

Report

International Fact-finding Mission

Serbia: discrimination and corruption, the flaws in the health care system

Alternative report

**To the report submitted by the Government of Serbia-Montenegro to the
Committee on Economic, Social and Cultural Rights in application of the
International Covenant on Economic, Social and Cultural Rights (May 2005)**

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FIDH represents 141 Human Rights organisations

141 organisations

- Afrique du Sud**-Human Rights Committee of South Africa
Albanie-Albanian Human Rights Group
Algérie-Ligue Algérienne de Défense des Droits de L'Homme
Algérie-Ligue Algérienne des Droits de L'Homme
Allemagne-Internationale Liga für Menschenrechte
Argentine-Centro de Estudios Legales y Sociales
Argentine-Comite de Accion Juridica
Argentine-Liga Argentina por los Derechos del Hombre
Autriche-Österreichische Liga für Menschenrechte
Azerbaïjan-Human Rights Center of Azerbaijan
Bahrein-Bahrain Human Rights Society
Bangladesh-Odhikar
Bélarus-Human Rights Center Viasna
Belgique-Liga Voor Menschenrechten
Belgique-Ligue des Droits de L'Homme
Bénin-Ligue pour la Défense des Droits de L'Homme Au Bénin
Bhutan-People's Forum for Human Rights in Bhutan (Nepal)
Bolivie-Asamblea Permanente de los Derechos Humanos de Bolivia
Bresil-Centro de Justicia Global
Bresil-Movimento Nacional de Direitos Humanos
Burkina Faso-Mouvement Burkinabe des Droits de L'Homme & des Peuples
Burundi-Ligue Burundaise des Droits de L'Homme
Cambodge-Cambodian Human Rights and Development Association
Cambodge-Ligue Cambodgienne de Défense des Droits de L'Homme
Laos (France)-Mouvement Lao pour Les Droits de L'Homme
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Cameroun (France)-Ligue Camerounaise des Droits de L'Homme
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Centrafrique-Ligue Centrafricaine des Droits de L'Homme
Chili-Comite de Defensa de los Derechos del Pueblo
Chine-Human Rights in China
Colombie-Comite Permanente por la Defensa de los Derechos Humanos
Colombie-Corporacion Colectiva de Abogados Jose Alvear Restrepo
Colombie-Instituto Latinoamericano de Servicios Legales Alternativos
Congo Brazzaville-Observatoire Congolais des Droits de L'Homme
Côte d'Ivoire-Ligue Ivoirienne des Droits de L'Homme
Côte d'Ivoire-Mouvement Ivoirien des Droits de L'Homme
Croatie-Civic Committee for Human Rights
Cuba-Comision Cubana de Derechos Humanos y Reconciliacion Nacional
Ecosse-Scottish Human Rights Centre
Egypte-Egyptian Organization for Human Rights
Egypte-Human Rights Association for the Assistance of Prisoners
El Salvador-Comision de Derechos Humanos de El Salvador
Equateur-Centro de Derechos Economicos y Sociales
Equateur-Comision Ecumenica de Derechos Humanos
Equateur-Fundacion Regional de Asesoría en Derechos Humanos
Espagne-Asociacion Pro Derechos Humanos
Espagne-Federacion de Asociaciones de Defensa y Promocion de los Derechos Humanos
Etats Unis-Center for Constitutional Rights
Ethiopie-Ethiopian Human Rights Council
Finlande-Finnish League for Human Rights
France-Ligue des Droits de L'Homme et du Citoyen
Georgie-Human Rights Information and Documentation Center
Grèce-Ligue Hellenique des Droits de L'Homme
Guatemala-Centro Para la Accion Legal en Derechos Humanos
Guatemala-Comision de Derechos Humanos de Guatemala
Guinée-Organisation Guinéenne pour la Défense des Droits de L'Homme
Guinée Bissau-Liga Guineense dos Direitos do Homem
Irak (Royaume Uni)-Iraqi Network for Human Rights Culture and Development
Iran-Centre des Défenseurs des Droits de L'Homme en Iran
Iran (France)-Ligue de Défense des Droits de L'Homme en Iran
Irlande-Irish Council for Civil Liberties
Irlande du Nord-Committee On the Administration of Justice
Israël-Adalah
Israël-Association for Civil Rights in Israel
Israël-B'tselem
Israël-Public Committee Against Torture in Israel
Italie-Liga Italiana Dei Diritti Dell'uomo
Italie-Unione Forense Per la Tutela Dei Diritti Dell'uomo
Jordanie-Amman Center for Human Rights Studies
Jordanie-Jordan Society for Human Rights
Kenya-Kenya Human Rights Commission
Kosovo-Conseil pour la Défense des Droits de L'Homme et des Libertés
Kyrgistan-Kyrgyz Committee for Human Rights
Lettonie-Latvian Human Rights Committee
Liban-Association Libanaise des Droits de L'Homme
Liban-Foundation for Human and Humanitarian Rights in Lebanon
Liban-Palestinian Human Rights Organization
Liberia-Liberia Watch for Human Rights
Libye (Suisse)-Libyan League for Human Rights
Lithuanie-Lithuanian Human Rights Association
Malaisie-Suaram
Mali-Association Malienne des Droits de L'Homme
Malte-Malta Association of Human Rights
Maroc-Association Marocaine des Droits Humains
Maroc-Organisation Marocaine des Droits Humains
Mauritanie-Association Mauritanienne des Droits de L'Homme
Mexique-Comision Mexicana de Defensa y Promocion de los Derechos Humanos
Mexique-Liga Mexicana por la Defensa de los Derechos Humanos
Moldova-League for the Defence of Human Rights
Mozambique-Liga Mocancicana Dos Direitos Humanos
Nicaragua-Centro Nicaraguense de Derechos Humanos
Niger-Association Nigérienne des Droits de L'Homme
Nigeria-Civil Liberties Organisation
Nouvelle Calédonie-Ligue des Droits de L'Homme de Nouvelle Calédonie
Ouganda-Foundation for Human Rights Initiative
Pakistan-Human Rights Commission of Pakistan
Palestine-Al Haq
Palestine-Palestinian Centre for Human Rights
Panama-Centro de Capacitacion Social
Pays Bas-Liga Voor de Rechten Van de Mens
Pérou-Asociacion Pro Derechos Humanos
Pérou-Centro de Asesoría Laboral
Philippines-Philippine Alliance of Human Rights Advocates
Polynésie Française-Ligue Polynésienne des Droits Humains
Portugal-Civitas
RDC-Ligue des Electeurs
RDC-Association Africaine des Droits de L'Homme
RDC-Groupe Lotus
République de Djibouti-Ligue Djiboutienne des Droits Humains
République Tchèque-Human Rights League
Roumanie-Ligue pour la Défense des Droits de L'Homme
Royaume-Uni-Liberty
Russie-Citizen's Watch
Russie-Moscow Research Center for Human Rights
Rwanda-Association pour la Défense des Droits des Personnes et Libertés Publiques
Rwanda-Collectif des Ligues pour la Défense des Droits de L'Homme Au Rwanda
Rwanda-Ligue Rwandaise pour la Promotion et la Défense des Droits de L'Homme
Sénégal-Organisation Nationale des Droits de L'Homme
Sénégal-Rencontre Africaine pour la Défense des Droits de L'Homme
Serbie et Montenegro-Center for Antirwar Action - Council for Human Rights
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Tanzanie-The Legal & Human Rights Centre
Tchad-Association Tchadienne pour la Promotion et la Défense des Droits de L'Homme
Tchad-Ligue Tchadienne des Droits de L'Homme
Tchad-Asociacion Pro Derechos Humanos
Togo-Ligue Togolaise des Droits de L'Homme
Tunisie-Conseil National pour Les Libertés en Tunisie
Tunisie-Ligue Tunisienne des Droits de L'Homme
Turquie-Human Rights Foundation of Turkey
Turquie-Insan Haklari Dernegi / Ankara
Turquie-Insan Haklari Dernegi / Diyarbakir
Union européenne-FIDH AE
Uzbekistan-Legal Aid Society
Vietnam (France)-Comite Vietnam pour la Défense des Droits de L'Homme
Yemen-Human Rights Information and Training Center
Yemen-Sisters' Arabic Forum for Human Rights
Zimbabwe-Zimbabwe Human Rights Association Zimrights

The International Federation for Human Rights (FIDH) is an international non-governmental organisation dedicated to the world-wide defence of human rights as defined by the Universal Declaration of Human Rights of 1948. Founded in 1922, the FIDH has 141 national affiliates in all regions. To date, the FIDH has undertaken more than a thousand international fact-finding, judicial, mediation or training missions in over one hundred countries.

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I. INTRODUCTION

1) Presentation of the investigation mission and its partners

Serbia and Montenegro ratified the Covenant on Social, Economic and Cultural Rights on 12th March 2001 (Declaration of Succession). On 10th October 2003, an initial report on the application of the Covenant was presented to the United Nations Committee on Economic, Social and Cultural Rights (E/1990/5/Add.61¹). The report is divided into two sections, one relating to the Federal Republic of Yugoslavia and the Republic of Serbia and the other relating to the Republic of Montenegro, and covers the years 1990 to 2002, in other words the period of the Milosevic regime and the first years following his fall in October 2000 and the coming to power of a coalition of opposition parties under the DOS banner (Democratic Opposition of Serbia). A new State report should be presented in Geneva in May 2005 during the session of the United Nations Committee on Social, Economic and Cultural Rights.

In order to present an independent, alternative evaluation of the activities undertaken by the Republic of Serbia² to ensure application of the right to health, the FIDH appointed an investigation mission to evaluate the exercise of this right³.

The FIDH appointed a mission composed of Joël Hubrecht, jurist, specialist on the Balkans, chargé de mission FIDH and Boris Najman, an economist specialising in countries in transition, chargé mission FIDH, to visit Serbia from 16th to 27th December 2004 to investigate the state of the health care system and of right to health, and in particular to assess:

- the health situation with respect to the most vulnerable and marginalised groups, their access to information and their physical and economic access to the health care system, as well as to the underlying determinants of health;
- the state of the national health care system and progress made regarding reforms undertaken by the State to carry out its obligations to respect, protect and fulfil the right to health, as defined in the International Covenant on Economic, Social and Cultural Rights. In order to do this, the delegation was particularly interested in health budget allocations.

In order to obtain as complete picture as possible, the mission decided to visit three different areas, each one with specific characteristics in terms of population and socio-economic context: the capital, Belgrade, in the North; Kraljevo, a medium-sized town in the centre, where a great number of refugees live; and Bujanovac, a small town in the south of the country, the poorest area, where the largest part of the population is Albanian.

The mission was given support by the *Centre for Antiwar Action*, an affiliate member of the FIDH, and its President Aleksander Resanovic, who handled the organisation of the programme and meetings. The mission was also assisted by the *Lingva Center* team in Kraljevo, by Mr. Lazar Nisavic and Ms. Jelena Perovic, as well as the association *Susedi za mir (Neighbours for Peace)* in Bujanovac, in particular by Mrs. Violeta, Mrs. Haliti and Mr. Trajkovic, as well as Ms. Frankovic, mission interpreter. The FIDH wishes to express its sincere gratitude to all of them, and also to Doctor François Crémieux, assistant director of the *Assistance publique-hôpitaux de Paris*, for his invaluable advice and comments.

Finally, we would like to thank Stéphanie Mahieu for her comments and for her assistance.

¹ The initial report can be consulted on the following web-site :
<http://daccessdds.un.org/doc/UNDOC/GEN/G03/454/65/PDF/G0345465.pdf?openElement>

² The FIDH decided for the following reasons to examine the situation in Serbia alone and not in the Republic of Montenegro: the current separation of responsibilities between the two republics in this domain; the situation in Serbia is broadly representative of the whole of the territory (including Montenegro).

³ In this report we focused essentially on access to and availability of the health care system.

The mission is happy to have been able to meet and begin long-term collaboration with a group of local associations preparing a group report on the full range of economic, social and cultural rights:

- *Belgrade Center for Human Rights*, Mr. Vidan Hadzi-Vidanovic
- *The Child Rights Center*, Mr. Nevena Vuckovic, President; Mr. Ljubomir Pejakovic, Director; Mrs. Vesna Dejanovic, Programme Director
- *Group 484*, Mrs. Vesna Golic, Director
- *The Center for Advanced Legal Studies*, Mr. Sasa Gajin
- The Roma association *Demokratsko udruzenje*, Mrs. Danijela Antonic
- The association *ASTRA (Antisex Trafficking Action)*, Neda Ilic

The mission representatives would also like to thank those who agreed to receive them:

- Ministry of Finance - Mr. Radisa Djordjevic, Ministry Advisor
- Ministry of Health - Dr. Snezana Simic, Assistant to the Minister
- Ministry of Health - Dr. Olivera Jovanovic, Advisor to the Minister
- KBC, Zemun Hospital - Dr. Tomasic Liljana, Oncology specialist
- Institute of Public Health “Dr Milan Jovanovic – Batut” - Dr Milena Vasic, Assistant Director
- Kraljevo Institute of Public Health - Alexander Macan
- Kraljevo Municipal Health Clinic - Mme. Dragana Negojevic
- Center for Liberal-Democratic Studies - Dr Gordana Matkovic, expert, former Minister of Social Affairs in the government of Z. Djindjic
- Hospital “Studenica” - Assistant Director of the Kraljevo
- Kraljevo Social Workers’ Centre, Svetlana Stanic, Director
- Bujanovac municipal Health Centre
- KBC Zvezdara (town Hospital) - Dr Zoran Ivankovic,, Director and former President of the “Serbian Medicine Society”
- “Stari Grad” Municipal Health Centre (Belgrade) - Dr Slavica Kronic–Kuculovic, Director,
- “Stari Grad” Municipal Health Centre - Mrs. Slobodanka Radulovic, Ombudsman
- “Rational Emotive Behavior Therapy” Centre (TRAUMA Centre) - Dr. Vladimir Beara
- Health insurance fund (Zavod za zdravstveno osiguranje) - Mrs. Rada Maruska Lukovac, Assistant Director
- UNHCR - Mr. Davor Roka, co-ordinator
- World Bank - Tanja Boskovic, Marina Patrovic, Miodrag Stefanovic
- Refugee centres in Kraljevo: Refugees from Croatia, Displaced Persons from Kosovo and a Roma camp.
- The group “Zene u crnom” (“Women in black”) - Mrs. Slavica Stojanovic and Mrs. Ljiljana Radovanovic
- Handicap International - Mrs. Dominique Weiss,
- Association of Handicapped Students in Serbia - Mr. Ivan Balsic
- “Forum NVO-Kraljevo”
- The group “Iz kruga” (“Out of the Circle”) - Mrs. Lepojka Mitanski
- “Humanitarian Law Centre” - Mrs. Natasa Kandic, Director,

2) The health care system in Serbia: the historical context

Under the communist regime the Yugoslavian health care system was not financed, as it was in the rest of Eastern Europe, through the Health Ministry budget, but through a social insurance fund modelled on the Bismarck system. This system is named after the famous German chancellor who implemented it at the end of the 19th century. The system makes contributions compulsory for all employees who, together with their families, benefit from the Health Insurance Fund, whilst those who do not work come under a separate insurance system (financed by the State budget). The system is generally contrasted with a second form of State provision known as “Beveridge” after an English Lord who, in the 1940s, drew up a report on the “welfare state” that advocated a system of universal, uniform redistribution. No more than twenty years ago the Yugoslavian health care system seemed to be relatively efficient and had been developed and organised to provide free

health care (treatment, medicine, prosthetics - including dental prosthetics, etc.). The break-up of the SFRY (Socialist Federal Republic of Yugoslavia), followed by the war years and their tragic consequences (the embargo, the arrival of huge numbers of refugees, the collapse of the GDP and the destruction of the middle class), vastly changed the landscape of which the health care system formed a part. Internationally renowned institutions such as the Torlak Institute of immunology and virology, the great producer of vaccines, lost their external markets. Slobodan Milosevic, the President at the time, had re-centralised the system, but without re-sizing and reforming it, and the gulf between the enormous structure inherited from the communist era and the possibilities of financing it grew greater and greater, bringing about a downward spiral.

At the same time as the population's health worsened, the quality of health care deteriorated significantly. Patients began to have to pay for certain medicines and medical examinations that were in theory covered by social security. Discrimination and corruption developed.

It was this stricken system which was inherited by the "Democratic Opposition of Serbia" (DOS) coalition in October 2000, following the fall of Milosevic. Health reform was proclaimed a national priority by the new government. A commission for reform of the health care system, set up in July 2001, drafted a public health policy document that was adopted by the government in February 2002. Work was begun on many projects for the drafting and adoption of new regulations and laws. National specialist teams were set up in the fields of public health, mental health, dentistry, tuberculosis, etc. With the rise to power of the democratic coalition, international cooperation, which had been put on hold under the Milosevic regime, restarted. Tomica Milosavljevic, former Director of the Belgrade gastroenterology clinic, was appointed Health Minister in June 2002. He is a member of G-17 Plus, a group of experts that identifies itself under the slogan "breaking with the past" (which is also the title of a report on the FRY made by the World Bank and the European Union in 2001). A degree of continuity was ensured (after his resignation in July 2003 because of the reject of his law project by the Health Committee of the National Assembly), with his reappointment to this position following the parliamentary elections in December 2003. The elections resulted in the formation of a new government coalition of which the G-17 Plus is still a participant.

This ministerial stability in the health domain is made more remarkable by the fact that it is set against a political background that is especially tense and uncertain, unsettled in particular by the assassination, in March 2003, of Prime Minister Zoran Djindjic, leader of the Democratic Party (DS), and marked by the resurfacing of nationalist and extremist political tendencies, with the electoral breakthrough by the Serbian Radical Party led by Vojislav Seselj (against whom action is being taken by the International Criminal Tribunal for the former Yugoslavia at the Hague). The new government coalition no longer includes DS representatives. It is now led by Vojislav Kostunica, President of the Serbian Democratic Party (DSS). His election as President of the RFY in October 2000 permitted the eviction of Milosevic, but he remained a fervent political adversary of Zoran Djindjic within the DOS coalition and a symbol of the "moderate" nationalism that is in favour of a degree of continuity with the former regime and is extremely hostile to bringing war criminals before the international courts of justice. His differences of opinion on the way reforms were carried out led him to state during the 2003 election campaign that he would be the one to "reform reform". The SPS, Milosevic party, was not indifferent to the the new Prime Minister's words. It supports the new coalition in Parliament. However it took only a few months for the DS to obtain its revenge, with the victory of its candidate, Boris Tadic, during the 2004 presidential elections. The country is therefore not succeeding in defining a clear direction in the transition process, perhaps because, as Jacques Rupnik, a researcher at the Centre for International Studies and Research, writes: "one of the principal lessons of the past fifteen years in post-Communist Europe is that transition to democracy has very little chance of success if there is no consensus on State contours, in other words on the territorial framework in which the process of democracy

occurs”.⁴ Yet the political status of the country has not been defined and there are still arguments about the future of the Serbia and Montenegro Union and of Kosovo. Despite this unfavourable political context, the Health Ministry of the Republic of Serbia, especially between 2001 and 2003, embarked on several reforms of the antiquated system to bring the country into conformity with its international obligations. Some positive changes can be seen. However the reforms that have been undertaken have slowed down since 2003 and have not yet put an end to dysfunctions in the system or to the two realities that are hidden by official statements: discrimination and corruption.

3) Serbia's obligations regarding the right to health

The international framework

The right to health is guaranteed by article 25 of the Universal Declaration of Human Rights: “*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, (...)*”.

The right to health is also guaranteed by other international instruments ratified by Serbia and Montenegro, such as the International Convention on the Elimination of All Forms of Racial Discrimination, article 5 (e), ratified in 2001; the International Convention on the Elimination of All Forms of Discrimination against Women, articles 11 and 12, ratified by Serbia in 2001; and the 1989 Convention on the Rights of the Child, article 24, ratified in 2001. The International Covenant on Economic, Social and Cultural Rights is the most complete instrument concerning the right to the highest attainable standard of health. Article 2.1 outlines the general obligations of Serbia and Montenegro regarding the Covenant. “*Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative*”.

Article 12 specifies the obligations of Serbia and Montenegro concerning the right to health in relation to the Covenant. It states that:

Article 12

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

(a) The reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The right to health, as with all human rights, imposes three categories or levels of obligations on Serbia and Montenegro: the obligations for its *respect*, *protection* and *fulfilment*.

The obligation to *respect* the right to health requires Serbia and Montenegro to refrain from directly or indirectly interfering with its enjoyment, whilst the obligation to *protect* it requires Serbia and Montenegro to take measures that prevent third parties from creating obstacles to the guarantees in

⁴ Jacques Rupnik, “Dangers and limitations of the return of nationalism in Serbia?” Critique internationale, October 2004.

article 12. Finally, the obligation to *fulfil* the right to health requires Serbia and Montenegro to adopt appropriate legislative, administrative, budgetary, judicial, promotional or other measures to ensure its full realization.

Although its realization might be progressive and subject to limitations on resources, the right to health imposes various obligations that have an immediate effect. According to the Committee on Economic, Social and Cultural Rights, the core obligations are⁵:

- a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

By virtue of articles 2.2 and 3 of the Covenant, the Committee considers that “the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement (...) which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health”⁶.

Serbia and Montenegro has signed the European Social Charter (revised) on 22nd March 2005, but has not yet ratified it. Article 11 of the European Social Charter guarantees the right to protection of health. Furthermore, Article V.E. proscribes any discrimination in the enjoyment of the rights recognised in the Charter.

Serbia and Montenegro is also party to two other international conventions relating to discrimination against persons. These are the International Convention on the Elimination of All Forms of Racial Discrimination and the International Covenant on Civil and Political Rights.

The national framework

In February 2003, Serbia and Montenegro, the successor state to the Federal Republic of Yugoslavia, adopted the Charter on Human and Minority Rights and Civil Freedoms as an integral part of its Constitutional Charter. Article 3 of the Charter on Human and Minority Rights and Civil Freedoms forbids all discrimination in general.

The prohibition of racial or other forms of discrimination is expressly provided for in the Criminal Code of the Republic of Serbia. Serbia and Montenegro also have a law on the protection of minorities that forbids all forms of discrimination.

Health care and health insurance are subject to the Law on Health Care and the Law on Health Insurance (Official Gazette of the Republic of Serbia, n° 17/92).

⁵ General Comment N° 14, para. 43.

⁶ General Comment, para. 18.

II. HEALTH INDICATORS AND EPIDEMIOLOGICAL DATA: RELIABLE INDICATORS?

1) Database development

Basic economic data for Serbia and Montenegro

Since 2000, Serbia has experienced high growth (on average +4.5 over the period 2000 to 2004) and, in 2004, returned to the same level of GDP in real terms as in 1998 (prior to the NATO intervention). However, the most significant decrease in GDP occurred between 1990 and 1994 when the level decreased by more than 60 %. This period was marked by hyperinflation very largely due to financing of the war in Croatia and in Bosnia-Herzegovina. The collapse in the quality of the health care system essentially occurred during this period.

Basic economic data for Serbia and Montenegro

	1998	1999	2000	2001	2002	2003	2004*
Growth in GDP (%)	1.9	-18	5	5.5	4	3	3
GDP per inhabitant (US\$)	1475	2071	834	1386	1884	2492	n.a.
Inflation (% variation)	29.5	37.1	60.4	91.3	21.4	11.3	8.5
Variation in employment (%)	-1.8	-6	-2.6	0.2	-11.9	-4.4	
Net salary increase (%)		18.2	83.3	129.6	51.7	25.5	n.a.

Source: EBRD, Transition Report 2004. n.a. = not available. * Estimate

The level of GDP achieved in 2004 is 50% of the 1989 level, although countries in transition (including the CEI) are on average at 90% of their 1989 level. The economy of Serbia and Montenegro is rapidly catching up, but with an official unemployment rate of nearly 30%⁷ and a standard of living that is greatly inferior to that of its neighbours (US\$ 8,281 per inhabitant in Hungary, nearly US\$ 7,615 in Croatia). However, a large part of the Serbian economy is developing in the unofficial sector and is undeclared. Furthermore growth has been weaker since 2003. This situation does not permit an increase in social contributions, particularly since official employment levels decreased by nearly 25% between 1998 and 2003.

The health care system in Serbia

The public health care system in Serbia is essentially financed through an employee contribution system. These contributions are made to a Health Insurance Fund (HIF) which covers the majority of expenditure (over 80% of total public expenditure, cf. the table on the structure of public health expenditure). The HIF must, on paper, provide universal insurance cover for all citizens. The reduction in the quality of health care services, the development of the unofficial economy and corruption in the health care system reduce the incentives for paying social contributions. There was a rapid decrease in the number of contributors in the 90s. Refunds are made on a “subsidised” basis, but the real cost of medical treatment is far in excess of this level. 60 to 80% of HIF expenditure goes to pay the salaries of the health system employees⁸. The private sector has developed on the basis of the weaknesses in the public sector, making use of the infrastructure of the latter. Doctors who have a private surgery are all also public sector doctors. Almost none of the treatment, surgery

⁷ According to employment surveys the unemployment level is 11-12%, with a large number of unemployed registered with the employment centres in Serbia in reality working unofficially.

⁸ “State of Health and Health Care of the Population of Serbia”, Survey (Pregled) Serbia and Montenegro, N° 2, Vol. XLIV, 2003.

and examinations carried out by the private sector are refunded.

Evolution of health care budgets

The health care system is organised on three levels. The primary sector covers 161 health centres of varying sizes, 83 of which are independent and 78 linked to secondary level institutions).

The hospital sector – the second level - includes 102 institutions. The tertiary sector covers specialist institutions. The secondary and tertiary sectors total 147 organisations (42 general hospitals, 15 specialist hospitals, 23 independent institutes and clinics, 5 hospital centres and clinics, 3 clinical centres, and 59 other institutions).

The evolution of the number of those contributing to the health insurance system is of great concern: between 1989 and 2003 the number decreased by nearly 30%. This situation reflects a general bypassing in the financing of the public health system in Serbia. It appears that the issue is not so much that of the level of health expenditure, as of its allocation. Expenditure is principally at the secondary and tertiary health care levels, whilst the needs are mainly at primary level, in other words in the local health centres (clinics). There are not enough generalists and too many specialists (83 % of doctors are specialists). Almost none of these specialists have received any training in the last 15 years, and so their knowledge and experience is partly or broadly out of date.

Public and private health expenditure in the region

	Non-consolidated health expenditure			
	Public (% of GDP)	Private (% of GDP)	Total expenditure (% of GDP)	Per inhabitant (PPA US\$)
	2001	2001	2001	2001
Croatia	7,3	1,6	8,9	726
Bulgaria	3,9	0,9	4,8	303
Bosnia-Herzegovina	2,8	4,8	7,6	268
Greece	5,2	4,1	9,3	1522
Hungary	5,1	1,7	6,8	914
Romania	5,2	1,4	6,6	460
Serbia and Montenegro	6,5	1,7	8,2	616

Source: Columns 1, 2, 3: WHO (World Health Organisation). 2004. Correspondence on health expenditure. March, Geneva, taken from UNDP.

If we look at health expenditure in the region it can be seen that Serbia is at an intermediate level, with total health expenditure forming a relatively high percentage of GDP (8.2%). Private expenditure is probably under-estimated and closer to that of Bosnia-Herzegovina, which leads to the conclusion that the health care system is amongst the most expensive in the region. In dollars (PPA) total health expenditure is 616 dollars per inhabitant (around 250 current US\$), a figure that is relatively high given the standard of living in Serbia. In comparison, in 2002 military expenditure represented 4.5% of GDP in Serbia and Montenegro, whilst everywhere else in the region it was below 3% of GDP (Romania 2.3%, Bulgaria 2.7%, Albania 1.2%, Croatia 2.5% of GDP). The level of total public expenditures in Serbia and Montenegro is relatively high: in 2003 it reached 47% of GDP 2003 (EBRD).

The evolution of data on consolidated public health expenditure reflects a fairly high level of stability in public expenditure in this area

	2001	2002	2003	2004
Health Ministry Budget (% of GDP)	4,6	5,2	5,3	n.a.

Source: PRSP, IMF, 2004

However patient expenditure also includes payments made directly to doctors who often work cash in hand and are not refunded through the health insurance system. As we have already noted, the UNDP estimated this expenditure at 1.7% of GDP in 2001. It has probably doubled since then.

Structure of public health expenditure (in millions of Dinars at the current rate)

	1998	1999	2000	2001
Health insurance fund	9 727,10	11 757,90	20 473,70	40 968,20
Republic Ministry of Health	82,10	77,00	60,10	180,20
Directorate of Properties (health facilities)	60,60	79,90	148,40	300,00
Defence Ministry health expenditure	202,00	266,40	494,50	1 000,00
Health expenditure at federal level				0,10
Public revenue from health institutions	1 750,90	2 116,40	3 685,30	7 374,30
Public health total expenditure	11 822,70	14 297,60	24 862,00	49 822,80
Nominal GDP (in Billions of Dinars)	146,30	192,20	358,10	724,10
Public health expenditure (non-consolidated) as % of GDP	8,1%	7,4%	6,9%	6,9%

Source: World Bank, PEIR

Basic health data

We may note from this table that the greater part of this expenditure is covered by the health insurance fund, with more than 80% of expenditure insured. The nominal increase in expenditure is principally due to inflation, which was at a level of 60 % in 2000 and 91% in 2001.

	Prevalence of HIV (% from 15-49 years)	Cases of tuberculosis - Per 100,000	Population with access to essential medication at any time and at an affordable cost (%)
	2003	2002	1999
Bulgaria	<0.2]	60	80-94
Bosnia-Herzegovina	<0.2]	65	80-94
Croatia	<0.2]	74	95-100
Greece	0.2 [0.1 - 0.3]	22	95-100
Hungary	0.1 [0.0 - 0.2]	37	95-100
Romania	<0.2]	189	80-94
Serbia and Montenegro	0.2 [0.1 - 0.4]	51	80-94

Sources: WHO and UNDP

Prevalence of HIV in Serbia is, apparently, amongst the highest in the region. Cases of tuberculosis may appear to be fairly few but have increased since 2000, according to a government report. Serbia is more affected than Hungary or Greece and is closer to the levels of Bulgaria or Bosnia-Herzegovina. Finally, medication is less accessible in Serbia than in neighbouring Hungary, Croatia or Greece. This situation has partly improved since 1999, but in many rural zones it is difficult to obtain the necessary medication.

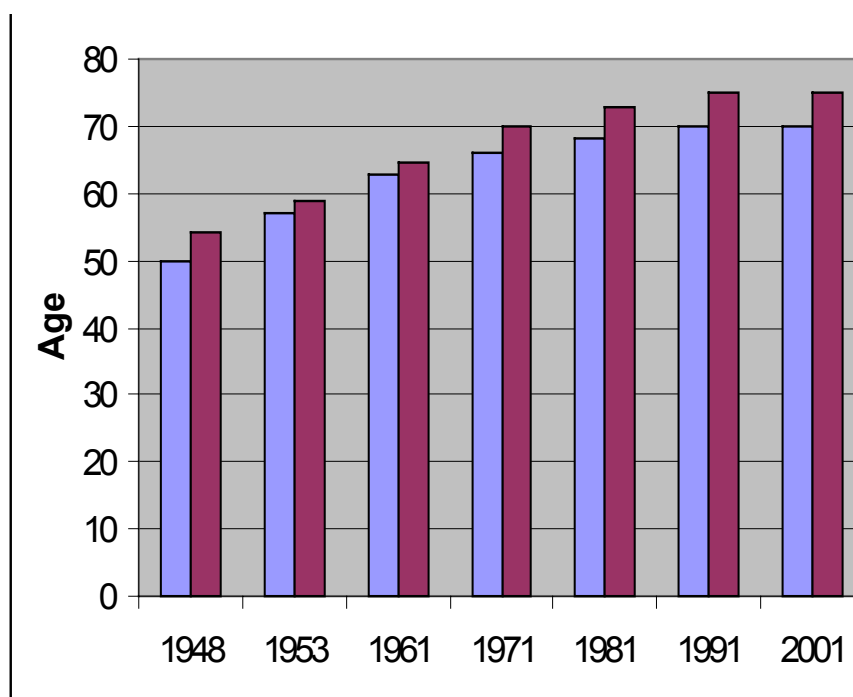
Life expectancy

	Life expectancy at birth (in years)		Probability at birth of reaching the age of 65, female population (% of population)	Probability at birth of reaching the age of 65, population masculine (% of population)
	1970-75	2000-05	2000-05	2000-05
Bulgaria	71	70,9	83,2	64,9
Bosnia-Herzegovina	67,5	74	85,2	74,1
Croatia	69,6	74,2	86,3	71,1
Greece	72,3	78,3	91,5	82,3
Hungary	69,3	71,9	82,6	62,7
Romania	69,2	70,5	81,5	63,7
Serbia and Montenegro	68,7	73,2	84	72,2

Sources: WHO and UNDP

Life expectancy in Serbia and Montenegro

Life expectancy is relatively high in Serbia and Montenegro and increased considerably in the 70s and 80s. It has since stagnated, as is shown in the following chart, showing life expectancy of Men (1) and life expectancy of Women (2) :



Source: "Serbia in Figures 2003"

Infant and maternal mortality

Infant mortality is a good indicator of the quality of health care and conditions of living. Infant mortality has decreased in Serbia-Montenegro but remains higher than in the rest of the region (UNDP, United Nations Development Programme). Thus it appears that Serbia and Montenegro, together with Romania, is amongst the countries in the region with the worst results. This reflects the serious problems in monitoring children's primary health care after birth. On the other hand maternal mortality seems to be fairly low compared with the other countries.

	Infant mortality rate (per 1,000 live births)	Mortality rate for children under 5 years (per 1,000 live births)	Rate of maternal mortality (per 100,000 live births)
	2002	2002	2000
Bulgaria	14	16	32
Bosnia-Herzegovina	15	18	31
Croatia	7	8	8
Greece	5	5	9
Hungary	8	9	16
Romania	19	21	49
Serbia and Montenegro	16	19	11

Source: WHO and UNDP

Addiction phenomena

The consumption of cigarettes is highest in Serbia and Montenegro and in Romania. This risks aggravating the health situation in the coming years. A public awareness campaign is under way to reduce consumption.

Consumption of cigarettes (% of adults)		
	Women	Men
	2000	2000
Greece	29	47
Hungary	27	44
Croatia	32	34
Bulgaria	24	49
Romania	25	62
Serbia and Montenegro	42	52

Source: World Bank, UNDP

Numbers of beds and doctors

In 2001, 47 hospital beds could be counted per 1,000 inhabitants, according to the Health Office of Serbia (quoted by the Statistical Office of the Republic of Serbia). Also according to Yugoslavian statistics report for 2000, the hospitalisation rate was 11.5 per 1,000 inhabitants, with a bed occupation rate of nearly 70% and an average period of hospitalisation of 12 days. There were 165,401 health sector employees and 2.1 doctors per 1,000 inhabitants. The Statistical Office of the Republic of Serbia noted that there was little change between 1998 and 2001 (*Serbia in figures 2003*). The number of beds is relatively high, even though in 2001 a group of specialists from the *Center for policy Studies* recommended an increase in the figure from 5 per 1,000 inhabitants.

The number of doctors is below the European average (3.5 per 1,000 EU inhabitants). However a report by the World Bank and the European Commission (“Breaking with the past”) noted that they were under-employed and that 6,000 doctors were unemployed and that unequal distribution between specialities and regions appeared to be the main cause of this paradoxical situation.

2) Are the indicators reliable?

The data are incomplete. Data concerning the state of health of ‘minority’ populations like the Roma, are generally speaking unavailable. As one of the members of the UN Human Rights Committee emphasised at the session of 20th July 2004 concerning Serbia-Montenegro ‘the States Parties are often reluctant to collect statistics broken down on the bases of ‘ethnicity’ because the fear of discrimination brings with it an underestimation of the number of persons belonging to minority groupings, but a census is not the only scientific method of collecting reliable data’⁹.

In May 2004 the International Monetary Fund stressed the fact that the prevalence of HIV in Serbia is probably far higher - and could still increase rapidly - than the official statistics would indicate¹⁰. About 2000 persons are officially registered as carriers of the virus. This relatively low figure is really a reflection of low number of screenings carried out (only 0.15% of the population) rather than a true record of the spread of HIV in the country. The Health Minister, Dr. Tomica Milosavlevic recognised that ‘it is estimated that the number of infected persons is 6 to 12 times

⁹ Review of the reports submitted by the States Parties in accordance with article 40 of the Pact on Civil and Political Rights/ Initial report from Serbia-Montenegro. CCPR/C/SR.2208/15 February 2005

¹⁰ Serbia and Montenegro: Joint Staff Assessment of the Poverty Reduction Strategy Paper, April 2004. IMF Country Report No. 04/117

higher than the number of registered cases¹¹, which means that, in reality, there are between 12,000 and 24,000 persons infected by HIV in the country. UNAIDS and UNICEF believe that the factors favouring a wide and rapid expansion of the epidemic are present in Serbia and the surrounding region.¹² The IMF is asking the government to undertake to fight the pandemic effectively.

The associations complain about the lack of precise data in the sectors where they are operating. According to Handicap International, statistics about handicapped people are rarely available. According to the Child Right Centre, the information about children of refugees is likewise difficult to obtain. According to the 'Group 484', an association dealing with refugees and displaced persons, there are no data allowing a comparison between the incidence of poverty among refugees and displaced persons with those of the rest of the population, especially in the plan for a governmental fight against poverty, the PRSP (the Poverty Reduction Strategy Paper). Neither are there any precise data about violence against women, something which appears to be on the increase in certain regions. Generally, the enquiries and indicators do not take sufficient account of the distribution by sex.

The number of patients logged in the annual register would be distinctly smaller than in reality. A large number of patients are treated without any reimbursement, by cash-in hand payments. This situation produces a medical practice which is outside any legal framework of health insurance.

The poor quality of data collection on the causes of death (as the government's initial report recognises) is responsible for a large section (around 20%, third cause of death) of the death rate being unsatisfactorily explained or unexplained. This situation, already stressed by the PRSP, shows a lack of reform and transformation in the "Batut" institute which still seems to function mainly with outdated methods. For example, there are no data according to biographical type (for individuals). In general, this incomplete information demonstrates that political action takes no or insufficient account of these problems. One of the recommendations of the PRSP asks that the collection of data be more stringent on a periodical basis, in order to overcome the poor and irregular quality of the health data available.

¹¹ Press Conference of 25th January 2005 on the prevention of transmission of HIV from mother to child

¹² UNAIDS/WHO Epidemiological fact sheet - 2004 update.

III. PATIENTS: IS THERE HIDDEN DISCRIMINATION?

Non-discrimination in access to health care and underlying determinants health figure among the most important aspects of the right to health. According to General Observation no.14 of the Committee of Economic, Social and Cultural Rights when speaking of the right to highest attainable standard of health, non-discrimination in access to care is an essential aspect of this right. «*Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds*». ¹³

1) The wilful concealment and gaps in governmental policy

In October 2003 the government adopted the programme “Poverty Reduction Strategy Paper” (PRSP). In the health field, it emphasises the link which exists between people’s poverty and vulnerability with regard to health. The effect of this vulnerability for poor people is that they experience greater difficulty in accessing health services and, in particular, quality services.

The State and many practitioners understand and tackle this problem mainly from the point of view of poverty. Refugees are not categorised by their status and questions are not asked according to nationality. So in general, the existence of discrimination is not recognised as such. It is basically *a supposedly global strategy to fight poverty* which is developed. The weak point in this approach is that it does not develop strategies which are targeted and adapted against discrimination, or where these strategies exist as in the “National Strategy for resolving the problem of refugees and displaced persons” drawn up in May 2002, no cohesive action is worked out. This criticism is shared by a large number of associations like ‘Group 484’ which deals with refugees and displaced persons or by the European Roma Rights Centre which is appalled that: «Rather than focusing on the root causes of poverty among vulnerable and marginalised group such as Roma, the PRSP processes have tended towards a neo-liberal and macro-economic approach to poverty that looks at income and consumption rather than broader human capabilities, human dignity and human rights». ¹⁴

The government’s budget is supposed to cover directly the health costs of certain destitute or uninsured groups (unemployed, single mothers, refugees, displaced persons, the homeless - for example the Roma - etc) but in fact the contribution is very small and, as the initial report of October 2003 recognised that the “resources for these purposes have actually not been allocated in recent years” (para. 280) The state health insurance office, apart from its budgetary grants, has partly compensated for the State’s shortfall by giving extra assistance to those uninsured. This welcome assistance which, however, blurs a little more the clear division between the roles of insurance and national solidarity in a system that is already pretty incomprehensible, is still insufficient to insure equal rights.

2) Vulnerable categories

Several groups appear particularly vulnerable and likely to be discriminated against in their right regarding health:

- the handicapped and mentally ill

There are 800,000 (10% of the population) handicapped persons of whom 200,000 are afflicted with mental deficiency. A report from the “Centre for an autonomous life in Serbia” and Oxfam shows that the number of poor is three times higher amongst the handicapped than in the rest of

¹³ General observation no.14, para 12.b

¹⁴ Memorandum « The protection of Roma rights in Serbia and Montenegro » prepared by the ERRC and UN OHCHR, avril 2003.

the population.¹⁵ The survey on poverty of 2002 (PRSP) indicates that 61.2% of households where there are handicapped persons live below the poverty threshold.¹⁶ Of the 200,000 persons suffering from mental problems and mental illness, 71,000 have been placed in institutions. The services are inadequate. Towns like Kraljevo do not have a psychiatric clinic or outpatient hospital. Even in the KBC of Belgrade, the department of neurology and psychiatry is the one in the worst situation. Medical treatments practised on the mentally ill are particularly aggressive. What is more, placements in psychiatric centres are insufficiently monitored by the legal system. In effect, a person may legally be interned for over a month without there being any requirement for a magistrate to intervene.

– the elderly

In 2002 retired people made up 25% of the poor. There are not enough gerontological institutions. Elderly people suffering from psychiatric trouble are placed in retirement houses (the centre in Beanijska Kosa was quoted as an example) even if the personnel do not have the training to take care of them. The attention and care given to those with terminal illness to avoid unnecessary suffering and allow them to die with dignity is an important part of the right to health for elderly people. In 2002 there was no service for palliative care in operation. The *International Observatory on End of Life Care*¹⁷ noted that despite the activities of the IORS (Institute for Oncology and Radiology in Serbia) there was no national policy or strategy in this area.

– lone children

80% of handicapped children seem to be separated from their families.¹⁸ Placement in foster families does not exist. Handicap International states that the handicapped are for the most part still directed to specialists services and rarely integrated into public hospitals. Only lessons at primary level are organised for handicapped children. The prolonged hospitalisation of older children deprives them of secondary education. (CRC)

– persons suffering from post-conflict stress disorder

The troubles resulting from war affected not only soldiers on active service and volunteers in paramilitary units, but also all family members. Post traumatic illness, alcoholism and psychological problems increased, causing violence within families (numerous accounts of this were collected by the Belgrade association Women in black) It seems that there is not enough follow-up work being done on these people. There are no specialist centres capable of taking care of these pathological conditions. Furthermore, few doctors are trained in this area. Among the rare initiatives, a German NGO (“Ohne Rustung leben”) is working on the training of doctors in collaboration with the Novi Sad association *The Trauma Centre for the victims of war and veterans of the 1991-99 War*. The lack of attention paid to the consequences of war on mental health contributes to the growth of violence in families and in the outside world.

– women subjected to domestic violence

Some enquiries reckon that half the women in Serbia have suffered physical or psychological violence.¹⁹ One of the worrying factors is that the public services are particularly inadequate in this area. They often think that their duty ends with calling the police, as the mission discovered when on a visit to the social workers centre in Kraljevo. Now, as many police officers had themselves been sent to the front (either in uniform or in paramilitary units), the question cannot

¹⁵ Centre for independent living Serbia and Oxfam, “Report on the specificity of poverty among persons with disabilities” quoted in “Disability Monitor Initiative South East Europe” “Beyond De-institutionalisation : the unsteady transition toward an enabling system in South East Europe”, 2004. www.disabilitymonitor-see.org

¹⁶ 2002, “survey on the living standards of the population” Serbia. *Serbia-Montenegro Survey* 2003/2.

¹⁷ www.eolc-observatory.net

¹⁸ According to the Vreme newspaper, 9.12.04

¹⁹ US Department of State. Country Reports on Human Rights Practices – 2004. Released by the Bureau of Democracy, Human Rights, and Labour / February 28, 2005

be dealt with by their intervention. As they may themselves be responsible for domestic violence, they may be inclined to minimise the gravity of the call-outs and complaints about this situation. An enquiry based on calls to the Association for the Support of Battered Women (SOS Hotline) shows that 79.3% of women who approached the police, claim to be dissatisfied with the help offered. Domestic violence is punishable by a prison sentence from 6 months to 10 years. As for the medical response, SOS Hotline's enquiry shows that 84.7% of women who had requested the support of a doctor had not received sufficient help.²⁰ The resources allocated to the fight against domestic violence are broadly insufficient.

– isolated rural people

In the Bujanovac region, in the South of the country, there are about 10 general practitioners to cover the surrounding villages (37,000 inhabitants), that is one practitioner for 3000 to 4000 people (about 4 times below the national average of 213 doctors for 100,000 inhabitants according to World Health Organisation data). The Belgrade Human Rights Centre noted that the “basic criterion for setting up medical centres, clinics, pharmacies etc. depends on the district's demography. The law does not provide for mobile medical teams to make care more accessible to inhabitants of remote villages and areas of mixed population; on the contrary, all systems are centred on the towns and the needs of densely populated areas.”²¹

– refugees

In January 2005, the UNHCR counted 187,000 refugees from Croatia, 98,500 from Bosnia-Herzegovina (including displaced persons - see below - about 6% of the population). Affiliation to the ‘National Health Service’ works for the first stage (health centres ie dispensaries) and for appointments with general practitioners, but becomes more problematic at the second level (hospitals and specialist centres) and for hospitalisations. It is very difficult for refugees to gain access to hospitals, and when it is possible, they are on a separate waiting list which is longer and therefore slower.

– displaced persons

According to the UNHCR there are 220,000 displaced persons from Kosovo. The Roma represent about 26,600 registered persons. This figure is probably an underestimate, either because the Roma do not make a declaration or because they are not registered by the authorities.²²

– repatriated people

Recent bilateral agreements between certain EU countries and Serbia- Montenegro (since 2002) have given rise to the arrival of a significant number of repatriated people. It does not seem that Serbia-Montenegro foresaw their arrival, and there is a shortfall in capacity to receive them. As for health questions, repatriated people often find themselves once again without health cover.

Two groups seem to be even more marginalized:

- The Roma

The Roma are discriminated against in almost all aspects of life, housing, education, jobs, justice as well as health. In the report of the United States State Department²³, it is said that: “Roma continued

²⁰ Violence Against Women - An International Interdisciplinary Journal, Vol. 3, No. 2, pp. 101-128. 1997, <http://www.uri.edu/artsci/wms/hughes/sos.htm>

²¹ Human Rights in Serbia and Montenegro 2003, Belgrade 2004, p. 249

²² The chairman of the session of 20th July 2004 concerning the report from Serbia-Montenegro in accordance with article 40 of the Pact on Civil and Political Rights expressed the hope that «the future law against discrimination will contribute to the elimination of all forms of discrimination which victimise in particular the Roma and displaced persons». CCPR/C/SR.2208/15th February 2005. op.cit.

²³ US State Department, Country Reports on Human Rights Practices - 2004 Released by the Bureau of Democracy,

to be targets of numerous incidents of police violence, verbal and physical harassment from ordinary citizens, and societal discrimination. Police often did not investigate cases of societal violence against Roma”.

The kind of racist behavior found among different sections of society is also found among the medical professions. Obviously this does not mean that all physicians are guilty of this kind of behavior. Nevertheless, about one quarter of the Roma questioned by OXFAM²⁴ said that this was a recurrent problem during medical exams. The physician or the nurses treated them with contempt or remoteness and even in some cases refused to give care or make a diagnosis. Furthermore, the authorities have done nothing to improve the hygiene of their housing. There is a lack of drinking water, of electricity and air, the homes are damp, even dangerous and crowded, etc. Therefore, there are many problems of chronic asthma and bronchitis. According to the Roma association “The open hand”, on the basis of their inquiry on the Roma of Kraljevo, almost 90% of the community are affected by these diseases and 25% have cardiovascular disease. There are many cases of tuberculosis because of malnutrition. The situation is therefore similar to what the “European Roma Rights Center” and the High Commissioner for Human rights of the UN had denounced two years ago in a memorandum. According to the report: “Frequently housing conditions are so substandard as to cause a public health risk, highlighting the intersection between the right to adequate housing and the right to the highest attainable standard of health”.²⁵

- Refugees and displaced persons in unregistered centers

Group 484 had listed about sixty centers in 2003 that were not registered by the HCR out of 479 group centers in Serbia. There are about 3500 refugees and displaced persons who live in unregistered centers, i.e. out of almost 15% of the total number. Two thirds of them live in the Belgrade area. In Kraljevo, there are almost 500. A program to close these centers has started; however, as far as the unregistered centers are concerned, the pressure and the ultimatums of the authorities are just one more difficulty and uncertainty for the inhabitants if no help and other possibility is given them.

The mission visited three centers in Kraljevo (where almost 40% of the total number of refugees and displaced persons live in centers²⁶) where the basic and essential equipment for health care were not available or were insufficient. These were the Vitanovac center where 17 families of Serbian Kosovars live, the so-called *stari aerodrom* where there are almost 200 Kosovar Roma and a center in that same industrial area where 44 refugees from Croatia have been living for 8 years.

In the first camp the authorities have not even taken measures to ensure the supply of drinking water and elementary means of cleanliness and purification; even worse, the facilities provided by an international NGO to provide access to running water for the families were stopped by neighbors in the vicinity so as to pressure the refugees into leaving. In the second camp, the showers installed by the same NGO were no longer in working order, and were damaged.

The three groups of refugees that the mission met were all living in unhealthy and unsafe conditions. The heating systems remained very uncertain. At the Vitanovac center, there was just one stove in a corner that was supposed to heat the whole building. Electrical power could not allow for additional individual heating. In the Croatian refugee centers, collective wall heating was not operating despite the fact that the temperature in winter was very low. An old woman whom we met told us that she didn't have the money to pay for individual heating. The sanitary appliances were also extremely rudimentary. The Roma camp, *stari aerodrom* (the old airport) is only about a hundred meters from the garbage center.

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²⁴ OXFAM, «The Roma livelihood in Belgrade Settlements », Belgrade, December 2001.

²⁵ Op. cit..

²⁶ Data of the UNHCR

3) The way discrimination operates

Many groups are discriminated against, among which the most vulnerable ones. This applies to the right to health, both regarding access to health care, particularly because of the economic difficulties of many groups, and concerning access to fundamental and essential aspects of health, mainly the right to decent housing.

There are two important points here. First of all, the discrimination that was noted is not based on openly discriminating laws, but it is constant all the same. Furthermore, the problem is not necessarily one of access to health care per se; but to work well, the right to health requires that other elements be present and these do not exist. For the Committee, the right to health is a comprehensive and includes more than just health benefits, but also the basic factors that ensure health, i.e. access clear drinking water, adequate means of cleanliness and purification, access to sufficient healthy food, nutrition and housing (...) ²⁷. Thus the main channels of discrimination can be connected to the following factors:

- Insalubrity

The crux of the problem is extremely deteriorated living conditions that are not in keeping with the minimum standards of the right to health. Though it is true that the Roma group the mission met did benefit from access to health services and regular vaccination campaigns, nothing had been done to control the humidity in their homes made of bits and pieces except placing some nylon; this is the main cause for asthma and bronchitis.

- Isolation

The fact that they are very far from the specialized institutions of the cities and towns is a real problem (about handicapped children, Vreme, 9/12./2004 mentions Kulina, Tutin, Stamnica etc.). They are not as far from the cities as they are in other countries like Bulgaria, but the centers are often in the periphery. The psychiatric hospital in Belgrade is an exception for it is in the center of the town.

- Administrative obstacles.

The difficulties in registering and obtaining administrative certificates can hinder access to health care. According to the UNHCR report, "many displaced persons, particularly the Roma, have never been registered... they now need to be registered so as to enjoy their legal rights. Nothing is provided to assist them in this. In Serbia, it is even more difficult to solve these problems because government policy is not clear" ²⁸. One of the problems the Roma often face is the need to give a fixed address or to give the civil status of their parents, who have never been registered either. A person who doesn't have the address of a residence cannot have sickness insurance. It is difficult for displaced persons to get identity documents and social insurance from the local authorities.

- Physical obstacles.

Handicap International has informed the public authorities of the fact that many disabled persons have great difficulties and even impossibility of gaining access to non specialized medical centers and means of public transportation.

- Financial obstacles.

The most vulnerable people with regard to health are precisely those who are most poor. Very often, they cannot follow the whole course of the medical treatment prescribed to them because of a lack of money. The mission heard evidence of this.

²⁷ Para. 11 of general observation no. 14

²⁸ «Analysis of the situation of internally displaced persons from Kosovo in Serbia and Montenegro: Law and Practice» Under the lead of UNHCR, Belgrade, October 2004.

- Negligence and indifference.

The mission heard of many cases. Though on one hand, the associations of handicapped persons are in touch with the Belgrade municipal authorities and have organized projects with them, on the other, about one hundred buses were ordered without making sure that they had access ramps for handicapped persons. Furthermore, 5% of women are handicapped, but gynecological services do not have special beds for those who need them. As for mental patients, the system that aimed at putting them in families following the Trieste example is in a crisis in Serbia. To really achieve the aim of socializing these patients, they need to be seen regularly by a psychiatrist, to benefit from workshops as out patients or to have access to psychiatric dispensaries. Since this is not done as it should, patients are really left to themselves.

- Stigmatization.

In the case of patients who are HIV positive, there is no policy aimed at high risk groups such as young drug addicts, homosexuals or prostitutes. According to the *Child Rights Center*, there is even a general agreement to keep quiet which makes it impossible to devise a strategy²⁹. According to UNAIDS, “the insufficiently accurate diagnoses and the underestimation of the number of HIV positive cases are due to the social and economic conditions and to the fact that high risk groups are stigmatized and discriminated against”³⁰. The stigmatizing of certain groups, as the Roma, can also lead to humiliating behavior or distrust among some members of the staff of health centers. Some politicians and part of the press have made hate calls against the refugees and displaced persons. No complaint have been lodged and the authorities have applied no sanctions.

4) Insufficient social security coverage

Social insurance has adjusted to the economic crisis of the nineties by artificially lowering official prices and thus, reimbursement of expenses; this has made it possible to avoid taking measures such as reducing the number of staff or the number of beneficiaries. Because of this, the system is no longer commensurate with the actual costs. Thus, to have a scan, you had to pay, or else the doctor would simply pretend that the equipment did not work. This problem still exists. The system is deeply flawed by the unwillingness of the people to pay relatively high amounts for an insurance fund that does not perform well. It is also affected by the large gray section of the economy (which is obviously outside of the system) as well as by the fact that many physicians belong both to the public and private systems. This means that the patients of the public system where the coverage is not adequate are sent on to the private system, where there is no coverage at all. According to Doctor Gordona Matkovic of the *Center for liberal-democratic studies*, the problem is one of including the private system within the whole security system.

In 2004, the budget was approximately 82 billion dinars (about 1 billion Euros). This breaks down as 60% for wages, 16% for medicine, 14% for artificial limbs and other equipment and 1.2% for administration. A debt of 11 billion dinars has piled up, mainly as the result of difficulties in forecasting income; this has been included in the budget for the first time, whereas before it was simply passed on to the next budget by an accounting ploy. A new bill is being prepared on health insurance and social security. The social security administration should then be able to set repayment criteria more independently. Only contributors would be covered. A number of minimum services would be ensured and the rest would be covered by mutual insurance or by a combination of various contributions and services. The people who would not contribute would be covered by the state budget, according to the law. Thus, the state budget has never, so far, been able to cover them.

²⁹ Report on *Child Rights in Serbia* 1996-2002, Belgrade 2003, p. 169

³⁰ UNAIDS/WHO Epidemiological fact sheet - 2004 update

Unsatisfactory and limited remedies

The Committee on Economic, Social and Cultural Rights notes that any person victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.³¹ The mission considers that the remedies available in Serbia, whether judicial or internal to the health system, are unsatisfactory and limited.

- Few people turn to the courts. And yet, a case relating to a blood transfusion that turned out to be infectious (HIV) was resolved in favour of the two patients who had filed a complaint. Public opinion nevertheless remains sceptical of judicial institutions, and medical law is embryonic. There is no legislation on the professional liability of doctors. On the other hand, Serbia is the only country in the region with legislation that penalizes non-accessibility, but the legislation is not applied.
- Health centre ombudsperson. Established in 2002, this institution is typical of the kind of positive reform whose application has slowly ground to a halt for lack of follow-up and genuine means. In the medical centres where the system works, the patients are informed of their rights and can file a complaint with the ombudsperson, who has a week to respond. If, on inquiry, the complaint does not appear admissible, the ombudsperson gives the patient the doctors' justification or the contextual reasons at the root of the problem. If there are grounds for the complaint, the ombudsperson alerts the management to the problem or to the error that was made. If the error is acknowledged, the patient's costs may be reimbursed and the medical staff involved penalized (usually in terms of salary). Services may also be re-organized. In the centre visited by the mission, most of the complaints about the quality of the services had been deemed to be unjustified. In general, they concerned either what were considered to be excessive waits for examination or treatment or conflicts between the patient and the doctors or the staff. Two to three complaints are lodged every month. Except in cases in which the complainant did not turn to the ombudsperson but had gone straight to the courts, mediation served to prevent litigation. Previously, complaints were handled by the directors, who often acted arbitrarily and tended to follow up on those complaints that served to penalize subordinates they had a dim view of. The directors no longer have this authority, but how well the new system functions still depends entirely on their support. The ombudsperson is appointed from among the hospital staff. This is both an advantage, because they are familiar with how the institution and their colleagues function, and a risk or weakness, because they can be seen as spies or traitors. If the ombudsperson is not backed by management and management does not act on his or her proposals or suggested penalties, he or she may have little incentive to propose any. At Zemun hospital, on the outskirts of Belgrade, there was no volunteer for this sensitive position. The director can appoint someone, but the ideal profile is hard to find: the ombudsperson must have a minimum of legal training and, if possible, be held in esteem by his or her colleagues. A number of institutions have in fact informed the Ministry that they have not found members of their staff able to fill that role. Others simply made a *pro forma* appointment. At the other end of the process, the State has shown little determination to correct and remedy the system's shortcomings. It does not seem inclined to see local criticism work its way up (it is more used to functioning in the opposite direction), and does not seem willing to allocate funds to encourage people to step forward as ombudspersons (the person the mission met with devoted 1/3 of his working time to that role) or to give the ombudsperson the means needed to be independent (such as a personal office in which to hold private meetings with complainants). It is a sign of this growing disinterest that the annual report drawn up in 2003 by the ombudsperson at the Ministry of Health was not requested in 2004.
- The private sector: the private sector, which emerged in the 1990s, has never been properly regulated or supervised. For the time being, the health system has been privatized in the absence

³¹ General Comment No. 14, para. 59.

of any real legal framework, to the extent that the public hospital sector is largely financed by cash payments (from patient to doctor). The more or less official links between the private and public sectors have provided a major breeding ground for corruption and misappropriation of funds. The private sector has nevertheless also helped make up for the shortcomings of the public services. The quality of private doctor's surgeries is subject to few regulations and little supervision. Private clinics (gynaecology, ophthalmology, orthopaedics, etc.) can sign a contract establishing the price of their services and their reimbursement with the social security fund if they provide specific medical services that do not exist or are inadequate in the public sector. There is no detailed information, however, on how much of the social security fund goes into the private sector. The government's policy is to improve and increase the ties between the for-profit and the public sectors. The private sector is nevertheless not in a position generally to present itself as an alternative to the public sector's shortcomings.

- associations: there are 70 NGOs³² and associations for the disabled. In April 2002, the *Center for advanced legal studies* proposed the adoption of legislation protecting the disabled and of anti-discrimination legislation. Disabled persons' associations have worked with the Ministry to draw up the legislation, which is in the process of being adopted. Civil society is organizing so as to have a greater impact and be recognized as a partner by the government. Handicap International, together with UNICEF, is setting up alternative systems that can serve as models, and provides associations of families and patients with accreditation. The activities of the *Centre for Independent Living - Serbia* and the *Association of Disabled Students - Serbia* receive broad coverage in the report "Beyond Deinstitutionalisation: the unsteady transition toward an enabling system in South East Europe". In February 2002, the Association of Disabled Students, working with a Canadian institution, launched a one-year programme to do away with physical obstacles. Ramps were installed in the faculty of mathematics and science, at city hall, in the post office and at the central library. The sidewalks on the main avenue in downtown Belgrade were fitted with sensory paving stones to guide the vision-impaired, and a request has been made that city buses also be equipped. In the town of Cacak almost all obstacles to movement have been removed (an operation carried out thanks to the strong support of an association of paraplegics). In Kraljevo, demonstrations had to be held in front of city hall for measures to be taken. It is the associations, and not the local authorities, who come to the aid of the neediest. They visit centres for refugees and displaced persons who have not been registered by UNHCR, such as that in Vitanovac (see above), and work to curb the risks of epidemics.

³² On the International Day of Disabled Persons, 3 December 2004, article by Dejan Kožul in the weekly *Vreme* of 9 December 2004 (translated by the *Courrier des Balkans*). According to the government's initial report, 230 disabled persons' associations received Health Ministry aid to obtain computer equipment.

IV. THE HEALTH SYSTEM: INADEQUATE AND CORRUPT INSTITUTIONS?

1) Improvements

Despite the slow pace of the reforms and many problems, during the last three years there has been undeniable progress. At the Belgrade KBC (Hospital Centre), working conditions, the quality of service (supply of medicinal products, heating, composition of patients' meals) and personnel salaries have improved. At the Kraljevo clinic, waiting lists for a diagnostic consultation are now on average thirty days, which is considered to be a success. Furthermore, in 2004 the hospital and the health centre have managed to operate without incurring a financial loss. Equipment is bought out of hospital funds. External collaboration, as between the Kraljevo hospital centre and a neighbouring thermal baths and cure institute, can constitute a notable source of income. The Bujanovac health centre has been able to repaint its frontage thanks to an international grant, and the name now appears in Serbian and Albanian.

2) A persistently inadequate system

- The law lays down standards (for instance the number of doctors or the regularity of visits in psychiatric institutions), but in practice they are not applied.
- The hospital system is both over-dimensioned and under-financed. The health system is not clearly structured according to the three separate levels of health coverage. The main problem is that there are too many specialists and not enough general practitioners. This means that in practice part of the secondary and tertiary levels provide primary level services.
- The system is not adapted to the needs. There is a lack of general practitioners and a surplus of specialists (83% of physicians are specialists). Almost all the specialists have undergone no training for 15 years, which means that their knowledge and practices are all or in part obsolete. Despite the over-specialisation, some skills are nevertheless lacking in certain regions. At Kulina, one of the biggest specialised centres for handicapped children, there are only 2 persons with specialised training for around 600 children (Vreme. 9.12.2004). At Bujanovac (10,000 inhabitants), there is no women gynaecologist, and no psychiatrist.
- The teaching at the 5 medical schools in the country is mainly theoretical, without giving the students speedy access to practical training. It would also appear that the quality of tuition varies from one medical school to another.
- Certain facilities are totally lacking, in particular in the poorest regions. At the Bujanovac health centre even the basic necessities are lacking (syringes, lint,...). The diagnostic equipment at the Kraljevo clinic is worn out or inadequate (there is in particular no X-ray or ultra-sound equipment).
- There are still very few hospitals where medical waste is dealt with properly. Organic material or surgical instruments are often disposed of without prior sterilisation or treatment.
- The centralisation process under the Milosevic regime has disconnected the health system from specific local conditions.
- The health system is too partitioned, too enclosed. There are no bilateral exchanges, except between capital cities like Sarajevo and Belgrade; when there is regional co-operation, it is mainly due to the personal initiative of certain doctors. In the situation as it is at present, exchanges are not organised by hospitals, but by the patients themselves: those who have the means and the information go for treatment wherever the service is the best. The fact that there are no meetings arranged among the ombudsmen to share their experience is another instance of

the way everything is partitioned. In Kraljevo there is no partnership protocol between the social centre and the hospital for establishing genuine co-operation in matters of alcoholism or finding homes for children. Nor is there adequate and clear co-ordination between departments (police, social centres, etc.) for dealing effectively with cases of family violence. Yet far from diminishing, the phenomenon is increasing in certain regions, such as south-eastern Serbia. And the exchanges between the social centre and the UNHCR are not deep enough to define and confront the fundamental problems. There is another tell-tale symptom: the Ministry of Health has reservations about the HCR's direct aid programmes for displaced persons (it is the only organisation that gives the medicine directly to the patients).

- The ministries pass the responsibilities on to each other. No long term health policy has been adopted.
- Health awareness is at a low level, particularly in the provinces. The majority of patients adopt a high-risk conduct, and do not seek treatment early enough. Primary education is neglected.

3) A built-in system of corruption

In 2003 Transparency International placed Serbia in 106th place (out of 133 countries) on the corruption ladder. This reflects a generalised system of corruption in the economic and political spheres. In the area of health, corruption is a long-standing practice, but it has now become the rule, and whereas it used to be mainly in kind, it now in the form of money. In a recent study carried out by a Kraljevo NGO "Lingva", health is seen as the most corrupt area (28.1% of persons questioned mentioned health)³³. This confirms what had already been highlighted two years earlier in a World Bank "Country Procurement Assessment Report", i.e. that "The health sector is considered to be the epicentre of corruption financing in Serbia".

The corruption mechanisms have several effects: First, they discriminate among individuals according to their income and their contacts with the medical profession. If one knows a doctor personally, one gets better treatment; if one pays, treatment can be faster. Secondly, corruption means that fewer dues are paid into the health service, thereby reducing public expenditure in health and education. Thirdly, corruption as practiced in Serbia by no means guarantees the delivery and quality of service, because the real cost is not divulged by the State. So the patient never knows whether the money in the envelope is enough, and whether the doctor will take it into account by providing good treatment. And lastly, the corruption system is bolstered by the number of doctors and the disproportionate size of the health system, corruption block all possible reforms. There is a large number of doctors, they are badly paid (the average salary for a specialist is 27,000 dinars, or 335 €, and for a general practitioner 22,000 dinars, or 275 €) and therefore easily corruptible. Corruption is also linked to the lack of a clear-cut separation between public and private practice, so that a patient may find himself having to pay the same doctor twice for the same service, first in the hospital and then in his private office. The salaries of medical personnel, although they have been raised, are inadequate, and lead to corruption. Corruption is not necessarily, or systematically, more prevalent than in other public services (police, justice, education), but it is sufficiently present to appear as one of the major factors preventing rationalisation of the health system. Health insurance funds are subjected to no real auditing. There is no assessment of the money wasted or embezzled, nor of the extent of corruption. Funds are not well oriented, and do not go to the efficient units, but to the largest ones, and on a project basis.

The IMF, in its assessment of the PRSP, urges the government to elaborate "mechanisms to reduce barriers to access (such as informal payments, and corruption) and redistribute resources. (For the IMF) it will be important to embed such measures in the budget process and to monitor public and private expenditure since progress would involve a reallocation of public expenditure and a

³³ Similar results are recorded in the PRSP and in a recent (January 2005) survey, the socio-political barometer.

reduction in out-of-pocket payments for basic health care, particularly by the poor and vulnerable. The PRSP acknowledges the problem of direct payments, corruption and bribes but does not include specific measures to tackle these problems³⁴. The Council of Europe report issued at the end of 2004 is not over-optimistic, stressing the doubts voiced by the Vice-Chairman of the Council's monitoring activities regarding the true determination of the authorities to deal more effectively with corruption³⁵. Although caught in the act by an inspection, the Director of the Kraljevo Health Centre has not been dismissed from his post. He has even been put in charge of the internal health reform project for Kraljevo which is cited as a model by the Ministry of Health. Similarly, the Ministry of Health did not publicly accuse a professor of surgery at the Belgrade medical faculty at the beginning of 2004 when he was caught in the red-handed (Politika, 26 February 2004).

In a statement made on 21 March 2005, Verika Barac, President of the Council for the fight against corruption, asserts that the recent amendments presented by the Serbian government prove that the government is not prepared to fight corruption³⁶.

Examples of corruption that are very common in Serbia³⁷:

If a woman wants to have her baby under good conditions, i.e. if she wants to see a doctor before and/or during delivery, the mission was told of the two following possibilities:

1. The gynaecologist works in a public clinic (and in Serbia one can only give birth in a public clinic) and does not have a private office. In that case, in order to get an appointment it is necessary from time to time to make an informal payment. The cost is around 100 to 200 € every two months (and more often if there are complications), and 1,000 € before the delivery itself.
2. If the gynaecologist does have a private practice, then he will examine his patient in his own office. Fees vary considerably, but at least they are posted up, and a receipt is given for the consulting fee. At the time of delivery, the doctor undertakes to be present, because in any case he is employed by the public clinic.

The mission was told of another case, that of a young man who needed minor knee surgery. He went to hospital, and was then left to wait: each day, for one reason or another, the operation was postponed. The reasons became more and more absurd. This is a common way of getting the patient to understand that he must give the doctor some money. When he finally gave him 200 €, he was operated on the very same day. There was also the case of an older person who needed hip-bone surgery (a bigger operation than the preceding one). At the hospital, the doctors said that they did not have the necessary material (bandages, lint, drugs...), meaning that payment was required. The patient had to pay almost 1000 € to be operated on.

³⁴ Serbia and Montenegro: Joint Staff Assessment of the Poverty Reduction Strategy Paper, April 2004. IMF Country Report No. 04/117

³⁵ Council of Europe, "Serbia and Montenegro compliance with obligations of the post-accession co-operation programme", Information documents, SG/INF(2004)23 revised 2, 14 September 2004.

³⁶ Beta, quoted by B92, 21 March 2005.

³⁷ These examples were collected by our mission, through semi-directive interviews.

V. THE REFORMS: NON-APPLICATION OF LAWS?

1) Efforts and achievements

- Job insertion of handicapped persons: The Ministry of Labour gives grants of up to 60,000 dinars, plus exemption from social levies for the first year of employment, on condition the employer keeps the handicapped person for at least two years. The Ministry reacted to attempts to circumvent the law when the project was launched (pressure for getting rid of the employee once public aid had been received). A law introducing quotas is being prepared. The information is conveyed through the National Associations for Employment (there is a special department for handicapped persons).
- The reform of the categorisation commissions, which is under way, should increase transparency. A lot has been done, in particular in Belgrade, to improve the freedom of movement of handicapped persons. The Ministry for Employment (apparently the most active in this area) is also preparing anti-discrimination legislation. A law on mental disability is also in preparation.
- A multi-sectorial approach. In January 2005 a committee for the prevention of the abuse of psycho-active substances (narcotics and alcohol) held its first meeting, comprising representatives of several ministries (health, labour, interior, justice, culture).

Also in January 2005, Serbia-Montenegro participated in a conference organised in Helsinki under the auspices of WHO, where a binding action plan for mental health was adopted. In Nis, a pilot community mental health service should be set up in March 2005, in the framework of a vast regional programme led by WHO.

2) Reforms slowed down or not applied

The obstruction is not so much ideological as linked to past habits, and to the difficulty of getting rid of the monopolistic system inherited from the old system. All the more so, owing to the fact that under the old system patients received good service free of charge. It is difficult to carry out reforms that remove certain rights (many of which have admittedly become virtual with the passage of time) without sufficient social consensus and a government prepared to shoulder its responsibilities. Unfortunately there has been an uninterrupted series of elections over the last two years, and the politicians, who are perpetually campaigning, avoid using frank and realistic language. To be in a position to introduce and sustain the reforms, to make the population understand their necessity and to overcome the doctors' fears for their employment, at least four years of political stability and action are needed. Such a condition is far from being met. Health is not a political priority. The reforms started under Djindjic are slowed down. At the beginning of 2003, the EBRD considered Serbia-Montenegro to be the country in Eastern Europe that had made the most progress in introducing reforms³⁸. Such a rate of progress was not, alas, to be sustained over time, particularly in the field of health care.

The adoption by Parliament of the law on health care has been postponed several times. The minister will try to pass the bill through Parliament in March 2005, but he is by no means sure of succeeding (according to the Vice-Director of the Kraljevo hospital). As was the case when the ombudsmen were introduced in hospitals and clinics, some of the positive reforms launched by the State are still problematic when it comes to their application in practice.

The "Disability Monitor Initiative in South East Europe" gives another example of this, with the legislation authorising disabled children to join the mainstream school curriculum, but without any

³⁸ *Transition report*, 2003, 2004. EBRD

special training for the teaching staff, nor any alterations to enable access to the classrooms³⁹.

Several causes can explain the difficulty in introducing reforms:

- The reform of the health system is politically one of the most risky, as it calls both for restructuring the medical and nursing staff and a re-evaluation of the real cost of health care.
- After the 2003 general elections, the new coalition sought to change substantially the rhythm and content of the programme of reforms of Zoran Djindjic's government. In the field of health, this systematic revision of the reforms led to the postponement of the adoption of the draft bill, and the replacement of many senior civil servants. A political vision and a sufficient consensus on the future of the health system are both lacking.
- Part of the medical profession and the "representative" institutions seem reluctant to increase the pace of reforms, in order to retain the monopolistic positions that enable them to increase their income- often through bribes.
- The central administration of the health system shows signs of resisting the regionalisation process.
- The possibility of accession to the EU, at a distant and still uncertain date, is not a sufficient stimulant for introducing rapid reforms.

3) A health polity or a politicised health system ?

Some of the problems in the running of the health system, which could be termed "political", would appear to be to the advantage of certain categories, and to the disadvantage of others.:

- Officials in the health system are appointed on the basis of the party they belong to. Recruitment is not necessarily based on ability; responsible posts can sometimes be "bought".
- The instability of the political scene has an impact on the health system, in that there can be no continuity of reforms, nor recognition of ability.
- The quality of treatment dispensed can depend on who knows whom in the political parties.
- Excessive attention paid to status in the doctors' professional strategy has a deleterious effect on medical practice (the over-specialisation is a sign of this). Some sectors are neglected (gerontology), and rural areas are short of doctors.
- Recruitment of Albanian doctors is still very limited (only one active Albanian doctor in Bujanovac).

4) International aid

The European Union is the main international donor to Serbia: In 2004 the EU invested 8 million Euros in the health care sector. USAID is the largest bilateral donor. The European contribution is sharply on the decline, however: Since October 2000 the health sector has been the fourth largest in terms of investment, with 75 million (far behind the energy sector, however, which received 391 million Euros), but the 2004 figure puts it in 9th place among European investments for the year (EAR, www.ear.eu.int).

³⁹ Disability Monitor Initiative South East Europe “ Beyond De-institutionalisation : the unsteady transition toward an enabling system in South East Europe “, 2004. www.disabilitymonitor-see.org

Apparently the results of the CARDS⁴⁰ European assistance programme (formerly Obnova) are still mediocre. There are many recurrent problems linked to that type of aid. Projects are very often short-term, and the well-paid experts mainly come from EU countries, and take up most of the budget. Furthermore these projects fail to involve sufficiently local authorities and institutions, partly because of lack of interest on their part. There is a need of more transparency in the EAR projects⁴¹.

⁴⁰ Community Assistance for Reconstruction, Development and Stabilisation for the West Balkans.

⁴¹ See the case of the transfusion service reform for a good example of mismanaged project.

VI. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The FIDH welcomes the signature on 22 March 2005 by Serbia-Montenegro of the revised European Social Charter, which guarantees the right to health. The FIDH also notes the efforts made by the Serbian government to reform the health system.

Nevertheless the FIDH considers that a certain number of Serbia's minimal obligations concerning the right to health, in particular the obligation to guarantee the right of access to health facilities, goods and services on a non-discriminatory basis, especially towards vulnerable or marginalized groups, and to provide access to underlying determinants of health, such as housing, have not been fulfilled.

FIDH considers that there is substantial discrimination, in particular towards the two most vulnerable groups in Serbia, the Roma and the refugees and displaced persons. While the discrimination is not *de jure* but *de facto*, the FIDH feels that the Serbian State is not taking sufficient measures to remedy the situation. Furthermore, disability and mental health, particularly prevalent in a post-war context, are not given enough attention by the government.

The minimal obligation to implement at national level a public health strategy and plan of action corresponding to the needs of the population as a whole is not fulfilled. While the budget allocated to health does not necessarily appear inadequate, the way it is distributed does not meet the needs of the population. First, the needs of the most vulnerable groups (Roma, refugees, handicapped persons...) are not taken specifically into account. Secondly, primary care, despite being top priority, is neglected compared with the secondary and tertiary levels.

The health care system is therefore not adapted to national realities, and requires major reform. As the mission found out, however, the reforms undertaken come up against considerable obstruction, linked to political instability and to resistance on the part of those who benefit financially from the present system. At the same time, the lack of reforms designed to adapt the system to the new realities, and the absence of a clear distribution between the private and public sectors, also foster the development of corruption.

The Serbian State, therefore, is mainly guilty of failing to act. The mission's main finding was that the State fails to fulfil its obligation to implement the right to health, by failing to take the measures required to guarantee the realisation of that right.

Recommendations

To the Serbian government and the Ministry of Health

- To ratify speedily the revised European Social Charter signed by Serbia-Montenegro on 22 March 2005, along with the 1995 protocol providing for a system of collective complaints, allowing referral to the Committee of Social Rights of alleged violations of the Charter;
- To combat the whole range of discriminatory mechanisms: priority health aid should be given to the categories of persons subjected to discrimination under the present system. 2005 will be the year dedicated by the UN to the situation of the Roma. Programmes should be launched in Serbia to improve their access to health care, particularly for the displaced Kosovo Roma. All administrative barriers to health care and lodging for refugees and displaced persons should be dismantled rapidly.
- To alter the balance of recruitment of doctors in favour of the minorities;

- To ensure that in case of violations of the right to health, or of other human rights in connexion with health care, responsibilities are established and that effective remedies are provided to victims. In that respect the role, prerogatives and means of the ombudsmen must be strengthened, and their action must be co-ordinated with the patients NGOs;
- To strengthen the primary level of the health care system, and give it priority in allocating means. The government must adopt a policy for increasing the number of general practitioners, and for retraining specialists;
- To introduce an effective prevention policy, in conjunction with the primary and secondary levels of education;
- To set up a clear system of monitoring and regulation of the private health sector;
- To facilitate access to budgetary data and information at all levels of the health care institution;
- To promote a policy for treating persons suffering from post-conflict trauma, especially for people who were drafted into the army. The consequences of 10 years' war are not sufficiently taken into consideration in Serbia today. A network of mental health centres should be set up for patients with psychological problems.
- To develop a campaign for fighting violence against women. This recommendation should be linked to the preceding one.
- To refrain from closing down "collective" centres without explicit agreement on the part of the refugees and displaced persons who live there. Permanent, quality housing solutions must be found, respecting the wishes of the residents of these "collective" centres. In the event of the residents of the "centres" not wishing to leave, it is nevertheless absolutely necessary to improve living conditions there.
- To reinforce rapidly policies for fighting HIV and to facilitate access to the treatment of HIV/AIDS;
- To adapt the health care infrastructure for receiving handicapped persons. One of the requests of the associations is that handicapped and non-handicapped persons should be treated in the same institutions.
- Regarding the fight against corruption, to increase the salaries of the doctors, while controlling expenditure more effectively. The government of Serbia should adopt a national strategy for fighting corruption, in accordance with the UN Convention against corruption, which was ratified in December 2004. The government should see to it that users of the health system are not expected to make illicit payments.
- To strengthen regional co-operation (among countries of former Yugoslavia and the CEECs) on the basis of the freedom of circulation of patients and horizontal institutional agreements (directly between hospitals, for instance).

To the international community:

- To put an end to the forced return of former Yugoslavia refugees, which contributes to the deterioration of the situation of refugees and displaced persons already in Serbia;
- To strengthen co-operation in health matters, in particular between doctors' NGOs in the

European Union and in Serbia.

- To reinforce training (or retraining) for general practitioners in the framework of the CARDS or USAID programmes.
- To give active financial support to an observatory of infectious diseases and HIV in Serbia.
- To develop a co-operation policy for the reception in the EU of patients from Serbia.