Annual National Report 2011

Pensions, Health Care and Long-term Care

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1 Executive Summary

The global financial crisis has revealed weaknesses and long-term unsustainability of the Serbian economic and social systems. Their current characteristics are a sharp decrease in employment and a sharp increase in unemployment, low public revenues and high public expenditures, huge debts, and an overall deterioration of the position of beneficiaries of social benefits.

The latest changes in the public pension system were introduced at the end of 2010. Their essence concerns the extension of contributory periods for a full pension, an increase in the minimum retirement age, as well as a change in eligibility criteria for privileged categories and in pensions' indexation. Those changes were highly contested, while the pension indexation was the most controversial topic of the reforms. The whole process of reforms in the past year was carried out in mutual agreement between the Government and international financial institutions, with negligible influence of trade unions and other stakeholders.

Private pensions are largely lagging behind the public pensions, in terms of coverage and projected development, which is surely a result of low purchasing power of the population. A couple of new incentive measures for opting for private pension insurance was enacted but it is not very likely that the crisis will be a period which is favourable for the expansion of private insurance.

With regard to the OMC objective of pension adequacy, the current reform will have negative implications on the standard of living of pensioners in the future, and will be reflected in an increased poverty of the elderly.

The basic characteristics of the health care system are high expenditures along with average results and outputs. Therefore, the major part of the reforms has been directed towards announced changes in the financing of the health care sector. These include the introduction of capitation payments in primary health care, and payments based on diagnosis-related groups in secondary health care. Many areas of reforms have been neglected (such as the absence of compulsory accreditation of health facilities, incomplete decentralisation of the system, shortages in the policy of planning university enrolments, corruption, etc.) and one of the most important is still the unresolved position of the private sector (with a series of conseqent problems).

The current situation is significantly reflected in the spheres of access to health care, its quality, and the sustainability of the system. Access to health care is sometimes compromised in practice, and inequalities in access can be defined as financial, social and territorial. They are especially present in the vulnerable groups of the population. The surveys of the perceptions of health care quality include highly quantitative and descriptive data, representing more sheer information about provided health services, failing to enable an essential insight into the health care quality. Finally, the problem of financial sustainability of the system is in the focus of current reform efforts so that it cannot be assessed at the moment.

The long-term care scheme is divided between the systems of health care and social welfare. The period of reforms "bypassed"long-term care, especially its part belonging to health care, while certain changes in the social welfare were introduced. Indications of the existence of an independent long-term care system are not present. Reasons for this are, in the first instance, financial and organisational constraints, even though it can be expected that the pressure of forecasted changes (in the spheres of demography, work and family) will require taking into consideration the expansion of the current concept.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

The global financial crisis has revealed weaknesses and long-term unsustainability of the Serbian economic and social systems. The period of dynamic economic growth (2001-2008) with an average rate of 5.4% was interrupted in late 2008. In 2009, GDP declined by 3%, employment decreased by 8.3% compared to the previous year, the unemployment rate increased to 16.6%, while wages have remained at approximately the same level. A slight economic recovery was recorded in 2010, as well as a GDP growth of 1.2%, while inflation reached a rate of 10.3% (Ministarstvo finansija, 2010).

In 2010, consolidated public revenues were lower in real terms (0.3%), expenditures increased (0.7%), and the fiscal deficit amounted to 4.4% of GDP. The structure of public expenditures was dominated by spending on pensions (29%) and wages in the public sector (23%). Total external debt was EUR 23.8 billion (79.6% of GDP), while public debt was EUR 12.2 billion, 40.7% of GDP (Narodna banka Srbije, 2011a). In 2010, the labour market was characterised by an employment decline and unemployment growth to 20%, while average real wages increased by 1.2%.[1]

Short-term measures in order to mitigate the negative effects of the crisis were partially successful in maintaining fiscal stability. Control of expenditures in the national budget, changes in the distribution of funds, freezing of pensions and salaries in the public sector (2009-2010) led to a deficit reduction. A stand-by arrangement of the IMF provided financial support to Serbia in the value of EUR 2.87 billion for 2009 and 2010, which positively impacted negotiations with other international financial institutions and stability of the domestic banking system.

In accordance with the accepted obligations and the IMF programme, changes to the Law on Pensions and partial rationalisation of employment in the public sector took place in late 2010, while health care and education reforms had been at an early stage. For the period 2011-2013, the Government envisages measures to ensure macro-economic stability, economic growth, an increase in employment and the standard of living (Vlada Republike Srbije, 2010a).

The economic crisis and austerity measures have resulted in a slower process of social reforms, and, in some cases, in the abandonment of the planned changes. Originally proposed changes in the pension system were modified so that the accepted solution is more favourable in terms of the beginning of the implementation of new conditions. The strategic orientation towards building a financially sustainable system, shortages in insurance funds, and large budget expenditures negatively influenced the level of benefits and poverty. In the development of an "active social policy" the Government has relied upon the services of the World Bank, the International Monetary Fund, and a group of national neoliberally oriented experts. The crisis has revealed deficiencies in the adopted model of changes and problems in the protection against risks.

[1] In February 2011, Mr. Bogdan Lisovlik, Resident Representative of the International Monetary Fund in Serbia, stated in his discussions with the trade unions that 400,000 workers in Serbia lost their jobs since the beginning of the crisis. This figure is twice the official statistical data (200,000) and data of trade unions (280,000) on the number of lost jobs in the period 2008-2010.

Current debates on the future development of the social security system are going in the direction of reviewing achievements, responding to the challenges of European integration, and requirements concerning the achievement of the status of a Candidate Country and the EU membership. The Government is committed to meeting the conditions in the field of social policy; it carefully monitors the decisions regarding the Europe 2020 Strategy and is engaged in the preparation of the Joint Inclusion Memorandum (JIM).[2] The adoption of strategic national documents is directed towards meeting the European standards and aims in the areas of employment policy, social inclusion and social welfare.

2.2 Pensions

2.2.1 The system's characteristics and reforms

The Serbian pension system was reformed based on a new *Law on Old-Age and Disability Insurance* in 2003, its amendments in 2005, and the latest changes at the end of 2010.[3]

Parametric reforms within the public, mandatory PAYG system included raising the retirement age, changing the calculation formula and indexation of pensions, more stringent conditions for the drawing disability pensions and for early retirement, and elimination of some benefits. Radical measures taken in 2003 included raising the retirement age by three years (from 55 to 58 for women and 60 to 63 for men). Changes in the 2005 legislation were aimed at reducing public spending and achieving macro-economic stability. They were made under strong pressure of the IMF. The retirement age was raised by two years, but the implementation took place gradually (every six months) until 2011. These changes also included pension indexation, by the transition from the so-called Swiss formula to the indexation based on the cost of living (but not earnings), provided that the average pension may not be less than 60% of the average salary by the end of 2008 (Vuković, 2009).

Pension reforms in Serbia were structured around discussions on privatisation of pension funds and possibilities of implementing the World Bank's multi pillar system. The solution of parametric changes in the compulsory insurance (1st pillar) and the introduction of a 3rd pillar (voluntary private) were accepted, while the introduction of the 2nd pillar was delayed due to the high transition costs, the underdevelopment of capital markets, and the deficit in the compulsory insurance fund. The *Law on Voluntary Pension Funds and Pension Plans*[4] was adopted in 2005; it regulates the organisation and management of voluntary pension funds; the establishment, operation and business dealings of management companies; tasks and duties of the custody bank. The National Bank of Serbia supervises and regulates in more detail various aspects relevant for the functioning of the voluntary pension funds.

In late 2010, the changes in the pension system, which had been discussed with the IMF in 2009, were adopted (Vuković, Perišić, 2010). Proposed changes, which were adopted by the Government in June 2010, have met with harsh reactions from trade unions. Protests had also been announced for not having consulted the Economic and Social Council. After negotiations with the unions, and pressure from the IMF, the National Parliament adopted amendments to the *Law on Old-Age and Disability Insurance* on December 29th, 2010. The

[2] In December 2010, the Government adopted an *Action Plan in order to fulfil recommendations from the Annual Report of the European Commission in 2010*, in order to accelerate the process of acquiring the status of a Candidate Country. In January 2011, the Government submitted its responses to the questionnaire of the European Commission. In April 2011, the Government prepared the *First National Plan on Social Inclusion and Poverty Reduction*.

[3] The Law on Old-Age and Disability Insurance, "Official Gazette of RS" numbers 34/03, 85/05, 5/09, 107/09 and 101/10.

[4] The Law on Voluntary Pension Funds and Pension Plans, "Official Gazette of RS" number 85/05.

essence of changes concerns the conditions for retirement on the basis of the "full qualifying period" and minimum age, privileged qualifying periods and indexation of pensions.

Financing. The system of mandatory pension insurance in Serbia is based on the pay-as-you-go (PAYG) principle. This means that all employed and self-employed persons, members of freelance professions and farmers are obliged to pay contributions to the Republic Fund of Old-Age and Disability Insurance.[5] The contribution rate for compulsory pension insurance amounts to 22%[6] and is equally divided between employers and employees (each 11%). For those insurees being entitled to privileged years of service, employers are obliged to pay additional contributions. Collecting funds falls under the scope of tax administration, who distributes them to the pension funds and other compulsory social insurance funds. In order to reduce the effects of contribution evasion, in 2010 the Government decided to refund missing contributions in the period from January 1st, 2004 to December 31st, 2009.

According to the financial plan of the Fund for 2011, the revenues will amount to RSD 493.942 billion (EUR 4.93 billion),[7] out of which RSD 252.00 billion (EUR 2.52 billion) will be covered by contributions. Total expenditures in 2011 will amount to RSD 494.10 billion (EUR 4.94 billion). Out of this sum, RSD 486.352 billion (EUR 4.86 billion) will be used to pay pensions and other benefits from compulsory social insurance (for pensioners from the category of previously employed – RSD 437.865 billion (EUR 4.37 billion), for self-employed – RSD 19.43 billion (EUR 194 million) and for retired farmers – RSD 29.05 billion (EUR 290 million). The deficit in the Fund (about one third of expenditures) will be covered by the budget of the Republic of Serbia (Republički fond za penzijsko i invalidsko osiguranje, 2011).

Pensions are the state's biggest expenditure, despite the reforms (2001-2010) which aimed at the financial stabilisation of the insurance funds. In the *Revised Memorandum on the Budget*, the Government envisages a reduction of social assistance and transfers to households from 17.6% of GDP (in 2011) to 16.8% (in 2012), i.e. 15.9% of GDP in 2013. The *Law on the Budget for 2011* envisages a transfer of RSD 274.270 billion (EUR 2.74 billion) to the organisations of compulsory social insurance. Its largest proportion is for the expenditures of the Republic Fund of Old-Age and Disability Insurance – RSD 230 billion (EUR 2.30 billion) (the Law on the Budget). According to the estimations of the World Bank, Serbia can expect a drop in the level of pension spending as percentage of GDP from 12.7% in 2010 to 11.8% by 2015 and 10.7% in 2020 (World Bank, 2009).

Pensions. The *Law on Old-Age and Disability Insurance* provides for the rights to old-age, disability and survivor pensions, as well as the rights to compensation for personal damage, allowance for care and support, and funeral grant (Vuković, 2009: 90). The right to an old-age pension can be exercised at the age of 65 for men and 60 for women with at least 15 years of coverage. Contributors aged 58 with a qualifying period equivalent to 40 years (men) and 35 years (women) also have the right to old-age pensions. Finally, contributors realise this right with 45 years of coverage (Article 19).

Based on changes to the Law in 2010, the eligibility conditions for a pension regarding the "qualifying period" for women were modified. The minimum age was increased from 53 to

[5] According to the *Law on the Military of Serbia*, which was enacted on January 1st 2008, about 55,000 military pensioners (eligible based on the Law on the Military of Yugoslavia) will become the members of the Republic Fund of Old-Age and Disability Insurance.

[6] The *Law on Contributions for Compulsory Social Insurance* ("Official Gazette of RS"numbers 84/04, 61/06, 5/09) defines the following rates: for old-age and disability insurance 22%, for health insurance 12.3% and for unemployment insurance 1.5%. Therefore, the total burden for salaries is 35.8%.

[7] For the purpose of simpler calculation and in order to avoid every day fluctuations of exchange rate, this Report approximates the value of 1euro to 100 RSD.

58 years, and the required contribution period from 35 to 38 years. Based on the adopted Law, the change of the contribution period will be implemented gradually between 2013 and 2021, so that it will be increased by four months a year. The minimum retirement age will be increased from 2013 to 2016 by four months a year and from 2017 to 2023 by six months a year. Regarding men, there were no changes in the minimum contribution period, so that the solution of a contribution period of 40 years was kept, while the changes in the retirement age will be implemented as in case of women.

The second part of introduced changes relates to the accumulation of pension rights based on privileged qualifying periods. For the privileged categories, the new law provides for a raise of the minimum retirement age from 53 to 55, to be gradually implemented in the period between 2011 and 2016. The retirement age for some privileged professionals can still be reduced to 50 years of age if they exceed the statutory contributory period. Every additional year counts for six months of early retirement

In 2010, also the minimum retirement age for beneficiaries of survivor pensions (i.e. widows, widowers) was changed. Survivor pensions can now be drawn by a widow of the deceased insured if at the time of his death she was 53, and a widower if at the time of death of the deceased insured, he was 58. Children are entitled to a survivor pension until the age of 15, i.e. 26 provided that they are in education. The amount of survivor pension ranges from 70% for one member to 100% for four or more members of the family of the deceased insured.

Calculation and indexation of pensions. Since 2003, pensions in Serbia have been calculated pursuant to the so-called "German Point Formula" - the ratio of a person's wage to the average wage in Serbia in each year of his/her life presents a personal coefficient. The sum of those coefficients is divided by the number of years, months and days taken into account for the calculation, and the personal coefficient obtained in this way is multiplied by the total years of coverage, i.e. the personal point.

Finally, the personal point is multiplied by the general point, which is the same for the whole of Serbia. This is the way of obtaining a pension amount. In April 2003, the value of the general point amounted to RSD 218.30; in 2010 it was RSD 605 (about EUR 6).[8] The above mentioned formula was designed with a view to providing a direct relation between the pension amount and paid contributions during the whole period of employment, thus encouraging individuals to stay in employment for as long as possible.

Indexation of pensions was the most controversial topic in the process of legal changes in 2010. At the end, it was accepted to increase pensions by 2% in December (first adjustment after two years). In April 2011, the adjustment was supposed to be made according to the changes in consumer prices in the previous three months, and in October 2011 and April 2012 according to the changes in the cost of living and GDP growth. After October 2012, the adjustment is supposed to be done twice a year (April 1st and October 1st) based on the changes in consumer prices and GDP growth. Changes to the *Law on the Budget System* envisage the implementation of the agreed indexation by 2015 or "as long as the share of pensions in GDP reaches 10% of it."[9]

At the end of 2010, there were 1,626,581 pension beneficiaries, which was an increase of 1.4% compared to the same period of the previous year. The ratio of the total registered number of employees and the total number of pensioners was 1.1 / 1. The average paid pension accounted to 51.3% of average net earnings. Expressed in euros, the average pension

[8] For women the qualifying period is automatically increased.

[9] For the purpose of their compliance, on the same day the changes to the *Law on Old-Age and Disability Insurance* were enacted, the changes to the *Law on the Budget System* were also made.

in 2010 amounted to EUR 193, which was a decrease of 8.1% compared to 2009 (Ministarstvo finansija, 2011: 17). In February 2011, there were 1,641,129 pension beneficiaries, of which 1,349,361 belong to the category of employees, 58,978 self-employed and 221,795 farmers (Republički fond za penzijsko i invalidsko osiguranje, 2011).

Table 1: Pension beneficiaries (February 2011)

Old-age pensions		*Disability pensions*		*Survivor pensions*		*Total*		
Number	Average pension	Number	Average pension	Number	Average pension	Number	Average pension	% of net earnings*
Employed								
713,982	25,606	321,259	20,424	314,120	16,380	1,349, 361	22,224	63
Self-employed								
27,178	25,122	16,849	21,599	14,946	15,744	58,973	21,739	61
Farmesr								
183,298	9,014	13,305	9,425	25,192	6,416	221,795	8,743	25

** Average net earnings in February 2011 amounted to 35,538 RSD (EUR 350).*
Source: Republički fond za penzijsko i invalidsko osiguranje, 2011.

A guaranteed level of income in old age is realised according to legal regulations on minimum pension payment for old-age and disability pensions (without survivor pensions). The changes at the end of 2010 provided for extraordinary adjustment of the minimum pension on January 1st, 2011 by 1% compared to the minimum pension paid in 2010. It is determined that the minimum pension cannot be below 27% of the average salary in the preceding year (without taxes and contributions from the previous year). For retired farmers, the minimum (old-age and disability) pension was determined at RSD 9,000 (EUR 90) on January 1st, 2011, and shall be adjusted in the manner provided by the law.

Voluntary pension funds. Voluntary insurance, which is underdeveloped in Serbia, is realised via private pension funds. Since 2006, the National Bank of Serbia has issued nine working licences to management companies. At the end of the third quarter of 2010[10] there were eight management companies with 144 employees. The total number of beneficiaries (members) is 168,066, which is 2.5% more than in the third quarter of 2009. The management companies are owned by insurance companies, banks and pension funds.

Based on data of the National Bank of Serbia, in the third quarter of 2010, net assets of voluntary pension funds experienced an increase of 39.2% compared to the previous year. 36.1% of the total assets of voluntary pension funds was in euros, and 63.9% in RSD. The largest proportion are state securities (61.2%), out of which 19.6% are bonds belonging to old savings in foreign currencies, and 41.6% are treasury bonds (Narodna banka Srbije, 2010).

In the *Revised Memorandum on the Budget* (December 2010), the Government predicted measures for encouraging voluntary pension insurance. The *Law on Voluntary Pension Funds and Pension Plans* changed the years of life for withdrawing accrued funds by raising them from 53 to 58 years. The amount of accrued funds that can be picked up at once is limited to 30% of funds in the account. It is projected to encourage investments into private pension funds by the possibility to use the fund assets as a guarantee on the ocassion of buying individually owned residential property. The planned legal amendments include measures to

[10] These are the latest available data.

invest the funds' assets in short-term debt securities and investment branches of non-investment funds operating in Serbia and the EU and the OECD member states.

The whole process of reforms in the previous period (April 2010 - April 2011) was carried out in mutual agreement between the Government and international financial institutions, with negligible influence of trade unions. The IMF's[11] loan was conditioned by changing the pension system.[12] These changes (reduction of privileges for women and persons performing hazardous jobs) have not been given up despite sharp protests of pensioners' organisations (about indexation of pensions), trade unions and the reaction of some experts. The proposed changes were, with few exceptions, adopted, and the law came into force on January 1st, 2011, as it was mentioned in the Letter of Intent to the IMF.

2.2.2 Debates and political discourse

After the political changes in 2000, the changes in the social protection system were introduced in agreement with the World Bank and the International Monetary Fund, whose engagement clearly influenced the contents and trends in the pension reforms. The contents and aims of changes in 2010 are considered in strategic documents, action plans, scientific papers and communications.

In December 2010, the Government presented a *draft development concept "Serbia 2020"*[13] as a document for public consultation, which relies on the Europe 2020 strategy. The Strategy emphasises the seriousness of the "demographic problem" and provides for the reduction of relative poverty from 17.7% in 2009 to 14% by 2020. To achieve the projected targets in the field of social inclusion, improvement of the adequacy of the amount of social assistance, better targeting and development of programmes for full access to education, labour market, health and social services (active inclusion) are recommended.[14]

Serbia does not have a special strategy on pension system reforms, but the aims of changes are presented within the *Poverty Reduction Strategy Paper* (2003), *National Strategy on Ageing* (2006-2015), *National Strategy of Sustainable Development* (2008-2017) and other documents.[15]

Basics of the new Government's policy are contained in the amendments to the 2010 *Law on Old-Age and Disability Insurance*, and documents governing the budget policy - *Revised Memorandum on the Budget and Economic and Fiscal Policy for 2011 with Projections for 2012 and 2013* and the *Law on the Budget of the Republic of Serbia for 2011*. Pensions are

[11] In mid-April 2011, Mr Mirko Cvetković, Serbian Prime Minister, agreed a new credit arrangement in Washington with the World Bank. This arrangement envisages Serbia to withdraw at least USD 200 million per year in the following four years: half of the funds are intended to cover the budgetary deficits, and the remainder is for projects. This is a continuation of borrowing - Serbia has already borrowed USD 400 million from the World Bank for the infrastructure. According to the media, at the same time, during the spring session of the IMF, Serbian Prime Minister negotiated the last stand-by arrangement and the possibilities for new borrowing. Despite the fact that there are no official confirmations that Serbia is over-indebted, according to the magazine "Ekonomist", Serbia will have to provide more than EUR 4.1 billion only in 2011 in order to pay due interests and a part of the primary debt. In the previous 12 months, Serbian debt has been increasing by EUR 6.7 million per day, i.e. EUR 77 per second.

[12] See the previous asisp Annual Report (2010) about the contents of agreement and planned changes.

[13] *Serbia 2020,* The concept of development of the Republic of Serbia by 2020, available at: http://www.predsednik.rs/mwc/pic/doc/SRBIJA%202020%20FINAL%2018122010.pdf.

[14] During the public debate about *Serbia 2020,* many shortages regarding unrealistic development projections, exaggerated and unfounded optimism as well as lack of capacities for meeting objectives were highlighted.

[15] For a more detailed approach, see Vuković, D. Perišić, N. *Annual National Report 2010 – Pensions, Health and Long-term Care, Republic of Serbia,* available at: http://www.socialprotection.eu/files_db/910/asisp_2010_Serbia.pdf.

also an integral part of two documents regarding the Serbian obligations on its way to becoming a member of the European Union - *Answers to the European Commission's Questionnaire* and the *First National Report on Social Inclusion and Poverty Reduction in the Republic of Serbia*. Assessment of conditions and the reform effects is also found in a series of press releases, newsletters, and studies of the relevant government institutions, government advisory bodies, scientific research organisations and experts.

The process of the pension legislation changes in 2010 was followed by a debate on measures to raise the retirement age for women. On that occasion, once again, equalisation of the conditions for men and women was avoided. A gradual increase of the minimum age for early retirement based on contributory periods is the result of a compromise with trade unions and representatives of the IMF, which insisted on the adoption of agreed changes. Subjects of debates were also the issues of reduced contributory periods, and especially the indexation and provision of the minimum safety of pensioners, who have an above average risk of poverty.

Within the measures of economic and fiscal policy for the period 2011-2013, the Government predicted a reduction of the share of social assistance expenditures and other transfers to households by 1.7% (from 17.6% in 2011 to 15.9% of GDP). Pension expenditures are the largest part of the consolidated public expenditures (in 2010 – 12.6% of GDP). In the coming period, their share is projected to decrease to 10.0% (in 2020). The aim of these measures is to create a financially sustainable system, by increasing revenues from contributions and reducing budget subsidies. Attitudes of the official policy positions are reflected also in the answers to the European Commission's questionnaire, and the Report on Social Inclusion which deals with all aspects of poverty in the elderly population.

The study *Post-Crisis Model of Economic Growth and Development of Serbia 2011-2020* as a medium-term objective of pension reforms predicts "the reduction of the share of pension expenditures in GDP (from 12.5% to 10%), increasing redistribution from richer to poorer[16] pensioners, and the introduction of social pensions." Discussions about social pensions are becoming especially important from the point of view of the problem of insufficient pension coverage of elderly (77% of persons aged 65 and only 47% of those aged 85 or over). The subject of comparative research was the issue of pension reforms in the countries of the region and EU (Vuković, Arandarenko, 2011). Special studies deal with the issues of organisation of the pension system for farmers (Mijatović, 2010) and designing a pension system in Serbia (Stanić, 2010). Population ageing, negative effects of the global economic crisis and public debt also occupied an important place in debates and political discussions in 2010.

2.2.3 Impact of EU social policies on the national level

It is difficult to assess the immediate impact of the EU social policy on pension reforms having in mind that Serbia is not a member of the Union. The situation has changed somewhat in recent years, as a result of progress towards European integration, the achievement of the status of a Candidate Country (expected late 2011), and the aim of full membership. Ratings of the Commission on the progress[17] and efforts directed towards making necessary

[16] The differences in pension amounts are huge. In February 2011, the amounts in the category of previously employed pensioners ranged from RSD 11,500 (about 110 euros) to RSD 105,000 (about 1,000 euros) and in the category of previous farmers from RSD 5,000 (50 euros) to RSD 74,000 (740 euros) in only two pensioners.

[17] The EU Integration Office performs professional, administrative and operational activities for the needs of the Serbian Government. Coordination, monitoring and reporting on the process of accession and joining the EU, as well as a series of other tasks are within its jurisdiction ("Official Gazette of RS" numbers 126/07, 117/08, 42/10 and 48/10) (http://www.seio.gov.rs).

preparations in certain areas (political and economic) had a positive effect on the harmonisation of regulations and practices in employment policy and social assistance. *Employment Strategy* (2011-2020) was drafted in accordance with the objectives of the EU, and there has been progress in designing social inclusion policy.

Answers to the European Commission's Questionnaire are of relevance for the assessment of the impact of EU policies on the pension system. They contain a special section on pensions. Questions relate to the description of the current situation, problems in funding, incentives for greater participation of older workers in the labour market, coverage of compulsory social insurance, transparency of the system and assessment of future challenges The European Commission sought additional explanations for some answers from Chapter 19 (*Social Policy and Employment*). However, no further explanations were sought for the part related to pensions (Vlada Republike Srbije, 2011a).

The *First National Report on Social Inclusion and Poverty Reduction*[18] gives an overview of the situation for the period 2008-2010, with priorities for the next period. The production of the Report, according to Deputy Prime Minister for European Integration Affairs, aims to harmonise the reform measures with the goals of the *Europe 2020.*[19] The Report specifically deals with the pension system, and as the main challenges of future changes highlights the need for adequate and financially sustainable pensions. The report states that lack of revenues in insurance funds, inappropriate legal provisions with regard to indexation, the minimum level of pensions and the economic crisis have impacted the poverty of elderly and pensioners.

In the process of pension system reforms there was no special debate on the *Green Paper* and the OMC objectives, and there is no obligation to draw up a *National Reform Programme.* At the session of the Council for Ageing and Old Age of the Serbian Government,[20] held in mid-April 2011, "sustainable development of pension systems" and other objectives of the *Green Paper* were discussed. The Council has decided to recommend to the Government to create incentives to increase employment of older workers and pensioners, increase their mobility and create conditions for life-long learning. The drafting of the *Action Plan (2011-2015) of* the National Strategy on Ageing is in progress. It will specify the activities and responsibilities in achieving the projected goals.

2.2.4 Impact assessment

The global financial and economic crisis resulted in the aggravation of the labour market situation in Serbia and increasing poverty.[21] The risk of staying without a job is, according to the Labour Force Survey, the most prominent in this population. In particular, first-time job seekers and older workers lose their jobs faster. The results show that the unemployment rate of persons aged 45-54 in 2010 was 20.5%, and of those under 65 years 8.9% (Republički

[18] A Team for Social Inclusion and Poverty Reduction was formed within the EU Integration Office. The Team prepared the major part of the report relating to the cooperation with the relevant institutions, organisations and experts.

[19] The Government also intends, immediately after obtaining the status of a Candidate Country, to draft the *Joint Memorandum on Social Inclusion*.

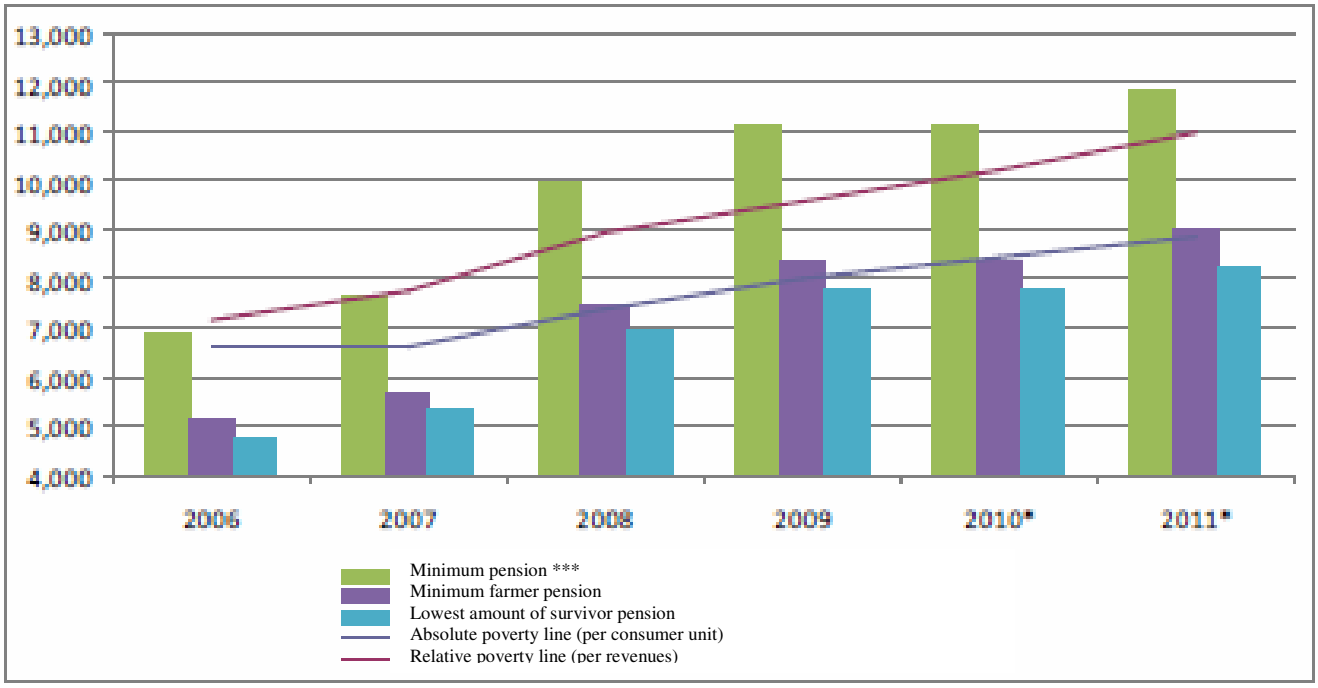
[20] The Council is a professional and advisory body of the Government dealing with the issues of old age and ageing, measures aimed at improving inter-sectoral cooperation, production of reports and analyses, reporting and other tasks (http://www.zavodsz.gov.rs).

[21] Employment drop and an extremely high unemployment rate (20% in 2010) are "the Government's nightmare, because it blames the privatisation for that, which causes unemployment by default, and also strong trade unions, working against increased employment, since they insist on short-term benefits for employees" – statement of Mr Mirko Cvetković, Prime Minister, during the conversation on a new credit arrangement with the World Bank and the IMF in mid-April 2011 (Source: Tanjug, April 18th 2011).

zavod za statistiku, 2011). A set of incentives for employers, their exemption of the obligation to pay contributions for social insurance, and tax exemptions have had little impact on the employment of older and retired people. It is estimated that in the future there will be no significant positive developments in the field of employment of these individuals and that, in spite of new development strategies,[22] employment of people over 65 years, will remain at the level of 5%. Such a situation is interpreted primarily as a result of downsising the agricultural sector (where the majority of elderly work), and changes in the direction of rising the retirement age.

Evaluations of the role of the pension system in the prevention of poverty of the elderly are based on data on the participation of average pensions to average net earnings, exchange rates and indicators of poor elderly. In February 2011, according to the Republic Fund for Old-Age and Disability Insurance, the average pension of insured employees was 22,224 RSD (EUR 220), amounting thus to 63% of the average salary. A similar proportion was noted with retired self-employed (61%), for whom during the same period the average pension was 21,739 RSD (EUR 210). The most unfavorable situation is for the farmers, where the average pension in February 2011 was 8,743 RSD (EUR 87) or 25% of average salary in Serbia. The lowest are the survivor pensions ranging from 16,000 RSD (EUR 160) for employees, to only 6,500 RSD (EUR 65) for farmers. The law does not provide indexation of survivor pensions, which particularly affects women who dominate in the total number of survivor pensioners.

Figure 1: Minimum pension and poverty line



** The evalution does not include in-kind revenues ** Old-age and disability pension from the insurance of employees and self-employed.*

Source: Vlada Republike Srbije, 2010b.

[22] The study *Post-Crisis Model of Economic Growth and Development of Serbia 2011-2020* envisages a rate of GDP growth of 5.8% per year, opening of more than 400,000 jobs during the following decade, an employment rate increase from 40.5% (in 2010) to 49.9% (in 2020), and unemployment rate decrease to 10.3% in 2020.

The replacement rate, as an important element of the pension system design, shows that in Serbia the insured with a full qualifying period can have benefits amounting to 72% of previous earnings (2010). It is expected that over the next five years, there will be a reduction by three to eight percentage points, depending on the GDP growth and real wages trends.

The rate of absolute poverty and relative poverty of pensioners is slightly lower than of the total population. According to the latest available data of the Statistical Office, in 2009 12.9% of pensioners were relatively poor, i.e. 5.3% absolutely poor. Pensioners over 75 years of age are even worse off, and the rate of relative poverty in the group of the oldest, according to the *Household Consumption Measurement Survey* in 2009 was 16.0%, with notable differences between men (13.5%) and women (18.0%). Data from the *Living Standard Survey* show that the poverty rate of the elderly aged 65 and over in 2009 was 7.5% and that of pensioners was 6.1% (Vlada Republike Srbije, 2010b).

The Government estimates (Vlada Republike Srbije, 2011a: 245) that the biggest challenges for security in old age are high unemployment, problems in collecting contributions, bankruptcy and liquidation of companies, an inadequate structure and the underdeveloped economy. In the long run, problems in the pension system will be caused also by rapid ageing. There are no summarised medium and long-term forecasts on the main pension parameters, except for projections of population and the share of pension expenditures in GDP by 2015. Voluntary pension funds have little impact on security in old age, due to limited coverage of the population.

2.2.5 Critical assessment of reforms, discussions and research carried out

The strategic objectives of pension reforms in Serbia are defined as "provision of stable and sufficiently high pensions for all, improvement of the equity of the pension system and extension of the options for choice by pension insurees" (Vlada Republike Srbije, 2003). Declaratory determinations are supported by the OMC objectives, but the practices have often opposite effects. Parametric changes in 2010 were aimed at tightening the conditions for early retirement, but the applied solutions for indexation are in conflict with efforts to ensure the adequacy of income in old age. Despite the relatively favourable ratio of pensions and wages, adjustment to the cost of living and GDP growth will be reflected in the decline of pension amounts.

A special restriction is the solution in the *Law on the Budget System*, determining the share of pensions in GDP to 10%. It will have negative implications on the standard of living of pensioners in the future and will reflect in increased poverty of the elderly. In order to achieve the projected reduction in pension expenditures, the replacement rate will probably drop to 50%, which leaves room for the introduction of social pensions. This will require an increase of budgetary expenditures for social transfers.

Social pensions presented an option in the first years of reforms (2001-2003), but they were not introduced, even though a significant number of elderly is without constant cash income.[23]

Deficiencies in the system of social assistance are noticeable, and a small number of elderly and pensioners receive social benefits.[24] In the entire transition process, Serbia devoted small funds to the poor (0.15% of GDP in 2010). Despite constant warnings by international institutions (World Bank, 2009), and activities of the civil society, almost nothing has

[23] According to some estimates, 400,000 elderly aged 65 and more do not receive pensions, because they were not employed or do not fulfil the minimum conditions in order to be eligible for pensions (Amity, 2007).

[24] Strict conditions for eligibility to cash benefits exclude huge numbers of the poor in Serbia from the social benefits scheme. In 2010, 66,000 families i.e. 168,000 people received cash benefits each month, while the average monthly amount per family was 6,500 RSD (about 60 EUR).

changed. Inefficiency of measures in combating poverty of the elderly and pensioners is proven by the fact that elderly constitute the largest number of beneficiaries of public kitchens, providing them with one meal per day.

There are major obstacles to increasing employment of older workers and pensioners. Discrimination by age is more prominently present. Despite low incomes, pensioners regularly pay their taxes and other financial obligations and vote at elections in huge numbers. They are also a passive group that is unable to fight for their rights. The Pensioners Party is a part of the coalition in office, but it did not prove to be a true representative of the interests of its members. Its representatives in the National Parliament voted in favour of adopting the legal changes of December 29th, 2010.

The pension system is not transparent enough and media promotion and activities of the Ministries are not appropriate. The content of reforms is mainly spoken about when everything has already been completed. The home page of the pension fund provides basic information. The fund also publishes the magazine "Voice of the insured", discussing the topics of importance for the system of compulsory insurance. Information on voluntary insurance are written in technical and unintelligible language, and there is a lack of confidence in the safety of savings. Almost no one talks about life-long learning while the positive results of the "University of the Third Age" are almost forgotten due to lack of funds.

A complex evaluation of the results of pension reforms is not carried out, and evaluations of the effects of individual measures are left to the "Government's" analysts, advisers and experts, who are well paid. International institutions (UNDP, World Bank) and the European Union have financed a significant number of projects and supported the work of NGOs, but the overall effects of invested funds are problematic. Projects of NGOs are implemented only during the time for which there are financial funds available. Therefore, their effects on the position of beneficiaries are limited.

2.3 Health Care

2.3.1 The system's characteristics and reforms

Organisation of the public health system. The major part of the health system in Serbia is under state responsibility. It is organised by a network[25] of 345 public health institutions (Institut za javno zdravlje, 2010), operating on primary, secondary and tertiary levels of care.[26] From the administrative and functional perspective, responsibilities for providing health services are divided between local and national levels.

Primary health care, which is carried out by health centres (as well as pharmacies and bureaus), currently exists in a dualistic form: it is not consistently separated and independent from secondary health care. Health centres in some cases are still part of larger entities, i.e. hospitals. General and special hospitals belong to secondary health care, and clinical centres, clinics and institutes to tertiary health care and are the responsibility of the state. Despite the division, the organisation of public health institutions is still characterised by the lack of a clear separation of the levels of care. The introduction of the concept of selected doctors, or

[25] The structure and number of public health institutions is determined by the Government, by proposal of the Ministry of Health.

[26] For a more detailed approach to the organisation of the levels of health care, see Vuković, D. Perišić, N. *Annual National Report 2010 – Pensions, Health and Long-term Care, Republic of Serbia,* available at: http://www.socialprotection.eu/files_db/910/asisp_2010_Serbia.pdf.

"chosen doctors"[27] at the primary level, as one of the reform directions, is supposed to enable inter alia a (better) coordination between different levels of care, but also to promote health and preventive services, as opposed to the current system which is dominated by a clinical (curative) approach.[28]

At the same time, not all financial aspects of decentralisation in health, although it started back in 2005, have been resolved. Specifically, municipalities are responsible, among others, to finance the construction, maintenance and equipping of health facilities at the primary level, and they de facto create health services which will consequently be of different quality and scale. However, funding of salaries, medical supplies, and medicines is under the jurisdiction of the Republic Health Insurance Fund and/or the Ministry of Health.[29] In addition, the rules of financing primary health care are regulated at the national level, as well as criteria and standards of service provision and the number of employees.

The number of employees in the public health system of Serbia increased slightly compared to the previous year and amounts to 114,175 employees[30] (Institut za javno zdravlje, 2010). Employees of the public health sector make for about 5% of total employment in Serbia, i.e. almost a quarter of employees in the entire public sector (Fond za razvoj ekonomske nauke, 2010).

Organisation of the private health system. Despite the traditional existence and dominant position of the public health care sector, there are also private health institutions, with steadily increasing numbers estimated at about 5,370 (Republički zavod za statistiku, 2010).[31] The largest number of private health care facilities (more than one third) is located in Belgrade (Institut za javno zdravlje, 2009).

The existing legislative framework enables the organisation of private physicians' or dental surgeries, polyclinics, laboratories, pharmacies or outpatient units for health care and rehabilitation, but there are some limitations.[32] In practice, with the exception of pharmacies and dental surgeries, which represent the highest percentage of private health care facilities, a significant segment of health care activities is performed at the level of specialised health care services. However, despite the obligation to keep records and share information with Government agencies responsible for recording and collecting data on health care, there are

[27] Based on the latest available data, 63.85% of insured people opted for chosen doctors by February 2010. The percentage of the population who opted for chosen doctors ranges from 42.5% in Bor to 80% in Valjevo (Republički zavod za zdravstveno osiguranje, 2011).

[28] More information on the concept of "chosen doctors" is available e.g. on http://europa.sw4i.com/code/navigate.php?Id=811; see also chapter 2.3.2 below.

[29] The Republic Health Insurance Fund finances costs of salaries and expenditures related to providing health care services, while the Ministry of Health finances costs related to national programmes. The Republic Health Insurance Fund finances 83.8% of costs of health care centres (WHO, 2010).

[30] Out of that number, 26,746 employees have university degrees; 7,519 employees have two-year post secondary school degrees; 50,634 employees have secondary school degrees. Even 28,839 employees are not medical workers. The share of women (63.9%) among employed medical doctors is significantly higher compared to men (36.1%). Average years of life of employed are between 45 and 54 (Institut za javno zdravlje, 2010). The number of medical doctors per 100,000 inhabitants is 281; and the number of nurses per 100,000 is 572 (Vlada Republike Srbije, 2011a).

[31] Problems regarding realistic determination of the number of private health facilities refer among other things to the application of the laws regulating private entrepreneurs to the private health sector. Apart from that, the Republic Statistical Office publishes aggregate data for activities classified as "health and social work", making impossible a further break down of data.

[32] Based on current legislation, emergency medical services, provision of blood and blood derivatives, taking, keeping and using organs and parts of human bodies, production of sera and vaccines, as well as pathological-anatomic activities and autopsies can be performed only in public health facilities (articles 48 and 56, the Law on Health Care).

no complete data available on the types of health care services provided by private medical facilities.

The latest available data on the number of employees in the private health care sector refer to the year 2007 and are insufficient to gain an insight into ongoing developments. Available data state 612 employees (Institut za javno zdravlje, 2009),[33] but this does not include employees of the dental surgeries and pharmacies which surely employ the largest number of people in the private health care sector. The dynamics of employment is striking: from 2005 to 2007, the number of employees has tripled, but the starting figure (of 110 employees in 2005) is extremely low.

Accreditation of health institutions. Health care facilities[34] (both public and private) are not subject to a mandatory system of accreditation. It is currently voluntary and carried out by the Agency for the Accreditation of Health Care in Serbia, which began operating in 2009, as an independent public organisation, established to define standards of accreditation. A complete system of standards has not been established; results of accreditation are delivered to the management of the institution, as well as to the local, regional and national health administration, but not to the public. In addition, sanctions for health care facilities that do not meet the minimum criteria do not exist.

Financing and management. In the composition of total GDP, health care expenditures come immediately after pension expenditures, amounting to 5.4% in 2010 - this being a decline of 0.2% compared to 2009 and 0.3% compared to 2008. Projections for the period 2011-2013 predict their slight decrease in the share of GDP or stagnation on the same level, i.e. 5.5% in 2011, and 5.3% in 2012 and 2013 (Vlada Republike Srbije, 2010b), meaning that health care expenditures are not directly affected by the national consolidation programme.

The public health care system is financed mainly from contributions from health insurance (at a rate of 12.3%), which represent the largest source of incomes of the Republic Health Insurance Fund (70%). The rest of the revenues are transfers from the budget, transfers of organisations of mandatory social insurance and the other revenues and income. The Republic Health Insurance Fund centrally collects and redistributes funds. The largest proportion of its expenses are the salaries of employees in the public system (45%). The second largest share are the costs for medicines and medical devices (14%), as well as for prescription drugs (12%) (Republički zavod za zdravstveno osiguranje, 2011). Regarding the projections of total revenues and expenditures for 2011, compared to the previous four years, there are almost no differences in nominal terms that would reflect the potential impact of the crisis on the collection of contributions. Similarly, the structure of revenues and expenditures in the last four years has been almost identical.

Except for contributions, other sources for financing health care are private, e.g. the so-called out-of-pocket payments, which are made mainly, but not exclusively, for medicines (which are not on the positive list).[35] These expenditures amount to about 25% of total expenditures on health care (WHO, 2010), which ranks Serbia highly unpopular compared to many other European countries.[36] Even worse, data from the National Health Account in Serbia suggest

[33] Similar to the state sector, employees with secondary school qualifications are predominantly employed. Contrary to the state sector, most of them are aged 25 to 34 years (Institut za javno zdravlje, 2009).

[34] Contrary to that, health care personnel is subject to the procedure of licencing, every seven years (except for chosen doctors, who undergo licencing every three years). Licencing is obligatory for employed doctors and nurses both in the state and private health sectors.

[35] At the same time, unclear legal wording on paying the so-called non-standard medical procedures in the public facilities is also included in this figure.

[36] Estimated data of the United Nations Development Programme show that an average amount of bribe in October 2010 was EUR 225. The amount of bribe in October 2009 was EUR 169 (Danas, 13/04/2011).

that more than 35% of costs of health care are financed by households (Ministarstvo zdravlja, 2010).

Co-payments of patients constitute a very modest source of health care financing, due to the low (almost symbolic) amounts, as well as a wide range of persons exempted from co-payment (elderly over 65 years, children, pregnant women and persons with disabilities). In addition, based on amendments in 2009, co-payments do not need to be paid by unemployed and recipients of social welfare benefits.

Private expenditure for private health care services significantly increases household expenses. Numerous strategic documents envisage the increase in the share of private (profit and non-profit) sector service providers in health care, especially through its financing by the Republic Health Insurance Fund. The assumption is that the involvement of the private health sector in providing health care through contracts with the Republic Fund, should result in the integration of these two systems. However, there have not been any developments apart from papers and for now, they operate in parallel and independently of each other. As a result, in the situation of actual inability to exercise the rights to certain services by the state sector, based on the compulsory insurance, beneficiaries are left with an option of paying for these services in the private sector.

Data on expenditures on health care *per capita* differ, depending on the source, although an increasing trend is clearly present. Based on data of the European Commission, they amounted to EUR 91.9 in 2001 and it was expected to increase to EUR 254.5 per year in 2008 (European Commission, 2008). According to the Institute of Public Health, in 2003 they amounted to EUR 200, and in 2007 to EUR 384 (Institut za javno zdravlje, 2008). The World Health Organisation estimated them at 395 U.S. dollars according to purchasing power parity in 2005 (as opposed to even 2,282 U.S. dollars in the same year in the EU-15) (WHO, 2010). Finally, the Government stated that they amounted to about EUR 270 per capita in 2008 (Vlada Republike Srbije, 2011a).

Compulsory health insurance covers 6,786,333 inhabitants of Serbia (Republički zavod za zdravstveno osiguranje, 2011),[37]so that the coverage rate is 93%. The "missing" 7% can be attributed to minority groups (Roma), refugees and internally displaced persons, asylum seekers, etc.[38]

The *Regulation of Voluntary Health Insurance* of 2008 envisaged that the Republic Health Insurance Fund or insurance companies (provided that they obtain a license of the National Bank, based on a revision of the Ministry of Health) conduct a voluntary health insurance. Currently, ten insurance companies are active in this area. The number of clients is modest standing at 95,739 (Narodna banka Srbije, 2011b), although it can be assumed that the increase in purchasing power could lead to an increase.[39]

[37] 43.60% of the total number of insured persons are insured based on employment; pensioners (27.14%) follow after them, and persons whose insurance is financed from the budget amount to 17.83% (Republički zavod za zdravstveno osiguranje, 2011).

[38] See 2.3.5 – Access to health care.

[39] The *Regulation of Voluntary Health Insurance* of 2008 is only one of the latest acts regulating this area, and the private health sector existed also in the period before 2008. Therefore, certain conclusions can be made about the trends on the number of beneficiaries, which was very dynamic in 2007, when it was doubled compared to 2006. However, since 2008 (the first year of the crisis in Serbia), stagnation set in and after that it began to drop.

Eligibility, rights and benefits. In the past year, the *Law on Health Care* saw two amendments,[40] but they had no effect on the coverage, rights and benefits of health services' users.

The legislation stipulates that health care cover children, pregnant women, elderly, disabled, persons suffering from HIV, beneficiaries of social welfare benefits (and their families), the unemployed, people with low income, and Roma without permanent residence (Article 13, Law on Health Care).

The right to health care is a fundamental right in the system of compulsory health insurance and includes broadly defined preventive measures, examinations and treatments, medical rehabilitation, medicines, medical devices and supplies (Article 34, Law on Health Insurance). The content of this right was last amended in 2005, but not significantly compared to pre-existing arrangements.

Rights in the health system are:

- health protection

- income compensation during temporary incapacity to work of the insured and

- travel allowance in connection with the use of health care (Article 30, Law on Health Insurance).

Eligibility for the benefits has been tightened in comparison with previously applicable statutory provisions. First of all, the funeral grant was eliminated. Another innovation is the conditioning of the right to travel allowance and income compensation to the previous qualifying period, motivated by the attitude of the policy makers that the contents and scope of the law should be brought into line with available resources.

The length of paying income compensation during temporary incapacity to work by the employer has been shortened.[41] The employer pays the income compensation during the first thirty days of temporary incapacity to work. After this period the Republic Health Insurance Fund steps is, i.e. from the 31st day. A person is eligible for this benefit until the elimination of the causes for the incapacity to work. However, one can receive this benefit for six months without any interruptions, or 12 months during the last 18 months with interruptions maximally. After that, the person is directed to a disability commission for the purpose of evaluating the loss of the working capacity.

Travel allowance can be claimed under more stringent conditions, i.e. the criterion of a distance to the place of health care provision has been changed (previously this allowance was paid from distances of at least 30km, now only from 50km).

2.3.2 Debates and political discourse

Reform programmes. The challenges faced by the health system of Serbia are very diverse. Depending on the actors of discussion, the focus is on different issues - long waiting lists, the impossibility of achieving certain legally proclaimed and guaranteed rights, poor conditions in health facilities, lack of adequate and sufficient equipment, low salaries, corruption, etc.

Despite that, improvements of the health care system in the Government's discourse and reform programme for the period after 2010 constitute only a narrow part of considerations

[40] Changes as of November 23rd, 2010 regulate in more detail the issue of supplementary work of medical doctors and changes as of December 22nd, 2010 regulate taking professional examinations by health professionals.

[41] Articles 78 and 81, the Law on Health Insurance.

within the context of the public sector transformation. Surely, health reforms are directed towards establishing a system of health financing that would be compliant with the current changed economic circumstances. The goal of its reform is explicitly and comprehensively stated as "providing top quality health services and patient safety, along with establishing appropriate human resources in health care and a sustainable financing system in accordance with the financial capacities of the society" (Vlada Republike Srbije, 2010a: 75).

Since the issues of health financing and costs of the health system are undoubtedly at the focus of professionals and the general public, the Government suggested to change the existing funding arrangements, in order to avoid inefficient use of available resources and to incorporate incentives for increasing the volume and quality of health services. Based on recommendations of the World Bank, the system of payment per patient would be introduced at the primary level, and the system of payment by results at the secondary level. That means that the payments would be based on performance and diagnosis-related groups (instead of the current allocation of funds based on the number of staff and beds). However, these innovations require amendments to the Law on Health Insurance, which are missing so far.

As a measure of more effective management in public health care facilities, it is planned to continue with the introduction of information technology and accreditation "to improve the work of medical facilities and patient safety and create a fair, sustainable highly efficient health care system in which health care providers are encouraged to achieve a continuous enhancement of standards of efficiency and quality" (Vlada Republike Srbije, 2010a: 76).

At the same time, according to the *Report on Improving the Quality of Work*, it is planned to introduce a national waiting list, on the base of which health facility users who have been waiting for a longer period will be able to exercise their rights in other health facilities, in which the list is shorter.

Sector Strategies. The Strategy of Primary Health Care in the working document *Better Primary Health Care for All of Us - Health Policy Guidelines for Strengthening Primary Health Care System in Serbia from 2010 to 2015* envisages that primary health care "provides better health outcomes and more equitable distribution of health services" and that health centres be the focal point of the primary health care. Accordingly, it is intended to strengthen health capacities at the local level. The Strategy defines the directions of health policy at the primary level, building on the strategic objectives and guiding principles from the document *Health for All*, in an attempt to create an integrated system of primary care, in line with the already adopted sectoral strategies and international recommendations. It is also consistent in the implementation of the concept of chosen doctors,[42] in order to create, among other things, conditions for changing the funding of the primary health care level.

Strategic sectoral documents were supplemented by the Strategy on HIV infection and AIDS in the Republic of Serbia, which is a five-year framework "for the development, implementation, monitoring and evaluation of the national response to HIV infection" (Strategy on HIV infection and AIDS, 2011: 2) and which is a sort of a continuation of the National Strategy to Combat HIV / AIDS adopted in 2005.

Moreover, a draft Strategy to Combat Alcohol Abuse and Alcoholism was prepared, with its adoption being expected in May 2011. The draft seeks to link the health sector with other sectors relevant to the prevention of alcoholism and treatment of alcoholics. The role of the

[42] The concept of selceted doctors or "chosen doctors" is one of the most important elements of primary health care reform. It requires from patients to choose and register with a general practitioner, a gynaecologist, a paediatrician, or an occupational doctor. A chosen doctor coordinates health care across all levels of health care (Ministarstvo zdravlja, 2010).

health system is defined as "improving the response of the health system by strengthening human resources and institutional capacity for early detection and treatment of alcohol addiction [...], improving the quality and range of activities in the field of health promotion and prevention of alcohol abuse [...], increasing the number of addicts to alcohol in all forms of treatments, as well as improving conditions in which and under which they are treated [...], strengthening capacities for monitoring prevention activities at the national level [...], improving mechanisms for early detection of disorders associated with alcohol [...], improving the procedures in the process of implementation of the measure of compulsory treatment of alcoholics in closed and open conditions" (Draft Strategy to Combat Alcohol Abuse and Alcoholism, 2011: 14-16).

In addition to strategic documents of national actors, the World Bank made a *Social Protection & Labor Strategy 2012-2022 concept note*, which does not refer solely to Serbia, but is planned to be implemented in Serbia as well as in other countries. One part of this document deals with the issues of health care and health insurance, equally with other segments of the social protection system. It is a part of the *three P* framework (prevention, protection, promotion) for resilience and opportunity as well as the role of social protection institutions. It points out the importance of health insurance in the "prevention against drops in well-being from income and expenditures shocks [...], protection from destitution and catastrophic losses of human capital [...], promotion of improved opportunities and livelihoods, notably through connecting to better jobs and opportunities" (World Bank, 2011: 1-2). In the context of gender equality, the basic preventive health care for mothers and their children, is taken into account, as one of the prerequisites for gender equity in outcomes.

2.3.3 Impact of EU social policies on the national level

Since Serbia is not a Member State of the European Union, the community social policies and instruments of their dissemination can be observed within the broader framework of general harmonisation of national policies with the European social values. Bearing in mind their differences (as proclaimed by the EU principle of "united in diversity"), the health system in Serbia is generally comparable to the health systems of the EU Member States, in terms of its organisation and costs. At the level of organisation, the health system in Serbia is comparable with the countries of the Union which are based on the Bismarckian principles. At the level of costs, it is comparable with the New EU Member States. A recent World Bank study pointed to the comparable situation in the health care conditions in Serbia and the New EU Member States, and to the fact that this situation is, in certain respects,[43] even better in Serbia (World Bank, 2009).

On the other hand, in the context of the declared orientation of the Government and policy makers towards joining the European Union, numerous efforts aimed at reforming the various parts of the health care system are concentrated in the direction of its improvement. In the Government's discourse this is frequently equalised with the harmonisation with the European framework and a better positioning of indicators and performances of the Serbian health care on the European "list". The first steps in that direction in the health sector have been made through harmonisation of the Serbian legislative framework with the EU, and the adoption of different strategies, inspired by the development of health care in the EU Member States.

[43] Firstly, the epidemiological structure in Serbia is similar to that in the Eastern Europe. Also, "the number of beds per 100,000 inhabitants is almost at the level of EU15" (World Bank, 2009: 24-25); [...]"and the number of medical doctors is comparable with their number in the EU" (World Bank, 2009: 25)

One of the most recent events related to the European agenda whose fulfillment is expected from the Serbian Government, was the submission to the European Commission of the Answers to the European Commission's Questionnaire. The chapter entitled *Social Policy and Employment* contains answers to questions relating to the issues of health care (including long-term care), from the point of its organisation, financing, the share of expenditures in GDP, accessibility and quality of services, etc.

An integral part of the *First National Report on Social Inclusion and Poverty Reduction*, are the health aspects regarding poverty and social exclusion in Serbia.

The concept and process of the OMC in the public discourse and policies in health are not represented, but certain instruments of the OMC (reports and indicators) have been partially implemented. At the same time, the objectives of the OMC in health care are the main objectives towards which the realisation of the health care reform in Serbia is directed - encouraging the accessability and quality of health services, as well as the sustainability of the health system (and health insurance). Subjecting objectives' to (re)evaluation, which is also in the spirit of OMC, is the obligation of state authorities.

2.3.4 Impact assessment

A comparison of the share of GDP of expenditures for the public health care system in Serbia with the health expenditures in the countries in the region indicates that they are higher, while on the other hand, the results or outcomes of the health system are average.[44] Based on that "it can be concluded that there is a cost inefficiency in the health system" (Fond za razvoj ekonomske nauke, 2010: 167), which should be addressed by appropriate reforms of the system.

In this regard, the recommendations of the World Bank range from reducing the number of beds[45] to decreasing the number of non-medical staff, but also of physicians in health centres, to improving decision making procedures in terms of the purchase of new technologies and approving prescription drugs (World Bank, 2009).

Although the reduction in the number of beds had been in an advanced phase even in 2008, it is obvious that this trend has still not been satisfying in terms of cost savings. In addition, the procedures for purchasing (new) equipment should be designed so as to avoid pitfalls of corruption. However, the biggest potential problem is the selective reduction of the number of employees. "The realisation of these reforms requires high vigilance in order to avoid the mistakes of the past. For example, the reduction in the number of employees in health professions in 2006 was based on the voluntary departure of employees with relatively high severance payments. The result was that some of the most necessary medical personnel left the health system, and moved to the private sector, while the non-medical personnel, where there are surpluses, rested in the public health system. Two years after that, due to drainage of necessary medical personnel, the Ministry of Health launched a recruitment campaign for new doctors" (Fond za razvoj ekonomske nauke, 2010: 167).

Starting from 2000, the number of unemployed doctors, dentists and pharmacists has increased. According to data of the Government of the Republic of Serbia, this trend reached its peak in 2005, and 2006 and 2008 there were 3,102 unemployed of these professionals (1,750 medical doctors, 1,145 dentists and 207 pharmacists). The increase in their unemployment is interpreted as the "absence of a coherent national policy of planning

[44] International monetary institutions, especially the World Bank and the IMF, evaluated that it is necessary to further rationalise the benefit package and that this area of reforms was neglected.

[45] In 1998, there were 48,302 beds and in 2008, there were 40,908 beds (Institut za javno zdravlje, 2009).

enrolment to universities and education, employment and continuous training of health employees and associates" (Vlada Republike Srbije, 2011: 261).[46]

Changes in the financing of primary and secondary health care, would also contribute to a more rational use of existing funds and to raising the efficiency of health care. This efficiency would be reflected not only in direct monetary terms, but also in terms of reducing the number of staff and rationalising infrastructure in general, as well as encouraging growing outputs, i.e. number of patients eligible for preventive services and/or treatment (World Bank, 2010).

Since the current system of funding is based on the number of employees, number of beds and used material, e.g. medicines, health care facilities are generally encouraged to maximise, and not to minimise their costs.

The change based on which health care facilities with a greater number of patients would receive more funding, could also change the responsibility for solving the problems of redundant employees. Responsibility for the determination of the actually needed number of employees would be within the health facilities (and indeed within the local community in which they operate). "This method would help shift some financial risk from the Health Insurance Fund to the health centres. If a health centre's expenditures are greater than the budget provided, it will be liable for the difference. If the health centre shows efficiency gains and its costs are lower than the capitation budget, it will be allowed to retain and re-invest the surplus for providing better health care" (World Bank, 2010: 1).

A study conducted by the World Bank[47] at the request of the Government, focused on the costs and effectiveness of work in 147 health centres before the implementation of the finance reform. It is planned to conduct new research, two years after the reform's implementation.

The main conclusion of the research pointed out essential differences in the level of efficiency among individual health centres. "Although health centres generally work with the same level of staff, medical equipment and space – which are largely dictated by the system - they produce different levels of output [...]. To some extent, the level of productivity in health centres may be affected by the age/gender structure of the population, particularly by the number in the health centre catchment area" (World Bank, 2010: 2). Overstaffed facilities, together with consequent excessive share of costs for salaries in total expenditures, and the existence of equipment that is relatively rarely used, are the three biggest challenges to effectiveness of health care facilities in primary care.

On the other hand, paying hospitals based on average costs of those services, "would press those health institutions which have above-average costs of treating certain diseases to reduce these costs" (Fond za razvoj ekonomske nauke, 2010: 168). At the same time, according to experts of the World Bank, these average costs could eventually be modified, taking into account regional differences and including indirect costs (teaching and capital costs) (World Bank, 2010).

A potential counter-effect of these changes could be an unrealistic representation of the actual scope of provided services or their decreased quality. Also "capitation may lead to higher referral rates to hospitals as health centres will have the incentive to reduce their costs and

[46] The National Employment Service presents only aggregate data for the category of unemployed per professional groups for various levels of school degrees. Therefore, it is not possible to draw a conclusion on the number of unemployed doctors, dentists and pharmacists, compared to the number of unemployed nurses, dental and pharmaceutical technicians. In December 2010, there were 13,423 unemployed doctors and other medical occupations, 2,772 unemployed dentists and 1,863 unemployed pharmacists (Nacionalna služba za zapošljavanje, 2011).

[47] It was published in July 2010.

hospitals paid by DRGs will have an incentive to hospitalise more patients" (World Bank, 2010: 3).

On the side of the users of health services, a survey to assess their satisfaction with public health facilities was conducted also in 2010 by the Institute of Public Health of Serbia. It showed some differences, caused by the level of care (Institut za javno zdravlje, 2011a). At the primary level, 4% of patients do not have chosen doctors, and about four fifths of those who have chosen a doctor, did not change them. Waiting times for an appointment extended (slightly) compared to the previous year. As for the nurses, affirmative statements about their work and relationship with patients were expressed by more than 80% of patients. At the same time, affirmative statements about the work of chosen doctors were expressed by over 85% of patients (Institut za javno zdravlje, 2011).

Although the share of patients who are aware of the existence of health centre websites as well as of the possibility to turn to the medical staff of health care institutions and receive information over the phone, is still unsatisfactory, they have been in a discrete increase over the previous year. However, these and other questions (and answers) reveal that users are still not fully familiar with all the rights and aspects of exercising the rights they have under the law.

The results of surveying general satisfaction showed that the general practitioner services and pediatrics services in health centres have a uniform quality of work, and that satisfaction with services in health care for women is lower than in the previous year. Overall, the mean rating of user satisfaction in primary health care in 2010 is 4.10 and it is higher compared to 2009, when it was 4.02 (Institut za javno zdravlje, 2011). Some differences were found in the satisfaction rating at the regional level (Table 2).

Table 2: General satisfaction of users in the primary health care facilities per regions

Vojvodina	Central Serbia	City of Belgrade	Kosovo and Metohia	Republic of Serbia - average
3.98	4.16	4.00	3.76	4.10

Source: Institut za javno zdravlje, 2011.

On the other hand, the evaluation of user satisfaction with the hospital treatment as a whole was 4.32. This is higher than the level of satisfaction with primary health care, but is negligibly lower than in the previous year (4.33 in 2009) (Institut za javno zdravlje, 2011). This decline in satisfaction by 0.1 points has stopped the trend of satisfaction growth initiated in 2005.

Of the four wards that were tested, the most satisfied patients are those treated in surgical wards (4.4), and the most dissatisfied patients are in gynecology and obstetrics departments (4.07) (Institut za javno zdravlje, 2011a).

The satisfaction survey of employees in public health facilities is a part of a package of measures for the improvement of health care quality. It was carried out on a sample of 64,000 employees, of which 77% are health workers. Half of the respondents were satisfied with the work they do, which is a drop compared to 2009. There were important differences in the satisfaction of employees, based on education level, type of institution, and monthly income. The effects of continuing education were positively evaluated (Institut za javno zdravlje 2011b).

2.3.5 Critical assessment of reforms, discussions and research carried out

Access to health care. Overall reform orientations in the health care system have emphasised affordability, accessibility and equity of health care, which is a legal, and ultimately, the constitutional right of all citizens of Serbia. The implementation of this right and principle in

practice is, however, faced with certain obstacles. Therefore, inequalities in access can be defined as financial, social and territorial.

Rights in the health care system continue to be broadly defined, so that one of the first restrictions on access to health care is de facto a large number of users, in relation to the availability of facilities and staff. Underused capacities in some health facilities exist along with the overload of these facilities in some other places (which is certainly a "burden" of the past where, compared to nowadays, the territorial distribution of the population was different). Differences in access to health care are especially present between developed and underdeveloped regions, and urban and rural communities. In communities with smaller numbers of inhabitants (underdeveloped rural areas), there are frequently problems in providing basic health services. Specialist facilities (institutes and clinics) are situated in big cities, the majority of them in the capital, Belgrade.

A noticeable downturn in the standard of living and purchasing power was not without consequences for the (re)orientation of the population to the state (and not private) health system. The impact of the crisis undoubtedly contributed to the increase in the number of users of the state health system.

The consequent occurrence of waiting lists, which have been a significant factor in lowering the overall satisfaction of patients with the work of the public services, surely represents limits in the (timely) access to health care. In addition, the territorial distance to health care facilities and factual impossibility of exercising rights (or even just lack of funds of the vulnerable groups to cover the cost of health care) compromise the principle of accessibility of health care.

This is precisely the case with high-risk population groups where the inadequacy of access to health care can be observed. Namely, a large number of Roma children[48] are not covered by the health care system, similar to asylum seekers, and potentially even refugees and internally displaced persons, who because of lack of personal documents, are not able to exercise rights under health insurance. In addition, due to stricter criteria and checks of actually paid contributions by companies, employees whose companies have not paid contributions for health insurance, cannot either exercise these rights.

Quality of health care. Enhancing the quality of health care is often a highlighted issue of health care reforms, but measuring quality and actual determining indicators is not high enough on the priority list. Moreover, the surveys of health care quality (conducted by the Institute of the Public Health of Serbia) include highly quantitative and descriptive data, representing more straightforward information about rendered health services, failing to provide an analytical assessment of the quality of health care services in Serbia.

Surveys of satisfaction with health services are partial evidence on their quality, from the perspective of patients. Along with the statements of beneficiaries, the quality of health care should be fully assessed by taking into account some additional measurable objective indicators.

The Report on Social Inclusion and Poverty Reduction cites that five indicators are taken into account when assessing quality and that two of them are actually available: satisfaction of beneficiaries with health services, and immunisation rates. Immunisation rates in children are above 95%. However, immunisation rates of children belonging to the Roma population are only between 55.6% and 88.8% (Vlada Republike Srbije, 2010b: 179).

[48] Significant progress in the health care coverage of the Roma population has been realised through introduction of a special budgetary line of the Ministry of Health aimed at the improvement of their health situation (Vlada Republike Srbije, 2010b).

It seems that there are significant regional disparities in practice, in terms of quality of provided services. As a rule, better quality of services is provided in major medical centres, especially in bigger cities and at secondary and tertiary levels of care. This is influenced by the lack of obligation of health care institutions (both public and private) to be accredited, i.e. existence of certain equipment and their adequacy, different coverage by an adequate health staff,[49] the diversity of the demographic structure of the population, and so on.

Financial sustainability of the health care system. The financial sustainability of the health care system is an essential issue and pre-condition for the development of the quality and accessibility of health care in Serbia. The projections of the system's financial sustainability were made for its mid-term development based on the contents of the Government's Revised Memorandum on the Budget of 2010. It is threatened by various factors, above all, the macroeconomic situation, and then the demographic structure of the population.

Macroeconomic trends, particularly low activity and employment rates[50] do not have a positive impact on the expansion of the contribution base and the collection of contributions. This requires cash interventions from the state budget. Except for compulsory insurance, the problems will be reflected in the system of voluntary health insurance, through reduction in the number of users and amounts of payments.

The demographic structure of the population, characterised by the increasing share of the elderly which is already at a high level, is prone to growth, and not reduction of health care costs.

The unresolved status of the private health sector and delayed creation of partnerships between private health facilities and the Health Insurance Fund, i.e. contracting with the Fund, is unhelpful with regard to solving the problem of financial sustainability of the public system.

The foundation of the financial reform is the introduction of new instruments of financing of primary and secondary care (as mentioned in chapter 2.3.2). These mechanisms have long been announced, they were piloted, and various feasibility studies were made, but they still have not been introduced into practice. Assuming the introduction of the capitation system in primary care and the system of diagnosis-related groups in secondary care, it would be necessary to avoid negative incentives so that these mechanisms could allow a more rational use of resources (as mentioned in chapter 2.3.4).

Expansion and increase of co-payments for the purpose of reducing health care costs is not a very probable option, due to low purchasing power of the population.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Organisation / institutional responsibilities and service provision. Long-term care is not a separate part (or the so-called fifth pillar) of the system of social protection in Serbia. Long-term care is composed of certain parts of the health care and social welfare system, and the

[49] Variations in the number of medical doctors per 100,000 range from 151 (in the region of Srem) to 437 (in the region of Nis). Regarding nurses, variations are between 314 (in the region of Srem) to 657 (in the region of Zajecar) (Vlada Republike Srbije, 2011a). These variations surely point to a disequilibrium in the quality of services.

[50] In its Revised Memorandum on the Budget, the Government of the Republic of Serbia "in the period 2011-2013 envisages employment growth of about 3.6%" (Vlada Republike Srbije, 2010a: 16). This increase should be taken into account only having in mind the employment drop in 2009 and 2010.

legislation governing its organisational, financial and other aspects (including the rights and benefits) does not use the term long-term care as yet.

Public health care facilities provide inter alia long-term medical care services, whose characteristics are conditioned, above all, by the level of care.

The implementation and provision of palliative care at the primary level is organised through services for home treatment and in health centres. However, more than 40% of health centres do not have services for home treatment and care (Vlada Republike Srbije, 2010b), but the activities of these services are performed as part of health protection (general medicine, emergency, polyvalent visiting services). The exception is Belgrade with its Institute for Gerontology, as an institution specialised in home treatment and palliative care.

The number and structure of physicians in services for home care and treatment, and their workload, are in accordance with accepted national standards of work. In contrast, the number of nurses and medical technicians is not sufficient, and, consequently, their workload is above prescribed standards.

Long-term medical care is also provided in the departments of so-called prolonged treatment and care, at the secondary (general and special hospitals), and the tertiary levels of care (clinics). Facilities providing prolonged treatment and care are actually those hospitals and clinics caring mostly about geriatric patients, dealing with palliative care, chemotherapy, psychiatric treatment, physical medicine and rehabilitation.

National standards provide for the existence of 0.20 beds per 1,000 people in the facilities for prolonged treatment and care.

In the social welfare system, long-term care is organised in two paths: institutional and non-institutional. Institutional services relate to accommodation in institutions, and non-institutional services are defined as daily services in the community, including, among other things, at-home assistance.

Accommodation in institutions for the elderly in Serbia is provided in 49 public homes, with a capacity of 9,320 elderly over 65 years. Most of the elderly are in Belgrade (1,160), and Novi Sad (868) (Ministarstvo rada i socijalne politike, 2011).[51]

Changes in the organisation of the system were introduced in March 2011 based on new legislation in the field of social welfare which stipulated the foundation of the so-called social-medical facilities "for those users who because of their specific social and health status have the need for social care and constant medical care or supervision" (Article 60, Law on Social Welfare). Establishing social-medical facilities is now the only option to link the two separated parts of the system and thus improve service delivery as well as their coordination.[52]

At the same time, there is a possibility to provide services in residential institutions for the elderly, among others, by "provider[s] of social welfare services that [are] licensed to do so through the procedure of public procurement of social welfare services" (Article 64, Law on Social Welfare), in those cases where it cannot be provided, within the necessary scope, in state institutions of social welfare. It is this new area of the law, where signs of an increased share of private provision of long-term care are visible.

Relocating home care into institutions for the elderly is one of the areas, the private sector has been showing a constant interest in for years. The reasons stem from the lack of sufficient capacities in the public institutions for care of the elderly and waiting lists that have resulted

[51] New regulations stipulate that homes for adults and elderly cannot have more than 100 places (article 54, the Law on Social Welfare).

[52] Frequently, bad results are attributed to the lack of cooperation among different sectors.

from mismatches between the needs and supply. Private homes for the elderly, who have seen quite an upswing in the past, however, lack qualified personnel. Due to the inability to satisfy this criterion and other standards, which are legally very strict, private homes for the elderly are in practice rarely registered as accommodation facilities for the elderly, although they are engaged in this activity.

According to data of the Ministry of Labour and Social Policy, 46 private homes have been established in Serbia in the period from 2004 to 2010 with a total capacity of 1,252 people (Ministarstvo rada i socijalne politike, 2011). Because of the many unknown facts associated with these problems, the number of private institutions that actually act as care homes for the elderly or the number of beneficiaries cannot be precisely stated.

Contrary to care homes, at-home assistance is provided as a form of supporting the stay at home in those cases where the person is unable to take care of himself/herself, i.e. the family is unable to provide adequate support or does not exist. In Serbia, domiciliary care is organised in only 39 municipalities (14 in Vojvodina, 13 in Belgrade and 12 in central Serbia) and offers the services of performing household activities (cleaning, buying food and other necessities, etc.).

The role of the family in meeting the needs for long-term care in Serbia is significant and manifold, but it also faces some substantial constraints. In the context of current demographic trends, which are characterised by an increased share of the elderly, it is quite probable that a growing population will require long-term care. In addition, because of the longer life expectancy of women, a larger number of older women is in need of long-term care than men.

Specific needs of the eldest often require residential care, because they cannot be met by their family. Waiting lists in the public care homes are forcing families to look for alternative solutions. Private care homes are a viable option only for those who have sufficient financial resources, which is not particularly widespread. A similar situation applies to the involvement of informal private carers, also requiring significant financial resources. On the other hand, in the case a family uses public services (such as at-home help and the so-called geronto-housewives), there are significant areas uncovered, i.e. a private carer should be engaged at least some time.

Engaging family members is often impossible and/or difficult due to physical barriers, such as territorial distances and modest comfort in apartments/houses. Since as a rule, female members of the family are carers, it is likely they will be “double burdened” - in addition to providing care to old family member(s), they are engaged in taking care over younger family members (because appropriate mechanisms of their care are often not available, and the work schedule of public schools does not comply with working hours of parents). In addition, few families manage to satisfactorily reconcile the need for long-term care and professional obligations.

Therefore, families surely need strengthening in order to carry out the role of taking care of the eldest. This is due to different and adverse trends in the society and involves the development of a number of services the family might rely upon and more evenly distribute the burden of care for the elderly. The economic crisis and social problems in the transition process impacted the rise in poverty of families with many members and the loss of the traditional protective role. The support families need is financial and in terms of providing for needs of children and elderly. On the other hand, the empirically (and theoretically) under-researched issue of family solidarity after twenty years of crisis in Serbia would certainly represent an important source of data for the issues of care and for meeting the needs of the elderly.

Financing and management. According to the estimates from the National Health Account, in the period from 2003 to 2006, the long-term care segment which belongs to health care was funded with 0.04% of GDP (with the exception of 2005 when long-term care expenditures amounted to 0.05%) (Gajić-Stevanović, Teodorović, Dimitrijević, Jovanović, 2010). At the same time, they represented 0.33% of total health spending in 2003, and 1% in 2008 (Vlada Republike Srbije, 2010b).

In the segment belonging to social welfare system, long-term care was funded with 0.74% of GDP in 2007, and 0.84% in 2008 (Vlada Republike Srbije, 2010b).

The part of health care and health insurance which de facto regulates the rights relating to long-term care is financed in the same way as the entire health system.[53] Persons aged over 65 years are exempted from paying co-payments.

The social welfare system is financed by taxes, i.e. the state budget. Accommodation in public institutions for long-term care is partly financed from the state budget, and daily services in the community are financed from the local budgets.

Accommodation in public homes for the elderly is partly financed by the users, and partly by the state (so-called subsidised financing, i.e. co-payments of beneficiaries to the cost of services). Elderly without income exercise this right at the expense of the budget in full. Accommodation in private care homes and other related services are completely user-financed. These prices are regulated by market principles.

The Memorandum on the Budget with projections to 2013 does not provide disaggregated costs for long-term care within the general projection of expenditures for the health care system, so it is not possible to achieve insight into the planned trends of these expenditures. The same applies to the data for social welfare, which do not contain separate items of long-term care.

On the other hand, a working group for the preparation of secondary legislation (related to the Law on Social Welfare) has been formed. Its subgroup for standards announced the introduction of minimum national standards in social welfare. In this context, it is planned to set higher quality standards for the accommodation of elderly, and to work on defining social-medical services and financial analysis of long-term care.

Eligibility, rights and benefits. In the health care system, persons older than 65 years constitute a distinct group towards which special attention is directed, given its increased exposure to risks of disease (Article 13, Law on Health Care). Except that, there are no specifically defined or wider rights of elderly to health care, compared to other age cohorts.

In the system of social welfare, the rights specifically related to long-term care are:

the right to services, i.e. at-home assistance and the services of institutional accommodation and

the right to material support (benefits), i.e. cash social welfare benefits and allowance for support and care by another person.

The contents of the right to at-home assistance and the services of institutional accommodation have not changed during the past year in relation to the legal solution valid up to March 2011.

[53] Employees and employers pay contributions, while the state pays for the health care from its budget for those who cannot aford to pay.

Regarding the right to cash social welfare benefit, elderly over 65 years are treated as individuals unable to work, so they have the right to increased cash benefits (20% increase compared to the regular rate).

The right to allowance for support and care by another person can be realised by those who need help "in order to meet the basic needs and cannot get out of bed, move inside the home without the use of appliances, eat, undress, dress or maintain basic personal hygiene without assistance of another person" (Article 92, Law on Social Welfare).[54] The number of benefit seekers is on the rise (Table 3), and the average regular amounts are unsatisfying compared to actual costs.

Table 3: Allowance for care and assistance by another person

	Average number of beneficiaries	Average regular amount in RSD	Average increased amount in RSD	Total amount in billion RSD
2008	41,832	6,152	16,130	5,3
2009	46,948	6,649	17,390	5,9
2010	50,320	7,015	18,275	6,3

Source: Vlada Republike Srbije, 2010b.

The right to cash benefits for care and support of another person based on old-age and disability insurance can be realised solely by contributors, i.e. not all citizens are entitled. In parallel, in the social welfare system poor elderly receiving welfare benefits are entitled also to cash benefits for care. Based on legislative changes in 2010, the right to payment of compensation for the care and support also for people accommodated in homes for elderly was re-introduced (based on changes from 2008, this right had been cancelled for those in homes for elderly).

2.4.2 Debates and political discourse

The problem of long-term care is not a number one topic in Serbia and in fact the absence of discourse in the society about long-term care (political, scientific research and professional, expert, user) is noticeable. The term of long-term care has begun to be used only recently, but it gets its place, for now in the form of integral social and medical care.

There are no indications of designing an independent long-term care system. Reasons and obstacles for that are mostly related to financial and organisational constraints, but it is very likely that the pressure of expected change (in the field of demography, work and family) will drive the Government to review its independent existence.

The status of elderly is much more in the focus in terms of their material deprivation, insecure income in old age and above average exposure to poverty, and also the problem of exercising the right to health treatments. These problems certainly are connected to challenges of the provision of long-term care.

The period of reforms has "bypassed" long-term care, which applies particularly to the segment that belongs to health. Long-term care in the social welfare system was modified in the direction of non-institutional services and provison of services for the elderly in their homes. Additionally, certain reform steps forward were made, primarily in terms of the adoption of strategic documents. Various aspects belonging to the field of long-term care and

[54] The monthly amount of this benefit is 7,600 RSD. Increased benefit amounts to 20,050 RSD (Articles 93 and 94, Law on Social Welfare).

improvement of the situation and position of the elderly were discussed in a number of strategic documents adopted in the past ten years,[55] which apply to the segment of social welfare, rather than health.

The working document draft *Better Primary Care for All of Us - Health Policy Guidelines for Strengthening the Primary Health Care System in Serbia from 2010-2015* briefly deals with long-term care from the health aspect. It is presented together with home care and treatment, starting from that it "covers a wide range of assistance in daily activities over a longer period of time for the elderly and persons with disabilities, in order to assist them and provide a higher quality of life" (Ministarstvo zdravlja, 2010: 29). At the same time, it envisages a variety of arrangements for providing long-term care services, taking equally into consideration accommodation institutions and the natural surrounding of the elderly. In the opinion of the policy makers, long-term care should be organised around supporting activities, which include "bathing, eating, walking or taking them to the toilet [...], help with housework and other activities, such as shopping, cooking, money management, paying bills, or travel to and from one's home" (Ministarstvo zdravlja, 2010: 29).

The *Memorandum on the Budget* does not specify the issue of long-term care within the considerations of improving the systems of health or social welfare. In general, it states the continuation with the orientation of the Government programmes of financial assistance (which are mainly paid to elderly). Allowance for care and support by another person, which is mainly paid to elderly, is considered from the point of view of "harmonisation with the European standards" (Vlada Republike Srbije, 2010a: 67).

2.4.3 Impact of EU social policies on the national level

Impact of EU policies in the field of long-term care can be observed through the impact on specific areas of health and social welfare.

As in health,[56] also in social welfare in Serbia the OMC is not directly presented or used as an applicable concept. (Sub)forms of the OMC that are applied in social welfare relate mostly to the adopted indicators for measuring poverty and social exclusion. The *First National Report on Social Inclusion and Poverty Reduction in Serbia* is designed based on the Laeken indicators (with the incorporation of two national-specific indicators).[57]

Given the characteristics of the existing scheme of long-term care in Serbia, material, i.e. financial deprivation, social welfare and health are aspects of poverty and social exclusion, whose relationship with long-term care is of relevance.

Results of the *National Report* indicate an above-average risk of poverty in persons over 65 years, which was 18.2% in 2009 (but it is comparable with the rate of the poverty risk of elderly in the EU27, which amounted to 18.9% in 2008), as well as a strong gender difference, or greater exposure of aged women to poverty. The impact of social transfers in reducing poverty of the elderly is extremely modest (from 18.9% to 18.2%) (Vlada Republike Srbije, 2010b). Data on the poverty of people with disabilities indicate their high exposure to poverty and the enormous difficulties in social inclusion.

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[55] Poverty Reduction Strategy Paper (2003), Strategy of Serbia for the Accession to the European Union (2005), Strategy of Social Welfare Development (2005), Strategy of Ageing (2006) Strategy of Sustainable Development (2008), Strategy of Continuous Improvement of Health Protection Quality and Patient Safety (2009), Strategy of Palliative Care (2009). The Strategy of Palliative Care refers mostly to elderly in the health care context, but there were no developments in 2010 regarding palliative care.

[56] The impact on health is presented in the previous part of the asisp Report (see 2.2.3).

[57] As previously mentioned in the asisp Report, Serbia is devoted to the production of the *Joint Inclusion Memorandum.*

Data relating to social welfare cannot be broken down and offer no insight into the structure of the beneficiaries of material benefits (among other things, by age cohorts). On this basis, claims about the potential growth and/or decline in the number of elderly beneficiaries of allowances in the system of social welfare cannot be made. Data from the *Report on Social Inclusion in Serbia* on the decreased number of users accommodated in public facilities point to a trend of developing alternative forms of care (such as placement in the family for the elderly and disabled persons), along with the increased number of users of at-home assistance.

One segment of health research states the issues of long-term care, by analysing underdevelopment of institutions for long-term care in the health care system and the lack of facilities for palliative care (Vlada Republike Srbije, 2011a).

Problems of long-term care in Serbia are presented descriptively (and factually) in the *Answers to the European Commission's Questionnaire*, offering a significant contribution to comparative analysis of the sector within the European framework. The long-term care sector is presented from the perspective of its organisation and financing, and the objectives of accessibility, quality and sustainability of long-term care are viewed in the context of health and social welfare.

The strategic framework dealing with the problem of long-term care is coordinated with existing European experience and guidelines, but a national reform programme does not exist. The link between long-term care and ageing, and poverty is present in the existing national documents, but it is often indirect.[58]

2.4.4 Impact assessment

In European comparison, Serbia has a comparatively old population - 1.25 million people are aged over 65 years, which is 17% of its total population. Therefore, it almost came to balancing the population under 15 and over 65 years. The number of persons over 80 years is 231,000 and represents 3% of the population. At the same time, a large percentage of elderly lives alone or in a household with someone who is also old[59] (Vlada Republike Srbije, 2010b). Forecasts of demographic trends in the future do not imply any change in the existing form, but rather its continuation.

The social situation of the elderly is complex, especially in rural areas. Results of a research of social exclusion show that access to social services in rural areas is very poor (1.9% of households receive welfare benefits) and households of elderly are in a particularly severe situation. The availability of services (educational, health, social) is limited, and the elderly face significant barriers to their use. A large number of elderly in the rural areas are not entitled to pensions, and a number of them are not covered by health insurance. Those households, in which one member is not capable to take care of him/her-self are in a particularly difficult situation so that the burden of care is transferred to another elderly person. Poor elderly in rural areas are less likely to use public social services and there are a lot of administrative and other difficulties in exercising statutory rights (Cvejić, Babović, Petrović, Bogdanov, Vuković, 2010).

Except for drafting certain strategic documents, such a demographic (and social) picture was not the starting point for an analysis of potential needs, and also the costs and benefits of

[58] Namely, ageing of the population as well as the poverty of the elderly are seen as an important question but direct linking of ageing and poverty on the one hand and long-term care on the other hand is not taken into appropriate consideration at the level of public policies.

[59] Every fifth elderly person lives alone, and 607,000 elderly (or every second elderly person) lives in an elderly household (Vlada Republike Srbije, 2010b).

organising a long-term care system.[60] Research and evaluations[61] of (un)availability of personnel that would be employed by such a system, quality standards to be met, or services that would be offered are not available, so that this problem is unknown. Also projections and forecasts of potential expansion of funding sources and stakeholders in long-term care are missing, although it can be assumed with high probability that expenditures of families (for the provision of both formal and informal services) for meeting the needs of its members for long-term care are very high. They further increased during the crisis, in which also the number of users of allowances for care and assistance of another person increased.

Media point to some specific problems and needs of the elderly in terms of long-term care, their inability to effectuate certain rights, etc. but frequently in rather extreme situations. The voice of civil society organisations, public social services and independent experts can be heard on rare ocassions.

The huge importance of research in this area is indicated by the results of a study in 2007 conducted by the NGO Amity, which supports the notion that the information on long-term care are not sufficiently avilable to the elderly. For example, the elderly do not have enough information about the rights and services in the system of non-institutionalised care. According to estimates, despite chronic diseases, in 80% of respondents over 70 the majority characterised themselves as functionally capable of living in their households, provided that they have appropriate support from another person. Family support in solving everyday problems presents the most important form of support, unlike the institutional state support, which is only marginally represented. Supporting services are used by 9% of people over 70, mostly by those who are chronically ill or better off. Respondents with higher incomes use services providing at-home assistance and daily care, and they visit clubs for the elderly more frequently. The research showed that the services of at-home assistance and daily care are used by only 0.28% of people over 65 and clubs are only used by 1% of people over 60 (Amity, 2007).

The First National Report on Social Inclusion and Poverty Reduction in Serbia and the *Responses to the European Commission's Questionnaire* present the current situation in the area of long-term care. They point to the fragmentation of long-term care institutions and their insufficiency. In addition, those papers highlight the lack of sufficiently developed non-institutional networks as well as inconsistent implementation of the concept of deinstitutionalisation. Moreover, it is stated that "there are not enough solutions in everyday practice, such as mental health centres and other forms of integration between health and social welfare" (Vlada Republike Srbije, 2010b: 18-19).

However, in the existing indicators used for the assessment of various aspects of social security, those which would provide actual insight into the quantity and quality of services

[60] The absence of data results in the necessity to make a significant number of assumptions and many problems regarding long-term care are obsreved via indirect relations. In that way, it is sometimes hard to give evidence-based information, and numerous aspects of long-term care cannot be precisely seized.

[61] "More detailed research from external sources in this area, is a part of the report *Social protection and Social Inclusion in the Republic of Serbia* (2008). Apart from the overview of protection for the elderly in the system of health care, it also contains an analysis of the rights of the elderly to accommodation in care homes and home-based assistance. Based on the number and share of the elderly in the total population, the report estimates that elderly people will experience better health, due to the progress in medicine and the improvement in living conditions. However, it is said that "in the short run, deficiency in the capacities of formal care will not be resolved unless the local authorities prioritise social policy and, consequently, devote more resources to these purposes" (European Commission, 2008: 171). "The recommended measures should include data collection, earmarking emergency resources, and establishing an efficient information service targeting vulnerable groups and their needs" (Vuković, Perišić, 2010: 30).

belonging to long-term care could be singled out. This could be done by means of indicators belonging to two groups: health indicators (population coverage by health insurance, life expectancy at the age of 65, satisfaction with health services), and social welfare indicators (number of beneficiaries of material benefits, number of patients in instititutional care, daily care, etc.). Improving quality of services is an important goal of reform efforts in this area, and the first step on this path is to establish a national system of quality control.

2.4.5 Critical assessment of reforms, discussions and research carried out

Access to long-term care. The growing need for long-term care has not resulted in an increased access to it. This is aggravated for the time being by the absence of a self-contained system - in practice there are some (small) overlaps of laws, but more often there are gaps. These are not even in terms of the complete absence of a legal framework, but in the absence of its implementation. In this context, the absence of certain types of institutional accommodation and/or insufficient capacities point to the inability to meet the need for long-term care of those for whom the only option is institutional care. The situation regarding the degree of development of a non-institutional network is comparatively lower (even though it could be less costly to the state, along with increased customer satisfaction). Access to cash benefits is very strict - despite the increasing number of users, the coverage of this type of care is extremely low.

The design of the long-term care scheme, within the social welfare system, implicitly relies on the support of family members and their great role in meeting the needs for long-term care, as well as various forms of informal assistance. Engaging families (and especially its female members) often faces obstacles of factual impossibility to care for the elderly. Engaging nurses in such cases is a solution, but for a very small percentage of families.

Sometimes it is uncertain even that the right to health care can be excercised. The problem of access is especially pronounced in rural areas or in smaller cities and for the poor. The problem of lack of information regarding the rights of long-term care is particularly present in those groups, with a cumulation of risks.

Quality of long-term care. It can be assumed that the integration of a long-term care system would lead to improved quality (at least in regard of satisfaction), given that the essential recognition of the dual nature of the need for long-term care could offer overcoming of certain shortcomings in quality.

The quality of health care services have been monitored and evaluated for a number of years, while the standards for social welfare services are still being developed. Quality of services in the private sector constantly eludes insights, because its control is not sufficiently transparent. Processes of accreditation and licensing are still not obligatory, but it will certainly provide more reliable data in the future once they become mandatory. Finally, programmes of mandatory continuing education of employees in health and social welfare professions will certainly have a positive impact on improving the quality of services.

For now, the quality of long-term care in the public sector is different, depending on the right in question, and depending on the environment in which it is realised. There are indications that the quality of non-institutional services is higher than the quality of institutional care homes. There are sporadic reports that the accommodation of users in institutional care homes is not always in compliance with their health characteristics and condition. This situation is a consequence of undiversified institutions in practice, and they surely entail a lower quality of long-term care.

Sustainability of long-term care. Despite the legitimacy of a system of long-term care in the future, there are no economic resources devoted to its sustainable independence. The division of this segment of policy into health and social welfare, as well as the division of sources for their financing, along with private payments for certain services and informal work women are performing in care, make a precise determination of resources devoted to its financing impossible. In the current situation, better coordination of different levels of financing and organisation could potentially result in a more productive use of existing resources. Potentially, directing finances into long-term care provision could have elements of prevention and, thus, save resources.

Private payments for long-term care, to complement the state system, are not viable options due to low purchasing power. Since the cost of care is extremely high, families' ability to hire professional nurses are often limited. As the last remaining mechanism remains a long-term care within the family. However, it can be assumed that their capacity for direct care of family members is reduced.

Sustainability of the system could be built on the right mix of public and private systems, institutional and non-institutional support, monetary benefits and in-kind services.

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3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[**R1; R4; R5**] ARANDARENKO, Mihail, Tržište rada u Srbiji - trendovi, institucije i politike, Centar za izdavačku delatnost Ekonomskog fakulteta u Beogradu, Beograd: 2011.

"Labor Market in Serbia – Trends, Institutions and Policies"

The book contains the results of labor market researches in Serbia since 2000 in order to explain the causes of permanent deterioration in employment despite high rates of economic growth by 2009. The separate parts of the book deal with the trends, factors shaping the activities of the labor market, institutions and policies. The author points out the limitations and shortcomings of statistical sources, insufficiently researched problem from the point of science and lack of adequate employment policies.

In considering the situation and employment projections by 2020, age structure of the labor force is analysed, and the risks of unemployment of marginal groups are highlighted. Older workers lose their jobs faster, they are presented more in the grey market, they are less involved in active employment programmes, and most commonly use social welfare benefits. Analysed legislative changes include new developments in unemployment insurance, which caused the decrease in the number of users and shortening the period of using rights. The author criticises the lack of activation of older workers and higher percentage of spending on passive measures in comparison with active labor market programmes. Employment policy has been studied from the point of view of models, segmentation of the labor market, and strategy of employment and growth in the period to 2020.

[**R1; R3; R5**] BEGOVIĆ, Boris, BISIĆ, Milica, (ur), Institucionalne reforme u 2010. godini, Centar za liberalno-demokratske studije, Beograd: 2011.

"Institutional Reforms in 2010"

The study is the result of regular reviews of transitional changes in Serbia and contents of institutional reforms in the period since 2000. It contains an overview of changes in 2010 in the political, economic and social system. Articles indicate the inefficiency of reform measures in overcoming the existing shortcomings, so that the final assessment can be summarised in the opinion that "after a whole decade, Serbia is not even close to a transition." Institutional changes were studied from the point of characteristics of the system compared to

the "European perspective", the process of joining the European Union, public finances in Serbia in 2010, and especially the effects of reforms and new changes to the pension system in Serbia. The author of the article on pension system reforms more closely examines the factors of change, the impact of international financial institutions, new legal concepts, high expenditures and deficits in insurance funds.

[**R1**] BOŠNJAK, Marinko, Globalna finansijska i ekonomska kriza 2007-2010 i njen uticaj na privredu i finansije Srbije, Ministarstvo finansija Republike Srbije, Beograd: 2011.

"Global Financial and Economic Crisis 2007-2010 and its Impact to the Serbian Economy and Finances"

The study examines issues of global financial and economic crisis on the basis of its causes and consequences for economic trends in Serbia. The author sees the roots of the crisis in the economic system, taking into account the fact that many factors can cause macroeconomic distortions. Emphasises is on the role of institutional adjustments and economic policies to combat the destructive consequences of macroeconomic shocks.

Analysis of the economic crisis in Serbia is presented in the context of global changes, with emphasis on effects on the economy and economic policy programmes. The study includes a comprehensive examination of the situation in 2009, 2010 and in early 2011. A special attention is given to fiscal policy during and after the crisis, and guidelines for macro-economic recovery and growth are given along with elements of long-term development of Serbia until 2020.

[R1; R3; R4; R5] CVEJIĆ, Slobodan, BABOVIĆ, Marija, PETROVIĆ, Mina, BOGDANOV, Natalija, VUKOVIĆ, Olivera, Socijalna isključenost u ruralnim oblastima Srbije, UNDP Srbija - Sektor za inkluzivni razvoj, Beograd: 2010.

"Social Exclusion in the Rural Areas of Serbia"

The book contains results of an empirical survey (of 1621 households) conducted in late 2009, with a view to identifying major problems in rural areas. The results include a review of the social inclusion policy and measures to encourage balanced regional development. Relying on the concept and methodology for monitoring social inclusion in the EU, the research has focused on preparing for the implementation of the Open Method of Coordination in poverty and social exclusion in Serbia.

[**R1; R2; R5**] DANAS - dnevne novine, Tematske tribine, Beograd: 2011.

"Thematic debates"

Daily newspaper "Danas" prepares and publishes the contents of thematic debates planned on an annual basis. In March 2011, two meetings were held: "The health system of Serbia - European funding model" (March 2nd) and "The insurance industry and sustainable development" (March 30th). It was discussed about issues relevant to the functioning of the health care system and insurance. The participants were representatives of relevant government institutions, experts, managers of private insurance funds, the directors of some health institutions. The aim of debates was to present issues of importance for the life of Serbian citizens in an adequate way in the media.

In April this year, one of the debates will be devoted to the effects of migration and diaspora - economic development of Serbia, while at the beginning of May, demographic trends and the regional development of Serbia will be debated.

[**R2; R3; R4; R5**] FOND ZA RAZVOJ EKONOMSKE NAUKE EKONOMSKOG FAKULTETA UNIVERZITETA U BEOGRADU, Postkrizni model privrednog rasta i razvoja Srbije 2011- 2020, Ekonomski institut u Beogradu, Fond za razvoj ekonomske nauke Ekonomskog fakulteta Univerziteta u Beogradu, Beograd: 2010.

"Post-Crisis Model of Economic Growth and Development of Serbia 2011-2010"

The aim of the study was to highlight the necessity of making a fundamental shift in Serbia in the next decade for the purpose of realising a successful economic growth and development. Before the global economic crisis, which has additionally worsened the situation in Serbia, especially in the real sector and employment, Serbia faced two fundamental macroeconomic imbalances: too rapid growth of private and public consumption relative to gross domestic product (GDP), and excessive reliance on the growth of non-exchangeable goods in the creation of gross added value (GAV) which increased foreign trade and current account deficits of the country. Given the drying up of privatisation revenues and the limited possibilities of further excessive external borrowing, Serbia has to turn to a new model of economic growth and development that is pro-investive and export-oriented. The authors think that the projections by 2020 are optimistic, but realistic and achievable. It is the only way to achieve dynamic economic growth supported by increased employment and productivity, which also provides internal and external macroeconomic stability and opens space to increasing the living standard on the realistic basis.

[**R1; R2; R3; R4; R5**] GERONTOLOŠKO DRUŠTVO SRBIJE, Za evropske standarde socijalne sigurnosti i kvaliteta života u starosti - zbornik stručnih saopštenja, Beograd: 2011.

"For the European Standards of Social Security and Quality of Life in Old Age"

The Collection contains papers from the Eighth Congress of Gerontology (21-23 May 2010) about the quality of life in old age. The aim was to examine the viability and compliance of the objectives agreed in the National Strategy on Ageing 2006-2015 with the European standards. The Collection is divided into sections relating to general population trends, health care, institutional and open care for elderly, and the broad field of education and culture.

The voluminous Collection (360 pages) contains contributions of a large number of authors (139) with different profiles of expertise, dealing with aging and old age from the point of theory, empirical research and practice. Therefore it resulted in a not surprising abundance of presented topics, diversity of approaches, criticality and relative limitations in the assessment of the problem. The Congress has shown a high interest in professionals and staff in health, social and other institutions to solve the problem of old age but also the absence of the Government's representatives and the competent authorities (no one of them attended the Congress). Readers have comprehensive and interesting material, as the result of work of enthusiasts from the Gerontological Society of Serbia.

[**R1; R2; R3; R4; R5**] GERONTOLOŠKO DRUŠTVO SRBIJE, Časopis "Gerontologija", 2/2010, Beograd: 2010.

"Gerontology"

Contents of this issue of "Gerontology" include introductory lectures presented at the Eighth Congress of Gerontology in 2010. All articles are divided into five thematic parts, and the second part of the journal contains three very important documents of the Gerontological Society of Serbia.

The pension and disability insurance reform, provision of quality living conditions in old age, education for elderly towards a society for all, improving mental health, poverty in elderly, gender inequality and discrimination in old age, intergenerational solidarity and measures for improved integration of elderly into society, represent the contents of this issue of "Gerontology."

[**R4; R5**] KRSTIĆ, Gorana**,** ARANDARENKO, Mihail, NOJKOVIĆ, Aleksandra, VLADISAVLJEVIĆ, Marko, Položaj ranjivih grupa na tržištu rada Srbije, Program Ujedinjenih nacija za razvoj – UNDP Srbija, Sektor za inkluzivni razvoj, Beograd: 2010.

"Position of Vulnerable Groups on the Serbian Labour Market"

The publication is the result of work on the project funded by the United Nations Development Programme (UNDP) with financial support of the Delegation of the European Union, entitled "Mapping Vulnerability in Serbia." It is divided into several thematic parts, full of statistical indicators of the labor market in general and especially from the position of vulnerable groups.

Starting from the impact of the global economic crisis and possible exit strategies, the authors deal specifically with the structure of the vulnerable groups in the labor market, such as women, youth, older workers (50-65 years of life), people with lower educational attainment, rural population and population from vulnerable regions. The situation of Roma, refugees, displaced persons and persons with disabilities was explored in the context of increased risk, high unemployment, above-average poverty, educational levels, access to social and other services, and social exclusion. List of recommendations is based on the conclusion that most of the working age population belongs to at least one of the vulnerable groups in the labor market in Serbia and that the crisis has disproportionately more affected members of vulnerable groups.

[**R1; R2; R3; R4; R5**] MIJATOVIĆ, Boško, Penzijsko osiguranje poljoprivrednika, Centar za liberalno-demokratske studije, Beograd: 2010.

"Pension Insurance of Farmers"

The book contains an analysis of pension insurance for farmers in Serbia from the period of its introduction (1979 - voluntary, 1982 - mandatory) to the most recent reforms and changes in legislation. Starting premises of the author are contained in the dilemma about the justification of introducing compulsory insurance, with a comparative analysis of the situation in the EU Member States. The following chapters explain the statutory provisions, functioning, problems and possible directions for reforms.

The research results include data on the degree of coverage of rural population with this form of insurance, problems in its funding, low income in old age, avoiding the payment of

contributions and measures to reduce administrative costs (creating a single fund). Pension insurance of farmers as "ignored issue" of pension reforms in recent years requires radical changes for the purpose of solving identified problems. The book also proposes measures for the improvement of existing models, as well as options that include two possible ways of development – retention of exisiting solutions or abolition of pension insurance of farmers.

[**R1; R4**] NIKITOVIĆ, Vladimir, Demografska budućnost Srbije - imigracija kao izvesnost?, Institut društvenih nauka i Službeni glasnik Srbije, Beograd: 2010.

"The Demographic Future of Serbia - Immigration as a Certainty?"

The book contains a detailed analysis of demographic trends in Serbia by 2050, implying the conclusion on the real reduction of the population by 10%, i.e. return to the situation from 1950. The fertility reduction, aging of the population and mass migration in the last decade of the twentieth century, have made changes in the demographic structure of the population that are particularly visible regarding the working population.

Forecasts indicate that the observed trend of increasing the share of elderly in the general structure of the population will continue, and that in 2050 every fourth resident in Serbia will belong to the older population. According to the author, this largely determines the functioning of labor market and affects the pension insurance system. The dependency ratio increase and the young people migration will mark the next decade and determine the demographic future of Serbia.

[**R1; R2; R3**] REPUBLIČKI FOND PENZIJSKOG I INVALIDSKOG OSIGURANJA**,** Informator o radu Republičkog fonda za penzijsko i invalidsko osiguranje 2007-2011, Beograd: 2011. Retrieved from http://www.pio.rs/sr/cr/informator/ on 15.04.2011.

"Information on the Work of the Republic Fund of Old-Age and Disability Insurance 2007-2011"

The Information was prepared in accordance with the regulations on the obligation of reporting on the work of state bodies in the past year. The latest edition covers the period 2007-2010 and contains basic information on the organisational structure, scope of work, agencies, and the number of employees in the Fund. A separate part of the Informant has a list of laws and regulations in the field of pension insurance in Serbia. The structure of revenues and expenses of the Fund is given in the form of financial plan for 2010. There is a review of rights belonging to old-age and disability insurance, conditions and procedures for their realisation.

[**R1; R2; R3; R4; R5**] REPUBLIČKI ZAVOD ZA RAZVOJ, Izveštaj o razvoju Srbije u 2009, Republički zavod za razvoj, Beograd: 2010.

"Report about the Serbian Development in 2009"

The report presents a comprehensive analysis of development results in the two decades of transition in Serbia, with special emphasis on the effects of the global recession in 2009. The aim of this report was to examine the developmental position of Serbia through the application of comparative analysis of the EU structural indicators, and to present the main transition problems and difficulties in implementing strategic development goals. The initial part of the Report contains an overview of the demographic development of Serbia, which features a "population regression", reflected in the reduction of the total population,

declining birth rates, increasing average age of population, its concentration in urban areas, emptying of rural areas, and massive external migration. Social development is analysed by measuring social exclusion based on the Laeken indicators, detailing the fertility rate, the dependency rate, infant mortality rates, and poverty in Serbia. The structure of public expenditures, spending on pensions, health and other forms of government assistance, are analysed through the indicators for 2009 and large expenditures for social assistance and transfers to households (18,7% of GDP). The report deals with insurance, and especially with private pension funds.

[**R1; R2; R3; R4; R5**] STANIĆ, Katarina, Penzijski sistem u Srbiji - dizajn, karakteristike i preporuke, Centar za liberalno-demokratske studije, Beograd: 2010.

"Pension System in Serbia – Design, Characteristics and Recommendations"

The book is a complex analysis of the pension system in Serbia, starting from the general theoretical discussion of the models and comparative review of the systems. Characteristics of old-age and disability insurance are analysed through the number of insured persons, and the structure of pensioners, as well as beneficiaries of old-age, disability, and survivor pensions. The issues of early retirement are also taken into consideration.

The book analyses in detail the living standard of pensioners in Serbia, based on indicators of their total income, pension benefits and the poverty of elderly. Results of the Living Standard Surveys 2002-2007 show that the elderly and children are the poorest, that there are no adequate programmes of care and that women are particularly vulnerable. The poor elderly have poor health and inadequate protection. The proposed recommendations relate to strengthening the public (compulsory) system, re-determining retirement age, improving equity and reducing poverty of pensioners in Serbia.

[**R2; R4; R5**] VLADA REPUBLIKE SRBIJE - MINISTARSTVO FINANSIJA, Analiza makroekonomskih i fiskalnih kretanja u 2010. godini, Beograd: 2011.

"Analysis of Macro-Economic and Fiscal Development in 2010"

The Serbian Ministry of Finance continues its practice of issuing special publications related to assessment of macroeconomic trends in the previous year. The main contents of the study consist of data on economic activity, inflation, balance of payments, employment, wages and pensions, fiscal development and structural reforms in 2010. General trends in the pension system are analysed through the total number of pension beneficiaries, the amount of average, minimum and highest pensions, ratio to average earnings compared to the previous year. There is a brief outline of public revenues and expenditures in the public system of pension and health insurance.

[**R1; R2; R3; R4; R5**] VLADA REPUBLIKE SRBIJE, Odgovor na Upitnik Evropske komisije, Beograd: 2011.

"Answers to the European Commission's Questionnaire"

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[**R1; R2**] VLADA REPUBLIKE SRBIJE, Revidirani memorandum o budžetu i ekonomskoj i fiskalnoj politici za 2011. godinu sa projekcijama za 2012. i 2013. godinu, Beograd: 2010.

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In December 2010, the Government adopted a Revised Memorandum on the Budget for the next three years. Deficit reduction and increase in spending for the poor, according to the explanation of the Government, make the basis of the new budget. The Memorandum contains a review of macroeconomic developments and projections for the period 2011-2013, the fiscal framework, public debt management strategy and opverview of structural reforms in the real, financial and state sector. The guidelines for sector reforms particularly analyse the labor market, health care, pension system and social welfare.

[**R1; R2; R3; R4; R5**] VUKOVIĆ, Drenka, ARANDARENKO, Mihail (ur), Socijalne reforme - sadržaj i rezultati, Univerzitet u Beogradu – Fakultet političkih nauka, Beograd: 2010.

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[H] Health

[H1] BOŠNJAK, Marinko, Globalna finansijska i ekonomska kriza 2007-2010 i njen uticaj na privredu i finansije Srbije, Ministarstvo finansija Republike Srbije, Beograd: 2011.

"Global Financial and Economic Crisis 2007-2010 and its Impact to the Serbian Economy and Finances"

The study examines issues of global financial and economic crisis on the basis of its causes and consequences for economic trends in Serbia. The author sees the roots of the crisis in the economic system, taking into account the fact that many factors can cause macroeconomic

distortions. Emphasises is on the role of institutional adjustments and economic policies to combat the destructive consequences of macroeconomic shocks.

Analysis of the economic crisis in Serbia is presented in the context of global changes, with emphasis on effects on the economy and economic policy programmes. The study includes a comprehensive examination of the situation in 2009, 2010 and in early 2011. A special attention is given to fiscal policy during and after the crisis, and guidelines for macro-economic recovery and growth are given along with elements of long-term development of Serbia until 2020.

[H2; H3] CVEJIĆ, Slobodan, BABOVIĆ, Marija, PETROVIĆ, Mina, BOGDANOV, Natalija, VUKOVIĆ, Olivera, Socijalna isključenost u ruralnim oblastima Srbije, UNDP Srbija - Sektor za inkluzivni razvoj, Beograd: 2010.

"Social Exclusion in the Rural Areas of Serbia"

The book contains results of an empirical survey (of 1621 households) conducted in late 2009, with a view to identifying major problems in rural areas. The results include a review of the social inclusion policy and measures to encourage balanced regional development. Relying on the concept and methodology for monitoring social inclusion in the EU, the research has focused on preparing for the implementation of the Open Method of Coordination in poverty and social exclusion in Serbia.

[**H1; H3; H4**] DANAS - dnevne novine, Tematske tribine, Beograd: 2011.

"Thematic debates"

Daily newspaper "Danas" prepares and publishes the contents of thematic debates planned on an annual basis. In March 2011, two meetings were held: "The health system of Serbia - European funding model" (March 2nd) and "The insurance industry and sustainable development" (March 30th). It was discussed about issues relevant to the functioning of the health care system and insurance. The participants were representatives of relevant government institutions, experts, managers of private insurance funds, the directors of some health institutions. The aim of debates was to present issues of importance for the life of Serbian citizens in an adequate way in the media.

In April this year, one of the debates will be devoted to the effects of migration and diaspora - economic development of Serbia, while at the beginning of May, demographic trends and the regional development of Serbia will be debated.

[**H1; H3**] FOND ZA RAZVOJ EKONOMSKE NAUKE EKONOMSKOG FAKULTETA UNIVERZITETA U BEOGRADU, Postkrizni model privrednog rasta i razvoja Srbije 2011-2020, Ekonomski institut u Beogradu, Fond za razvoj ekonomske nauke Ekonomskog fakulteta Univerziteta u Beogradu, Beograd: 2010.

"Post-Crisis Model of Economic Growth and Development of Serbia 2011-2010"

The aim of the study was to highlight the necessity of making a fundamental shift in Serbia in the next decade for the purpose of realising a successful economic growth and development. Before the global economic crisis, which has additionally worsened the situation in Serbia, especially in the real sector and employment, Serbia faced two fundamental macroeconomic imbalances: too rapid growth of private and public consumption relative to gross domestic

product (GDP), and excessive reliance on the growth of non-exchangeable goods in the creation of gross added value (GAV) which increased foreign trade and current account deficits of the country. Given the drying up of privatisation revenues and the limited possibilities of further excessive external borrowing, Serbia has to turn to a new model of economic growth and development that is pro-investive and export-oriented. The authors think that the projections by 2020 are optimistic, but realistic and achievable. It is the only way to achieve dynamic economic growth supported by increased employment and productivity, which also provides internal and external macroeconomic stability and opens space to increasing the living standard on the realistic basis.

[**H2; H3; H5; H6; H7**] GERONTOLOŠKO DRUŠTVO SRBIJE, Za evropske standarde socijalne sigurnosti i kvaliteta života u starosti - zbornik stručnih saopštenja, Beograd: 2011.

"For the European Standards of Social Security and Quality of Life in Old Age"

The Collection contains papers from the Eighth Congress of Gerontology (21-23 May 2010) about the quality of life in old age. The aim was to examine the viability and compliance of the objectives agreed in the National Strategy on Ageing 2006-2015 with the European standards. The Collection is divided into sections relating to general population trends, health care, institutional and open care for elderly, and the broad field of education and culture.

The voluminous Collection (360 pages) contains contributions of a large number of authors (139) with different profiles of expertise, dealing with aging and old age from the point of theory, empirical research and practice. Therefore it resulted in a not surprising abundance of presented topics, diversity of approaches, criticality and relative limitations in the assessment of the problem. The Congress has shown a high interest in professionals and staff in health, social and other institutions to solve the problem of old age but also the absence of the Government's representatives and the competent authorities (no one of them attended the Congress). Readers have comprehensive and interesting material, as the result of work of enthusiasts from the Gerontological Society of Serbia.

[**H2; H3**] GERONTOLOŠKO DRUŠTVO SRBIJE, Časopis "Gerontologija", 2/2010, Beograd: 2010.

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Contents of this issue of "Gerontology" include introductory lectures presented at the Eighth Congress of Gerontology in 2010. All articles are divided into five thematic parts, and the second part of the journal contains three very important documents of the Gerontological Society of Serbia.

The pension and disability insurance reform, provision of quality living conditions in old age, education for elderly towards a society for all, improving mental health, poverty in elderly, gender inequality and discrimination in old age, intergenerational solidarity and measures for improved integration of elderly into society, represent the contents of this issue of "Gerontology."

[**H1; H2; H3; H4; H5**] INSTITUT ZA JAVNO ZDRAVLJE SRBIJE "Dr Milan Jovanović Batut", Pregled najvažnijih rezultata ispitivanja zadovoljstva korisnika u državnim zdravstvenim ustanovama Republike Srbije 2010. godine, Beograd: 2011.

"Survey of the Most Important Results of Researching Satisfaction of Beneficiaries in the Public Health Institutions of the Republic of Serbia in 2010"

This is the seventh Report, as a part of a programme to improve the quality of work of the public health institutions. Research is conducted in primary care institutions, inpatient wards and specialist outpatient consultation offices in internal medicine.

The presentation of results includes an overview of satisfaction with services and selected physician, regional characteristics, information and evaluation of professional staff. There is a noticeable drop in satisfaction with nearly all services compared to the previous years.

[**H1; H2; H3; H4; H5**] INSTITUT ZA JAVNO ZDRAVLJE SRBIJE "Dr Milan Jovanović Batut", Pregled najvažnijih rezultata ispitivanja zadovoljstva zaposlenih u državnim zdravstvenim ustanovama Republike Srbije 2010. godine, Beograd: 2011.

"Survey of the Most Important Results of Researching Satisfaction of Employed in the Public Health Institutions of the Republic of Serbia in 2010"

Annual reports on satisfaction of people employed in the public health institutions are a part of a package of measures for improvement of health care quality. The survey was carried out at the end of 2010, on a sample of 64,000 employees, of which 77% are health workers. Half of the respondents in 2010 are satisfied with the work they do, which is a drop compared to the year before. There were important differences by education level, type of institution, and the amount of monthly income. The effects of continuing education are positively evaluated.

[**H3]** KRSTIĆ, Gorana**,** ARANDARENKO, Mihail, NOJKOVIĆ, Aleksandra, VLADISAVLJEVIĆ, Marko, Položaj ranjivih grupa na tržištu rada Srbije, Program Ujedinjenih nacija za razvoj – UNDP Srbija, Sektor za inkluzivni razvoj, Beograd: 2010.

"Position of Vulnerable Groups on the Serbian Labour Market"

The publication is the result of work on the project funded by the United Nations Development Programme (UNDP) with financial support of the Delegation of the European Union, entitled "Mapping Vulnerability in Serbia." It is divided into several thematic parts, full of statistical indicators of the labor market in general and especially from the position of vulnerable groups.

Starting from the impact of the global economic crisis and possible exit strategies, the authors deal specifically with the structure of the vulnerable groups in the labor market, such as women, youth, older workers (50-65 years of life), people with lower educational attainment, rural population and population from vulnerable regions. The situation of Roma, refugees, displaced persons and persons with disabilities was explored in the context of increased risk, high unemployment, above-average poverty, educational levels, access to social and other services, and social exclusion. List of recommendations is based on the conclusion that most of the working age population belongs to at least one of the vulnerable groups in the labor market in Serbia and that the crisis has disproportionately more affected members of vulnerable groups.

[**H1; H2; H3; H4, H5; H6**] REPUBLIKA SRBIJA - MINISTARSTVO ZDRAVLJA, Informator, Beograd: 2011. Retrieved from

http://www.minzdravlja.info/downloads/2008/Sa%20Zdravlja/dokumenta/InformatorMinistarstvaZdravlja04042011.pdf on 16.04.2011

The Information contains basic information relevant for the Ministry of Health in 2010. The first part is devoted to issues of legal regulations and organisational scheme of the Ministry, with graphics of its jurisdictions and names of managers of services. There follows an analysis of work of the sectors (for health care, health insurance and financing in health and inspection). Finally, information about the procedures at the request of the parties and work of the groups for planning and budget execution, accounting operations and personnel management is given. The Information contains the Report on the budget for 2010, and a detailed review of projects undertaken by the Department for the European Integration.

[**H3**] REPUBLIČKI ZAVOD ZA RAZVOJ, Izveštaj o razvoju Srbije u 2009, Republički zavod za razvoj, Beograd: 2010.

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[**H1; H2; H5**] VLADA REPUBLIKE SRBIJE, Prvi nacionalni izveštaj o socijalnom uključivanju i smanjenju siromaštva u Republici Srbiji, Beograd: 2011.

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Pension and health systems are an integral part of the report, and are analysed from the point of description of the current situation - organisation, pillars, calculation and amount of pensions, financing, minimum level of benefits, etc. The Report contains relevant statistics,

and each section is followed by the conclusions and recommendations to overcome the problem. In the analysis of pension insurance, poverty of survivor pensioners and farmer pensioners is stressed. It is therefore recommended to take measures to ensure adequate income in old age. State of health was analysed based on a set of indicators on the coverage of the population, the availability and quality of services and factors of exclusion. It is emphasised that the strategic framework for health care is in compliance with the programmes and requirements of the EU, but that there are problems in their implementation. The issue of long-term care is considered in the context of increasing needs and deficiencies of the system which is divided between health and social welfare.

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[**H1; H2; H3; H4; H5; H7**] VLADA REPUBLIKE SRBIJE, Odgovor na Upitnik Evropske komisije, Beograd: 2011.

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[**H1; H2; H3; H4**] VUKOVIĆ, Drenka, ARANDARENKO, Mihail (ur), Socijalne reforme - sadržaj i rezultati, Univerzitet u Beogradu – Fakultet političkih nauka, Beograd: 2010.

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[**H1; H2; H3; H4; H5**] WHO REGIONAL OFFICE FOR EUROPE, Evolution of the Organisation and provision of Primary Care in Serbia – a Survey Based Project in the Regions of Vojvodina, Central Serbia and Belgrade, World Health Organisation: 2010.

This report gives an overview on the findings for Serbia regarding the reforms of primary health care. It uses the WHO Primary Care Evaluation Tool (PCET) in order to provide a structured approach by drawing on health system functions such as governance, financing and resource generation, as well as the characteristics of a good PC service delivery system: accessibility, comprehensiveness, coordination and continuity.

The project was implemented in Serbia in 2009 in the framework of the 2008–2009 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of the Republic of Serbia, which lays out the main areas of work for collaboration between the parties.

[L] Long-term care

[L] CVEJIĆ, Slobodan, BABOVIĆ, Marija, PETROVIĆ, Mina, BOGDANOV, Natalija, VUKOVIĆ, Olivera, Socijalna isključenost u ruralnim oblastima Srbije, UNDP Srbija - Sektor za inkluzivni razvoj, Beograd: 2010.

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4 List of Important Institutions

Univerzitet u Beogradu – Fakultet političkih nauka, Odeljenje za socijalnu politiku i socijalni rad – University of Belgrade – Faculty of Political Sciences, Department of Social Policy and Social Work

Contact person: Prof. Dr. Drenka Vukovic (full-time professor)
Address: Jove Ilica 165, 11000 Belgrade, Serbia
Webpage: http://www.fpn.bg.ac.rs/

The Faculty of Political Sciences is an integral part of the University of Belgrade. The Faculty has four departments: the Department of Political Studies, the Department of International Studies, the Department of Journalism and Communications and the Department of Social Policy and Social Work. As a unique educational, scientific and research institution, the only one of its kind in Serbia, the Faculty takes a prominent place in the area of educating personnel, creating policy and practice in the social sphere. The curriculum has courses in social security systems and related scientific disciplines in the graduate, masters and PhD courses.
The Department of Social Policy has published many publications – university books, expert brochures, studies and monographs, as results of work on the realisation of scientific research projects.

Centar za liberalno-demokratske studije - Centre of Liberal-Democratic Studies

Contact person: Dr. Boško Mijatović
Address: Kralja Milana 7, 11000 Belgrade, Serbia
Webpage: http://www.clds.rs/

The centre is an independent research institution analysing and publishing proposals for state policies, organising conferences and lectures on some central problems, as a part of its mission to influence the public opinion in Serbia. The basic principles in the creation of the Centre's proposals are: individualism, freedom, values of free market, individual choice and responsibility.
It publishes books and working documents, many of which refer to sociopolitical issues and reforms.

Institut za javno zdravlje Srbije "Dr Milan Jovanović Batut" - Institute of Public Health of Serbia "Dr Milan Jovanovic Batut"

Address: Dr Subotica 5, 11000 Belgrade, Serbia
Webpage: http://www.batut.org.rs/

The Institute is a health-care institution performing the tasks of general interest in the area of health care in Serbia. It has the character of a scientific and educational state institution. The work of the Institute is organised within several centres (for the promotion of public health, information and bio-statistics, analysis, planning and organising health care, research in the area of public health, etc). In cooperation with the Ministry of Health and other relevant institutions, the Institute of Public Health has participated in the creation of health policy and the realisation of a number of important projects.
It publishes studies, books, reports and documents relevant to the health system in Serbia.

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
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