to Serbia and Montenegro, whilst others refer to Serbia alone. There can also be confusion over whether or not Kosovo is included in the data. Due to rising political tension in Kosovo during the 1990s, data for Kosovo for this period of time are either incomplete or problematic. Since 1999, most data reported for Serbia and Montenegro exclude Kosovo. The problematic quality of health data is compounded by slow-moving data collection procedures whereby official statistics are often published with a two-year time lag.

What data exist indicate that the health of the population has deteriorated over the last five years. Life expectancy is declining; the incidence of cardiovascular diseases and various forms of cancer are increasing. Both are causes of death associated with risk factors such as smoking, alcohol consumption, a high-fat diet and lack of exercise. Life expectancy at birth in 2001 was estimated to be 69.7 years for males and 74.8 years for females.¹²

Women and Child Health

Mortality rates of children under 5 years of age has more than halved since 1989 and was 15.3 per 1000 live births in 2001.¹³ This is thought to reflect the prior level of investment in health and maternal education, the comparatively good level of maternal nutrition, the relatively small number of births, and the level of antenatal, delivery and postnatal services.¹⁴ Of serious concern is an increase in the reported level of anaemia among women of childbearing age.¹⁵

A growing number of children display signs of malnutrition and micronutrient deficiencies. One of the reasons for worsening child nutrition is low

awareness of the importance of breastfeeding. The percentage of children aged 0-3 months who are exclusively breast-fed has only increased in Serbia from 6.2% in 1996 to 10.2% in 2000, despite the majority of women giving birth in baby friendly hospitals.¹⁶ In Montenegro the figure is higher – 10% in 1996 and 18.1% in 2000.

Children living in collective accommodation centres are at particular risk of poor health, which is partly linked to higher rates of malnutrition.¹⁷ Roma children and children with mental or physical disabilities are other groups of children more likely to experience ill health.

Infant mortality has more than halved since 1989. In 2001 the infant mortality rate in Serbia and Montenegro was 13.1 per 1000 births¹⁸ but this is likely to be underestimated. Three out of four infant deaths occur in the first month of life.¹⁹ In 1997 respiratory diseases accounted for 3.5% of total infant deaths, for 73.6% of morbidity among children of six or younger, as well as for 65.4% of morbidity among those aged between 7 and 18 years of age. Respiratory problems were the most common reason for out patient visits to health centres, accounting for 73.7% of all visits.

It is likely that vaccination levels deteriorated during the 1990s. However, previous high levels of vaccination seem to have been established again and over 90% of all children receive coverage with BCG, OPV, DPT and MMR by the age of 24 months.²⁰ Vaccine-preventable diseases are relatively rare contributors to morbidity and mortality, but are likely to be underreported.

Tobacco

Marketing of tobacco is pervasive and persistent and is often targeted at young people. Cigarettes are inexpensive and locally produced tobacco products have high tar content. A significant but declining amount of tobacco is sold on the black market. It is estimated that as many as 23% of children smoke and a survey by the Institute of Public Health in 2000 indicated that 60% of the adult population are smokers, with smoking estimated to be the direct or indirect cause of 30% of all deaths in 1997.²¹ The minimum legal age for buying tobacco in Serbia was raised in 2003 to 18 years. A smoking ban in public places has been established by law, but is not properly enforced.

The Government of Serbia initiated an anti-smoking campaign in January 2003, but more rigorous anti-tobacco measures need to be implemented to curtail the current tobacco epidemic.

HIV/AIDS

By the end of 2001, a cumulative total of 1,302 cases of HIV were registered in Serbia. In Montenegro there were 43 cumulative HIV cases reported from 1989 to 2000.²² Real figures, however, are thought to be substantially higher. At the end of 2000 some 10,000 adults and children were estimated to be living with HIV/AIDS.²³ Almost half of reported AIDS cases in Serbia are attributed to drug injection, but in recent years the share of transmissions through sexual contact has risen. The proportion of women among new cases has risen from a quarter to half.

The availability of diagnostics tests varies but kits are often in short supply. Pre-test and post-test counselling is limited and would not meet international standards. Only a small number of individuals come forward for voluntary testing, because of concerns over stigmatisation and confidentiality. All donated blood is screened free of charge at transfusion centres, but otherwise access to free testing is limited. Treatment with antiretroviral drugs is virtually unavailable.

Surveys of young people and the general population show low levels of knowledge about HIV/AIDS, negative attitudes towards people with HIV/AIDS and high levels of unsafe sexual behaviour.²⁴ One survey found that 56% of the population acknowledged having unprotected sex.²⁵

Tuberculosis

The average estimated annual incidence of tuberculosis was 39 per 100,000 population in 2000²⁶ although this is almost certainly an underestimate. The Central Eastern European average in 2000 was 50.55 new cases per 100,000 population. There are concerns among local and international health professionals that TB has increased among more vulnerable groups such as refugees and IDPs in collective accommodation. This situation has been exacerbated by the failure of health professionals to comply with standard treatments; and by the scarcity and expense of drugs. Neither Serbia nor Montenegro have adopted the DOTS programme.

Health Service Structure and Provision

Public health services are provided by the two national Institutes of Public Health (IPH). In Serbia the national IPH is supported by a network of regional IPH facilities.

Primary care services are provided via a network of Health Houses, responsible for local public health, primary care and the administration of smaller ambulancias (which provide limited primary care facilities).

Secondary and tertiary care is provided in general hospitals, university clinical centres and specialised institutions that target specific groups such as women and children, or treat specific diseases such as TB and cerebral palsy. Each region has at least one general hospital and, in many cases, several in-patient facilities providing specialized or tertiary care.

Montenegro has 4 general hospital beds per 1,000 head of population. In Serbia there are less than 3 general hospital beds per 1,000 head of population compared to the 3.5 beds recommended by WHO. However, an excess of beds in some sectors does exist, for example in the capital and in specialised institutions. In common with other countries in the region, length of in-patient stay is high and bed occupancy rates low, indicating an inefficient use of resources.

Although health facilities are relatively well staffed, with doctor-to-nurse ratios in the region of 1:3, the quality of care is often poor, because services are not patient-centred, there is a lack of audit or independent monitoring, and equipment and buildings are in bad condition.

Many doctors in Serbia are unemployed, while approximately 1,000 more graduate from Belgrade University each year, although there are no doctors officially registered as unemployed in Montenegro. In Serbia there are 8,500 unemployed nurses, although there are many unfilled nursing posts at tertiary care level, and 9,300 unemployed physiotherapists. Measures have yet to be taken to match the health sector workforce to health need.

Rates of pay for health professionals are low by European and even national standards. The average monthly salary is Euro 130 for doctors and Euro 90 for nurses, compared to a national

average gross salary of Euro 176, although it is slightly higher in Montenegro where doctors earn between Euro 250-350 and nurses Euro 120. The low rates of pay for health sector staff are widely believed to exacerbate the pressure on patients to make informal payments to access health care. Many health sector staff are believed to work in the grey economy to increase their income.

Private health care is not well developed and is not incorporated into the national health system. The utilization of private sector health care is not known.

Health Service Financing

The publicly funded health sector is based on a system of compulsory social health insurance, financed by salary contributions paid by employees and operated by the Health Insurance Fund. The main weaknesses of the system are lack of coverage for uninsured people, lack of transparency in budgeting, evasion of contributions and arrears between the fund and institutions.

Health sector resources have declined significantly during the last 10 years, with spending falling from US \$200 per capita in 1990 to around US \$60 per capita in 2000. Health Insurance Fund data for the first six months of 2001 record health care expenditure of US \$250 million (approximately US \$32 per capita). This excludes humanitarian assistance and informal payments, which are thought to be considerable. During the 1990's expenditure on public health services as a percentage of gross domestic product ranged from 7.4% in 1990 to 10.4% in 1999.²⁷

Patients are required to make official co-payments to access health services. However, there is a significant problem with patients having to make unofficial, or informal, payments in order to receive health care. In Serbia and Montenegro it is estimated that out-of-pocket expenditure on health care is around 49% of the total expenditure on health care, compared to Bosnia-Herzegovina where it is estimated at 31% and Croatia where it is 15%.²⁸

Key Health Policies

It is widely recognized that a reform of the health sector is essential in order to improve the level of basic services and to develop more sustainable systems.

In February 2002 the Government of Serbia adopted the 'Health Policy of Serbia', which identified seven aims:

1. Safeguarding and improving the health of the population in Serbia and strengthening its potential for better health
2. Just and equal access to health care of all the citizens of Serbia, and improvement of the health care for vulnerable population groups.
3. Putting patients at the centre of the health care system.
4. Sustainability of the health care system, while ensuring transparency and a selective decentralization in the field of resources management, with diversification of sources and methods of financing.
5. Improvement of the efficiency and quality of the health care system, with the development of specialized national programs related to human resources, institutional networks, technology and medical supplies.
6. Defining the role of private sector in provision of medical services to the population.
7. Improvement of the human resources for health care.

In implementing this policy, the Government has identified a number of immediate priorities:

- Improved access to drugs – despite some activities to improve the situation, patients are still deprived of essential drugs, especially in hospitals, and some drug costs are prohibitively high for certain population groups
- Increasing the supply of perishable items of medical equipment, which are in short supply and often have to be bought by patients
- Rehabilitation of selected health institutions
- Development of a Health Master Plan to define optimal use of available human and physical resources
- Reform of health financing mechanism, with procedures to improve the effectiveness and efficiency of the contracting process, including private sector participation

In February 2003 the Ministry of Health in Serbia prepared a draft Health Strategy for 2003 to 2015. The draft includes specific short, medium and long-term goals for the reform of the health sector and proposes a number of changes to health financing,

essential health packages and the mandates of Serbian health institutions.

In Montenegro the policy document 'Health Services Policy in the Republic of Montenegro Up to the Year 2020' was adopted by the Montenegrin Government in January 2001. This policy was created in accordance with the WHO declaration adopted by the General Assembly of WHO in May 1998 and the documents on health policy of the WHO European Region. Proposals on health protection law and the law on health insurance, created and proposed by the former Ministry of Health, were not accepted by Parliament in 2002. The new Ministry will prepare and submit revised proposals to Parliament and work on this revision is anticipated before the end of 2003.

Multilateral/Bilateral Assistance

Donors and agencies providing assistance to the health sector in Serbia and Montenegro include the World Bank, the European Agency for Reconstruction, the World Health Organisation, United Nations Children's Fund, the United Nations Development Programme, the International Committee of the Red Cross, the UK Department for International Development, the Canadian International Development Agency, the United States Agency for International Development, the Swedish International Development Agency, the South African Development Community and the Government of Germany.

Notes

- 1 Referred to in some official documents as the State Union of Serbia and Montenegro
- 2 Kosovo is the subject of a separate Health Profile
- 3 The United Nations Security Council Resolution 1244 accords Kosovo "substantial autonomy and meaningful self-administration" whilst recognising the "sovereignty and territorial integrity of FRY"
- 4 Census 2002, Republican Statistics Office. Data excludes Kosovo and Metohija
- 5 WIIW Balkans Observatory 2002
- 6 Poverty Reduction Strategy Paper in the Republic of Serbia, First Draft, April 2003
- 7 Poverty Reduction Strategy Paper in the Republic of Serbia, First Draft, April 2003
- 8 Interim PRSP, Government of Montenegro 2002
- 9 as above
- 10 Serbian Commission for Refugees, 2003
- 11 UNHCR and ICRC data 2001
- 12 WHO Statistical Information System July 2003
- 13 Innocenti Social Monitor, UNICEF 2003
- 14 UNICEF 2000
- 15 Multiple Indicator Cluster Survey II, The Report for FRY, UNICEF, Belgrade 2000

- 16 WHO/UNICEF global initiative
- 17 WHO/UNICEF Global Initiative
- 18 Innocenti Social Monitor, UNICEF 2003
- 19 Assessment of Infant Mortality and Perinatal Mortality, WHO Belgrade 2001
- 20 Multiple Indicator Cluster Survey II, The Report for FRY, UNICEF, Belgrade 2000
- 21 Programme of Activities for the Realisation of Health Policy in Serbia by the year 2010, Institute of Public Health 1997
- 22 Rapid Assessment of Montenegro HIV/AIDS/STI Surveillance System, Canada Health 2002
- 23 UNAIDS and WHO 2002
- 24 Multiple Indicator Cluster Survey II, The Report for FRY, UNICEF, Belgrade 2000
- 25 Cucic V, Bjegovic V, Vukovic D AIDS Preventive Indicator Monitoring 2000
- 26 Yugoslavia MDG Health Indicators January 2003. WHO TB data submitted to the UN in May 2002
- 27 Poverty Reduction Strategy Paper, Republic of Serbia, First Draft, April 2003
- 28 WHO data 2000



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Other elements of the project including a database of identified references, an in-depth information review of published studies, health statistics and reports from governments and other agencies, and a summary report can be found at <http://www.lshtm.ac.uk/ecohost/see>

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