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EUROPEAN SOCIAL CHARTER

2nd National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF MONTENEGRO

(Articles 1, 11, 12, 13, 14 and 23 for the period of 01/01/2008 – 31/12/2011)

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CYCLE 2013

Montenegro

Government of the Republic of Montenegro
Ministry of Labour and Social Welfare

REVISED EUROPEAN SOCIAL CHARTER

SECOND NATIONAL REPORT ON THE IMPLEMENTATION OF REVISED EUROPEAN SOCIAL CHARTER

For the period 01/05/2010 – 31/12/2011

(Report for Group II – Health, social security and social protection, on Articles 3, 11, 12, 13, 14 i 23)

November 2012

Article 3 – The right to safe and healthy working conditions

Paragraph 1, paragraph 2, paragraph 3

1) By the end of year 2009, the Government of Montenegro adopted the NATIONAL STRATEGY FOR THE IMPROVEMENT OF OCCUPATIONAL HEALTH AND SAFETY AT WORK IN MONTENEGRO for the period 2010 – 2014, along with the Action Plan of its implementation. The procedure of consultation with the representative organizations of employers and employees was carried out prior to the adoption of the Strategy. The reform of the health care system of employees is planned as apart of the implementation of the Strategy for the improvement of occupational health and safety at work in Montenegro for the period 2010 – 2014, and shall be performed through a new model of organisation and service of occupational medicine, which among other things at the national level, provides for the establishment of the Institute of Occupational Medicine.
2) The implementation of the Project IPA 2009 started in early May 2012: Project "Harmonisation and implementation of regulations in the field of labor inspection oversight and occupational safety with the EU acquis", as part of which a Twinning agreement with Slovenia, as a chosen EU partner, is to be realised within 18 months, providing for harmonization and implementation of regulations in the field of occupational safety with the EU acquis.

Article 3, paragraph 4

As apart of the implementation of the National Strategy for the improvement of occupational health and safety at work in Montenegro for the period 2010 – 2014, the reform of the health care system of employees is planned and shall be performed through a new model of organisation and service of occupational medicine, which among other things at the national level, provides for the establishment of the Institute of Occupational Medicine.

The health care system in Montenegro is organized as a single unit health region and is predominantly based on the public sector. Public health institutions are organized through a network of primary, secondary and tertiary health care, consisting of: 18 health centers, 7 general hospitals, 3 special hospitals, Clinical Centre of Montenegro, Public Health Institute, Emergency medicine Institute and Pharmacy Institution of Montenegro.

In primary health care, health centers are the organizational form of health care provision through the concept of chosen doctors and support centers. Provision of specific health care has also been organised at the primary health care level.

The application of occupational medicine system in Montenegro dates back to the 1950s of the last century, and since then, it has been an integral part of the general public health care system. It is important to note that occupational medicine, at its early

stage of development, was institutionalized and recognized as an organizational unit of the Institute of Medicine Titograd, within the Health Centre.

Specific activities within occupational medicine were carried out through the organizational form of outpatient centers and occupational health services, within the public health facilities such as health centers. Also, specific health care was provided in dispensaries organised within larger entities.

The concept of occupational medicine which has been practiced in Montenegro for decades, was predominantly focused on persons employed in workplaces with special working conditions or at higher risk. In addition, this concept has mostly been focused on treatment and pathology, while the preventive aspect was considerably neglected. The process of political, economic and social changes initiated in the early 1990s resulted in the stagnation of economic activity in Montenegro, which had a negative impact on the working conditions, working environment, the quality of occupational health and safety, as well as on the working ability of employees.

Adopting the Strategy for Development of Health Care System in Montenegro until the year 2020, the Montenegrin Government has undertaken the first efforts in order to improve the healthcare system, highlighting the reform of primary healthcare as its priority. The reformed model of organising the primary health care has not recognized occupational medicine as an organizational segment, which resulted in its existence within an organizational vacuum, as well as in the lack of functionality of the occupational healthcare system in Montenegro.

Currently, the healthcare of the employees has been performed through the Occupational Health Center, which is located within the PHI Health Center Podgorica, with 6 occupational medicine specialists. Services provided by the Center are supported by a multidisciplinary team. The other six services of occupational medicine also operate within health centers and have one full-time specialist in occupational medicine and deal with specific health care.

The public health care system in Montenegro employs a total of 42 occupational health specialists, out of which a large number (30) have been engaged as selected doctors for adults. The remaining five occupational medicine specialists are not engaged in the specific health care, but in other institutions (Pension and disability insurance Fund, Health Fund, pharmaceutical companies, private practices of various profiles, the Ministry of Health).

Specific health care services provided by occupational medicine specialists are mostly preventive and include preventive check-ups: preliminary and periodical examinations for jobs with special conditions or at risk. Risk assessment in the workplace, work environment evaluation, as well as the estimation of ability to work in such working conditions are rarely conducted. Occupational health professionals are authorized to do check-ups for the purpose of issuing medical certificates for employment, for drivers, for possession and carrying firearms, for expert testifying at the request of the court, and others. With the introduction of the reform Model of the PHC organisation, the services of curative character (assessment of temporary working

disability, the treatment of occupational and work-related diseases, the proceedings and reporting occupational injuries, sending to DC) are provided by chosen doctors who have been partly educated in this field within the Programme of additional education for teams of selected physicians.

There are a number of circumstances that have been identified as aggravating factors in the improvement of the organization and provision of quality services within occupational medicine:

- lack of adequate connectivity in terms of horizontal and vertical communication among service providers in occupational medicine,
- lack of multidisciplinary collaboration between key partners in the implementation of activities on health protection of employees and safety at work, particularly among occupational medicine specialists, experts in safety at work, occupational safety inspectors, employers, trade unions,
- lack of a referential national institution that would play a leading role in research activities and projects, in providing education and professional training to strengthen national capacities, in generating relevant data and performing advisory role in the field of occupational medicine, as well as in coordinating overall activities in the field of occupational health and safety promotion, including the quality management system,
- lack of an adequate system of control over the implementation of the existing legislation regarding occupational health and safety, particularly with employers in small and medium-sized enterprises, the informal sector and with the self-employed,
- underdeveloped information system in the part concerning the services of occupational medicine,
- lack of an adequate funding model of occupational health services,
- lack of, and / or incomplete compliance of by-laws necessary for the full implementation of the requirements defined in the relevant EU directives.

System of specific health care is financed through health insurance contributions and reimbursements paid by specific healthcare protection beneficiaries (persons and entities).

3) Funds for providing protective measures and occupational health, as well as for the treatment of occupational injuries and illnesses, are provided from: Pension and Disability Insurance Fund of Montenegro, Health Insurance Fund of Montenegro and employers. From the employers' standpoint, such costs can be evaluated by the following items: internal costs, external costs (payment of contributions to cover the cost transferred to wider solidarity into health and disability insurance) and lost income due to premature disability or death, which could be assessed in terms of employer and the national aspect. There are no available statistical data on internal costs of employers and therefore the estimates are approximate. On the basis of the insight into a small

sample (in drafting legislation on risk assessment), rated internal expenses of Montenegrin employers in 2008 amounted to 0.4% of GDP.

Employers' expenses in 2008 for salaries during the inability to perform work up to 30 days due to treatment of occupational injuries and illnesses, were estimated based on the number of lost workdays, and the average compensation in the amount provided by the Health Insurance Fund of Montenegro for the same period. Expenditures for reimbursements of salaries paid by the employer for the year 2008 were estimated at a total amount of million € 2.1 or 0.07% of GDP. Thus, all the estimated internal expenditures of employers in Montenegro related to occupational safety and health in 2008, expressed in proportion to GDP, amounted to 0.47%.

Expenditures of the Health Insurance Fund of Montenegro for medical treatment services of occupational injuries and diseases in 2008 were estimated at million € 1.5 or 0.05% of GDP. In the same period, according to the method of valuation of human capital, around million € 3 or 0.1% of GDP were lost due to premature disability and death in Montenegro.

Pension and Disability Insurance Fund of Montenegro does not separately record expenditures for the rights directly related to injuries at workplace and occupational diseases. Therefore, these expenses were estimated on the ground of data on the number of persons who were entitled to a disability pension due to injuries at work and occupational diseases (about 20% of disability pensions) and an average amount of disability pension of €210 per month. Thereof, expenses of the Pension and disability Insurance Fund in 2008, amount related to other rights excluded, were estimated at million € 12.8, representing 0.4% of GDP. Expenditures which should be added to above mentioned amount are those for occupational injuries and occupational diseases in the large area of grey economy not included in the above figures, with groups at the highest risk, and the corresponding external employers' costs in the form of contributions paid for wider solidarity in health and disability insurance out of which those expenses are financed.

. It is estimated that in the next medium term, expenses for occupational safety and health will amount to 2.3 - 2.5% of GDP.

Article 11 – The right to health protection

With a view to ensuring the effective exercise of the right to health protection, the Parties are obliged, either directly or in co-operation with public or private organisations, to take appropriate measures designed inter alia:

1 to remove as much as possible the causes of ill-health;

2 to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;

3 to prevent as much as possible epidemic, endemic and other diseases, as well as accidents.

Information to be Provided
Article 11, paragraph 1

1) Please describe the general legal framework. Specify the nature, reasons in favour of reforms, as well as extent of reforms, if any

Article 11, paragraph 2

1) Please describe the general legal framework. Specify the nature, reasons in favour of reforms, as well as extent of reforms, if any
2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.
3) Provide relevant statistical data and other relevant information, including related services / counseling services and screening (mandatory periodic inspections) in schools and for the rest of the population.

Article 11, paragraph 3

1) Please describe the general legal framework. Specify the nature, reasons in favour of reforms, as well as extent of reforms, if any
2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.
3) Provide relevant statistical data and other relevant information on the percentage of smokers in the population in general, trends in alcohol consumption and rates of vaccination coverage against contagious and epidemic diseases.

Subject of provisions as interpreted by the European Committee of Social Rights

Paragraph 1: According to paragraph 11, health represents physical and mental well-being, as defined by the Statute of Health of the World Health Organization (WHO), adopted by all Parties. The health system must respond appropriately to avoidable health risks, i.e. those that can be controlled by human action. Such a health care system must be available to all without distinction. Medical treatment expenses (health care expenses) shall be borne, at least in part, by the community as a whole. There shall not be delays in providing health care. Availability of treatment, therapy, health care should be based on clear (transparent) criteria. Healthcare system must have a sufficient number of appropriately qualified staff as well as facilities, amenities ie. capacity. Conditions in hospitals shall be satisfying thus respecting human dignity.

Paragraph 2: Measures for preventing acts, actions and activities that are harmful to human health should be introduced, such as smoking, alcohol and drugs, and a sense of personal responsibility should be developed , including aspects such as dieting for healthy lifestyle, sexual education and the environmental issues. Health education should be taught in schools during the entire schooling period. Screening should be introduced for diseases resulting in high rate of premature death.

Paragraph 3: The authorities shall create a sufficiently advanced and detailed legislation framework and specific preventive measures against the air and water pollution, noise, nuclear risks, asbestos, food safety and for the Parties which have not adopted Article 31, public health standards in housing. Also, policies for prevention of smoking, alcoholism and drug addiction shall be established, as well as widespread vaccination programs and measures against contagious diseases. Finally, there should be measures for preventing car accidents, home and leisure time injuries, as well as occupational injuries, except for those injuries that are the subject of Article 3.

1.Primary legislation

Answer

- Law on Health Care,
- Law on Health Insurance
- Law on Medical Devices
- Law on Blood Provision,
- Law on Emergency Medical Services,
- Law on Protection of Mentally Ill Persons' Rights,
- Law on Data Records in Healthcare;
- The Law on Health Inspection;
- Law on Protection of Population against Infectious Disease;
- Law on Restriction of Usage of Tobacco Products;
- Law on Medicines;
- Law on Medical Devices;
- Law on Health Inspection;
- Law on Sanitary Inspection;
- Law on conditions and procedures for termination of pregnancy;
- Law on Treatment of Infertility with Assisted Reproductive Technologies;
- Law on Health Care;
- Law on Patients' Rights;
- Law on Genetic Information Protection;
- Law on Collecting and Using Human Biological Samples;
- The Law on Removal and Transplantation of Human Body Parts for Therapeutic Purposes;
- Law on Prevention of Drug Abuse;
- Law on Control of Manufacturing and Illicit Trafficking in Narcotic Drugs and Psychotropic Substances

- Law on Protection of Mentally Ill Persons' Rights.

Adopting the Strategy for Health has launched the reform of the health system in order to overcome the serious structural problems in its functioning, i.e. to bring health care system in the state of optimal functioning, so that maximum positive impact on the health status of the population would be achieved within the available resources.
The objectives of the reform are:

- to improve the quality, efficiency and accessibility of health care;
- to improve the financial sustainability of healthcare system;
- strengthening institutional/administrative capacities;
- development and maintenance of information systems, as indispensable tools in planning, managing and evaluating the effects and results of health policy measures;
- improving the organization and quality of service for the elderly and other vulnerable groups.

When designing reform, it was determined that the starting point would be in the reorganization of primary health care, as a support of any health care system. The first steps have been taken under the Project on the improvement of health care system in Montenegro, which is funded by the World Bank, as a strategic partner of the Government of Montenegro. The project started in September 2004.
In order to implement the reforms, and as a result of concentrated and carefully directed and coordinated efforts, a set of legal, organizational and technical prerequisites for the full implementation of the reforms was provided. A new legal framework was established in the form of a set of reform legislation, as a necessary condition for improving health care and stable functioning of the entire healthcare system:

Law on Healthcare, Law on Health Insurance, Law on Medical Devices, Law on Medicines, Law on Blood Provision, Law on Emergency Medical Services, Law on Protection of Mentally Ill Persons' Rights, Law on Data Records in Healthcare and Law on Health Inspection; Law on Protection of Population against Infectious Disease; Law on Restriction of Usage of Tobacco Products; Law on Medicines; Law on Medical Devices; Law on Health Inspection; Law on Sanitary Inspection; Law on Conditions and Procedures for Termination of Pregnancy; Law on Treatment of Infertility with Assisted Reproductive Technologies; Law on Health Care; Law on Patients' Rights; Law on Genetic Information Protection; Law on Collecting and Using Human Biological Samples; The Law on Transplantation of Human Body Parts for Therapeutic Purposes; Law on Prevention of Drug Abuse; Law on Control of Manufacturing and Illicit Trafficking in Narcotic Drugs and Psychotropic Substances; Law on Protection of Mentally Ill Persons' Rights.

These laws define the general principles of the health care system and health care organizations in order to improve efficiency and quality, according to the principles of democratic government. Numerous by-laws have been adopted creating conditions for full implementation of the reform laws, in order to provide equal rights to health care, optimal working conditions and adequate quality control system of health care.

By the reform of primary health care, a citizen and his needs have been placed in the center of the whole system of primary health care. As part of the Project on the improvement of health care system in Montenegro (MHSIP), funded by the World Bank, the following activities in the field of health system reform at primary level have successfully been implemented:

- Health center is set as the basic unit of primary health care (PHC) and its organisation has been transformed into teams of selected doctors and support centers;
- Material and spatial conditions have been ensured and harmonised for the provision of primary health care in the entire territory of Montenegro;
- The Basic package of health services for primary care has been defined;
- In order to create the conditions for an efficient, safe, affordable and cost-effective dental health care, structural changes have been made in the dental health service. Dental care is provided by a dentist selected by a citizen, under the contract with the National Health Insurance Fund, within a mandatory service package. After privatization RFHI contracted with 120 selected teams of dentists and 15 dental technicians.
- Primary health care (PHC) payment model has been transformed (based on 50% capitation and 50% services);
- Reorganization of personnel in primary health care has been completed (dentists have been privatized, the number of non-medical staff has been reduced to a minimum and redundancy in medical staff has been solved through social programs);
- Consolidation of the private and public primary health care has been carried out;
- An additional training of selected teams of doctors has been completed by 198 teams of chosen doctors (consisting of a doctor and a nurse / technician) by December 2010;

In this way, all segments of the reformed PHC throughout Montenegro have been assembled into a functional mosaic, and in order to make those reform efforts meaningful and fully effective regarding the overall health care system, it is essential to transfer the reform into the secondary and tertiary level .

New health strategy and health policy development is based on the recommendations of the World Health Organization, which proclaime that the main social goal is achieving a level of health for all its citizens to live a socially and economically productive life.

Rights in the field of health care have been determined by the Law on Health Care. This law has established the institutional conditions for health care reform, especially the reform of primary health care, in order to increase the efficiency and quality of health care.

The basic concept of the law has been defined on the basis of health policy and health development vision through:

- construction of a system of public health with a focus on promoting, improving and maintaining the citizens' health and intersectoral approaches to solving the health issues of the citizens, as well as the basis for sustainable economic and social development of the country;
- provision of healthcare to the entire population as the basis for achieving an acceptable level of health;
- increasing the availability and accessibility of health care of the population through the implementation of the system of selected team or a doctors in primary health care, which will monitor the health status of the citizens who elected him and solve most of their health isues;
- reorganization and training at secondary and tertiary levels of care in order to coordinate effectively all areas of the system, and in particular to support the development and implementation of goals in primary health care;
- systematic identification of health problems, more effective measures to address those issues and development of specific strategies for improving health and health status of vulnerable categories: mothers, children, elderly and disabled people.

The solutions provided by this law allow reform and the organization of thealth system on the basis of primary health care. Strengthening primary health care will ensure solving health problems at the primary level, by implementing the institute of selected team of doctors and by undertaking activities related to rising public health awareness, change attitudes towards health, promoting healthy lifestyles and strengthening accountability for their own health, along with defining national health priorities and programs. Health care professionals who deliver primary health care have been continuously trained to comprehensively deal with health problems and the provision of health care, health care rules and the creation of public trust.

Thus, this law has created conditions for the preservation and improvement of citizens' health, public health improvement, health-related quality of life, ensuring access to health care on equal terms to all citizens, with a special focus on health and socially vulnerable categories of the population, sustainability of the health system, improving efficiency and quality of health services along with defining special programs in the area of human resources, technology and medical supplies, as well as better functional association of health system institutions, harmonization of private and public sector, and the overall performance of health care services in accordance with national and international standards.Functioning of the health system is based on the principles of

universality, accessibility, affordability and continuity in the provision of health care, especially at the primary level.

Health activities are performed at the primary, secondary and tertiary levels, with the primary health care level at the first level, as the base of the health care. Primary health care is an integral part of the health system and presents the key point of the health care system.

Selected doctor or a team of doctors in primary care enable the first level of individual contact with the health system, providing health care to citizens as close to where they live and work as possible, and presents a "copy model" of the health system.

Primary health care is the center around which the health system shall organize other levels of health care, secondary and tertiary, which should provide primary health care to all citizens on an on-going basis.

Specialized health care facilities at secondary and tertiary level shall give support to the selected team, to thereby enable citizens to get this kind of specialist care in their place of residence.

Priority measures of health care, available to all citizens, and related to activities on health promotion, prevention, early detection of disease and disability, early treatment and rehabilitation of the sick and disabled, clearly point out the way and means of organizing the health system in order to maintain and improve the health status of the population.

This primarily relates to the prevention orientation and training for the effective provision of healthcare to the entire population with special emphasis on health care of the most vulnerable population groups (maternal and child health care, health care of the socially disadvantaged groups of population, protection of the elderly and infirm, etc..).

Provisions of this Law also stipulate specific health care of employees and prescribe the set of measures borne by the employer on the basis of contract which an employer concludes with the medical institution that performs this type of care.

Law on Health Insurance has introduced the scope of established standards of citizens' health care, which enumerate medical measures and health services financed by mandatory health insurance.

The scope of established standards of health care is known as the "Service Pack" and can be found within legislation of the neighbouring countries.

Mandatory health insurance, as part of the social security system of citizens, is based on the principles of obligation, reciprocity and solidarity of all the citizens of Montenegro, as well as others at the expense of the Health Insurance Fund.

In order to protect the most sensitive part of the population from predicted charges paid by health care beneficiaries, children, pregnant women, the persons over the age of 65, the handicapped and other vunlerabilne groups are not subject to cost of health care (so called participation).

This law prescribes the supplementary health insurance as a particular form of health insurance that covers the cost of health care on voluntary basis, up to the full amount of those expenses under the mandatory health insurance.

In addition to the above laws which determine the scope of exercising health care rights and standards, this Ministry proposes the following laws relating to health care:

The Law on Protection of Mentally Ill Persons' Rights, which ensures mentally ill individuals the exercise of rights and freedom in accordance with international documents and general rules of international law.

Ministry of Health is health policy holder, and a leading institution in the field of public health in Montenegro is the Institute of Public Health, whose establishment and activities have been regulated by the Law on Health Care.

The constitutional basis for the Law on Health Care is contained in the provisions of Article 69 of the Constitution of Montenegro, which provides that everyone has the right to health care. A child, a pregnant woman, an elderly person and a person with disability have the right to health care from public funds, if they are not covered by another insurance.

Along with the citizen in the center of the health care system, strengthening management, process development and detailed use of information and communication technologies are the most important drivers of transition structurally established on process-based health care. In the process of treating the patient, the principle of integrated and interdisciplinary care, from birth to death, included palliative care shall be followed. Insisting on the organizational and functional connectivity will enable a better response in the process of changing expectations and demands of the citizens in relation to primary health requirements in realistic expectations, in line with national priorities. (Pre) conditions for more efficient and higher quality work and motivation of health workers shall be prepared for better patient's satisfaction.

The demographic structure of the population, i.e. its age structure, determines the epidemiology of population, their diseases and needs. The aging of population and the increase in chronic diseases directly affect the quality of life and increase health care costs, as emphasized by the WHO and the EU. However, it is not always justified and necessary to increase the costs with age, a lot depends on the state of health and the need for services. It is not only the age factor which increases the cost of health care, but also the proximity of death (i.e. number of years in poor health before death). New researches show that in countries with high income elderly people remain healthy.

The need for prevention, screening programs, a permanent cure, control of chronic diseases and the use of relevant technologies will certainly increase health care costs, but timely beginning of these activities will reduce overall costs in the future. It is assumed that the most important causes of health care costs are not so much related to aging, but also to economic growth (rich countries spend more on health), the scope and quality of services and technological innovations related to medical equipment and medicines. However, depending on the state of health, older people have a greater

need for health services. It is therefore necessary to focus the approach to the patient in the local communities and at the primary level, where the efficient organization of various services allows greater access. .

1) **Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.**

Answer :

The basic principles of health care development in Montenegro are formulated in the following national and international documents:

- The Constitution of Montenegro,
- The Healthcare Policy Objectives in Montenegro until the year 2020 (2000)
- Strategy for Health Care Development in Montenegro (2003)
- Master Plan for Health Care Development in Montenegro for 2005 - 2010,
- Law on Health Care and Health Insurance Law (2004)
- The Evaluation of Health Care Programs in Montenegro for 2008:
- Reproductive Health Strategy,
- Mental Health Strategy,
- The International Conference on Primary Health Care, Alma Ata (1978.)
- Ljubljana Charter on the reform of health systems, the WHO (1996.)
- WHO Declaration on World Population Health (1999.)
- WHO European Strategy "Regional Health - 21 objectives for 21 Century "(1999.)
- The Tallinn Charter (2008).
- Strategy for Health Care Development;
- Strategy to improve mental health;
- Strategy for HIV / AIDS;
- Strategy for Prevention of Smoking;
- Strategy for Safe Blood;
- The strategy of Preserving and Improving Reproductive Health;
- Strategy for Food Safety;
- The Strategy for Prevention and Control of chronic non-communicable diseases;
- The Strategy for Hospital Sector Optimization;
- National Program for the Prevention of Violence;
- Action Plan to Combat Corruption in Healthcare;

- Action Plan on the Impact of the Environment to Children's Health;
- Action Plan for the Promotion of Mental Health in Montenegro 2011-2014,
- National program for Early Detection of Colorectal Cancer;
- National program for Early Detection of Cervical Cancer.

In the spirit of global goals set by these documents, Montenegro joined in a unique international health care development process, through the implementation of health policies, starting with the achieved level of population health care, health care needs and financial resources for their implementation, up to the realization of set objectives, the optimal preservation and promotion of health of all the citizens and the overall population.

After the activities undertaken within the reform of the primary health care and establishing the concept of selected doctor in the entire territory of Montenegro, by support centers development, this document defines the continuation of activities aimed at health promotion and disease prevention, and emphasizes rehabilitation and as soon as possible, reconnection of the recovered patient into his/her working environment, family and the wider society. Citizens and their needs remain a priority, but the citizens shall know their rights, duties and responsibilities and become partners with their doctos and other medical workers. Health becomes an integral part of all policies: tax, labor policy, social policy, traffic safety, environment, agriculture and food production, education and sport, which means that in all those areas we shall do as much as possible for health, as our most valuable treasure.

Changing unhealthy lifestyle and habits can and must improve the quality of people's lives, extend life expectancy in health and reduce health care costs. Protection, reduction of negative stress, avoiding psychoactive substances (drugs, alcohol, cigarettes), a balanced diet, regular physical activity and hygiene are fundamental areas related to health, which every modern country should strongly support.

Long-term development of health care shall be based on existing values and strategies of the health system in Montenegro, with respect to EU strategy and the fundamental laws, taking into account the specifics of the health care in Montenegro. The entire health care system, starting with the public health, primary health care, and later the secondary and tertiary levels, should be adapted to population changes. All plans and health policies should be adapted to the patient and his/her needs. The patient is at the center, as the purpose of health care system functioning. Therefore, the activities for the division of labor between the different levels are proposed, with strict monitoring and encouraging the transfer of best practices based on evidence-based medicine (EBM), with respect to clinical guidelines and clinical methods.

The introduction of telemedicine, telepharmacology and other information systems will enable health care professionals to specialize as consultants and accessibility to information and data to citizens, which shall further improve the quality,

safety and scope of health care services. Waiting time shall be shorten with the organizational changes in working plans and with the help of information technology, scheduling within a specific time unit, constant monitoring and upgrading the national waiting list, as well as imaging and diagnostic data on the web pages.

Structural changes in dental care practice have been followed by monitoring and the introduction of innovations for its future improvement resulting in better oral health of the population, with particular emphasis on prevention in children and adolescents, with constant supervision and monitoring data, in order to plan the necessary steps to improve this segment of health care.

In comparison with the international data, the healthcare system in Montenegro is encountering with fewer health professionals, especially doctors[1]. s. It should also be noted that the needs for health workers are relative. These needs shall be based on the needs of the health care system, by monitoring the productivity, efficiency and quality, not just on the standards.

. An indispensable part of the process of health care improvement is to upgrade the management knowledge and skills in leadership of health facilities and to increase limited opportunities of decision-making for the management of health institutions. Management and leadership in health care shall become the focus of HR development, leadership and management of public health institutions and coordinated activities of all the bodies included in the health care system network. In addition, it is necessary to clearly determine relations and rules between all the operating participants within the network of health facilities.

Professional behaviour and culture of health care employees should follow the direction of improving the relationship and responsibility to the patients, knowledge of the need for quality work and efficient management of human, financial and technical resources. Therefore, it is necessary to inform the public about the flaws, without penalty, and to allow patients to have an overview of the organization of work, as well as the insight into documentation at all levels. Good relationships, respect for differences and interdisciplinarity of teams are the fundamental conditions for quality work, which is of particular importance with the emergence of new technologies

Good relationships and communication with the public, informing the public in a pleasant and user-friendly way, will enhance confidence in the health system for all population groups, especially those at risk, and strengthen citizens' personal responsibility for their own health and the health of others.

Traditional treatment under supervision is an additional opportunity for the patient, if decided.

The holder of the mandatory health insurance (MHI) - Health Insurance Fund (HIF) shall follow the current Strategic Development Plan on Health Insurance in Montenegro until the year 2011, upgrade their own administrative management, reduce costs and realistically evaluate models of services' payments. These models shall encourage efficiency and quality improvement, along with focusing on the outcome of

the treatment. The introduction of additional opportunities in the voluntary health insurance (VHI), a public-private partnership shall increase the financial sustainability of the health system and access to services and rapid development without reduction of solidarity and equity of the healthcare system.

Reorganization on the principle of rationality in the secondary level is a platform for more efficient and higher quality health care. Tertiary health care, emergency medical care, the area of epidemiology and disease control, shall remain in charge of the state. The state shall make further efforts to improve these institutions in the field of organization and human resources to enable them to meet national and international requirements, especialy in the field of public health and contagious diseases control, as well as and the most important non-communicable diseases.

Chambers and authorities in the healthcare will adjust to the division of professional competence and funding, and take over the role of introducing a system of total quality and safety. Representatives of associations and other social partners remain equal partners in arrangements regarding labor and salaries policy, a civil initiative is an essential factor in planning process.

Documents in this field:

- Regulation on the Scope and Standards of Health Care within Mandatory Health Insurance;
- The Program of Mandatory Immunization against Certain Infectious diseases in Montenegro in 2011;
- The Rulebook on detailed conditions regarding standards, norms and ways of exercising primary care through a selected team of doctors or a selected doctor;
- Regulation on detailed conditions, duration, mode of implementation of apprenticeship, professional examination, practice curriculum and training for trainees - health-workers and associates with high education;
- Rules on working time arrangements in health care facilities;
- Regulation on detailed conditions of space, staff and equipment to be met by units and subunits for emergency medical treatment, manner of operating and number of emergency medical treatment teams;
- Regulation on detailed conditions for the issuance of marketing authorization;
- Rulebook on the contents and documentation to be attached to the application for the approval of facilities for plant origin food production and sale after primary production, combined food and other food;

- Rulebook on the detailed content of pharmaceutical examination of medicines;
- Rulebook on the form, content, methods of keeping records and the procedure of
- registration in the register of approved facilities;

- Rulebook on detailed content of pharmacologic-toxicological testing of medicines;

- Rulebook on permitted amounts of heavy metals, mycotoxins and other substances in food;

- Rulebook on the terms and conditions of implementation of mandatory immunoprophylaxis and haemoprophylaxis against certain infectious diseases;

- Rulebook on operation , composition and authority of the second level doctor commission;

- Rulebook on the implementation of health care of asylum seekers, persons who are recognized as refugees, persons who have been granted subsidiary protection and persons who have been granted temporary protection;

- Rulebook on detailed terms and conditions for performance of health care in hospitals and health resort;

- Rulebook on detailed conditions for performance of additional work of health workers in the network of health care institutions;
- Rulebook on Marking, Labeling, Advertising and Presentation of food of plant origin after primary production, combined and other foods;
- Rulebook on the Criteria for contracting on provision and payment of health care services;
- Rulebook on the manner of establishing ability of air traffic controllers;
- Rulebook on the manner of establishing ability of flight personnel in civil aviation;
- Rulebook amending Regulations on detailed conditions, duration, mode of implementation of apprenticeship, professional examination, practice curriculum and training for trainees - health-workers and associates with higher education;
- Rulebook on procedure of issuing and contents of approval for taking the human body parts from deceased donors and manner of issuer identification;

- Rulebook on procedure of issuing and contents of approval for taking the human body parts from living donors;

- Rulebook on specific health data records containing registers of diseases of major socio-medical importance, contagious diseases and other conditions related to public health;

- Rulebook on creating and submitting reports on the established disease or condition for which registers are kept;
- Rulebook on manner of filling, submission deadlines and application forms on the established disease for which the register is kept;
- Rulebook on detailed content, gorm and manner of keeping registers of diseases of major socio-medical importance, contagious diseases and other conditions related to public health;
- Regulations on the visual presentation of warnings on the package of tobacco products *;

Health Master Plan of Montenegro 2005 - 2010 is a basic document which sets forth development policy framework of the health system in Montenegro for the said period, in which the significant activities on reforming the health system were implemented , particularly of primary health care level. MP continues to direct the development of the health system, starting from the guidelines in this document, as well as the EU Health Strategy "Together for Health": a strategic EU approach for the period 2008–2013[2] and WHO guidelines[3].

The MP particularly emphasises the reforms in the secondary and tertiary leve of the health care system, to fully implement the core values which the socially oriented society such as Montenegro relies on.

WHO Framework Strategy "Health for All" sets the core values for preparation of public health policy. Among the values, equality comes first, meaning that everyone has equal access to optimal health. This value, related to health, requires policy makers to prioritize tasks. Health policies based on the principle of equality, allow equal access to the health services for the population, and give special attention to the poor and other vulnerable and marginal population groups. Framework Strategy Health for All, as an important identifier of values, also determines solidarity, which implies that any particular individual can make his/her own contribution to the health system according to his/her ability and everyone receives service according to his/her need. Solidarity is a way of achieving equality, as it helps to balance the impact of various health determinants (determinants) as well as access to health services. Equality and solidarity are directly related to the third value, participation. The active participation of individuals and various organizations in the health system significantly improves the quality of decision-making.

. Amended framework strategy "Health for All"[4] as of 2005, further underlines the specific direction in order to achieve the best health of the individual and reduce disparities in health. While an active role of each individual is required for health improvement, coordinated multi-sectoral and cross-sectoral approaches that influence

[2] source: http://register.consilium.europa.eu/pdf/sl/07/st14/ st14689.sl07.pdf
[3] source: Framework Strategy WHO »Health for All«, http://whqlibdoc.who.int/publications/9241800038.pdf
[4] source http://www.euro.who.int/ document/e87861.pdf

health determinants (determinants) are the basic prerequisites for better health. Everyone is responsible for the consequences of his/her actions on health.
Health is a priority for the definition and implementation of all EU health policies and activities.

The Founding Treaty (the Treaty establishing the European Community[5]) in Article 152 prescribes that high level of health and health care shall be provided within the definition and implementation of all the EU policies and activities.

Member States should actively participate in this area, regarding the implementation of measures for promotion, coordination and complementarity of national measures for the protection and improvement of human health, reducing harm associated with drug addiction, alcohol abuse and in particular the fight against tobacco, controling a number of diseases and cross-border threat to health, promoting cross-border cooperation and exchange of good practice.

European health policy is facing significant development of common challenges, in particular measures to reduce disparities in health, to adapt to demographic changes, and reduce of chronic non-communicable diseases, for increased mobility of health professionals and patients, to manage cross-border and global health threats (risks), providing protection of patients, for the rapid development of medical technology and the necessity of maintaining long-term, sustainable socially-oriented quality health and social systems, which will contribute to economic development, and also respond properly to the growing expectations of conscientious citizens.

The approach which emphasizes the prevention is an integral part of the activities of each member state, in order to reduce the economic burden on national health systems, because the improvement of health and prevention will significantly contribute to reducing health care costs, and thus to the financial sustainability.

The EU strategy "Together for Health" was adopted by the end of year 2007: a strategic approach for the period 2008-2013, which confirmed the commitment of the member states to the respect of shared values and principles of health policy, providing opportunities to exercise the rights and responsibilities of citizens to care for their health throughout life period, reducing inequalities in health between social groups and regions, investment as a prerequisite for economic development and full integration of health policy at all levels, based on scientific achievements and proven methodology of impact assessment. Achieving key strategic objectives of the EU - good health in an aging society, the protection of citizens from health threats, sustainable and flexible health care system and the development of new technologies - primarily depends on cooperation between national policies and actions at the EU level.

Therefore the Government of Montenegro and the Ministry of Health (GMN and MH) shall set health a priority value and, as a major development task, prepare a set of measures to achieve optimal population health, reduce disparities in health between regions and population groups, improvement in healthy behaviors and prevention of

[5] source: http://eur-lex.europa.eu/LexUriServ/site/sl/oj/2006/ce321/ce32120061229sl00010331.pdf

early mortality, improve availability, security and quality of health care service, investment in human resources and modernization of health facilities.

2) **Provide all relevant or other information on major health indicators and departments / services and professions (for example WHO and the data used by Eurostat).**

Answer :

Evaluation of health care programs in Montenegro, reports and researches conducted in Montenegro in the last 10 years, as well as other reports, press releases, and publications of the MH, the Public Health Institute of Montenegro (hereinafter: PHI), the Bureau for Statistics (MONSTAT), the Ministry of Finance the Health Insurance Fund of Montenegro (hereinafter: HIF). When comparing the indicators with the European Union (hereinafter: EU) and European region data from World Health Organisation (hereinafter: WHO) database "Health for All" (for the year 2007 or the most recent available), were used.
According to the estimates for 2008, Montenegro had about 639,900 residents[6], while by the same survey data, the population amounted to 642,200 in 2009. According to the HIF datebase of the insured residents in December 2008, there were 641,407 insured registered, (insurance carriers and their family members and refugees)[7]. The main features of the demographic situation in Montenegro in the period 1991- 2007 were the tendency of the aging population and declining birth rate, fertility and population growth rate. The birth rate in 2007 amounted to 12.44 per 1,000 people, and the death rate was 9.51 per 1,000 people, which led to a positive population growth rate of 2.93 per 1,000 people[8]. Stabilization of birth rate and general mortality rate have been monitored since 2004. Period 1991 - 2007 was characterized by a declined infant mortality rate and the population growth rate (as a result of decrease in the birth rate and the increase in the mortality rate), while reducing the value of vital index from 2.42 to 1.31 (MONSTAT).

Percentage of elderly aged 65 or over (12.8%) in overall population in 2008 was less than average in the European Region (15.1%), while the percentage of young people under the age of 14 (19.7%) was above the average (17%)[9]. In 2007, the average life expectancy (life expectancy at birth) for men was 71.22 years and 76.06 years for women, which is about 6 years shorter than the average for the EU countries. According to population projections of the Statistical Office of Montenegro, continued decline in population is expected until 2022[10].

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[6] Source: Labour Force Survey, Statistical Office of Montenegro - MONSTAT Podgorica 2008.
[7] Source: Report on Operations HIF for mandatory health insurance, Podgorica 2009.
[8] Source: Statistical Yearbook 2007, Statistical Office of Montenegro – MONSTAT, Podgorica 2008.
[9] Source: Women and Men in Montenegro, Statistical Office of Montenegro – MONSTAT,Podgorica 2008.

[10] Source: Statistical Yearbook 2007, Statistical Office of Montenegro – MONSTAT, Podgorica 2008.

An important demographic indicator, and also an indicator of socio - economic conditions and the functioning of health services of a country is infant mortality rate up to one year of age. In Montenegro, the infant mortality rate was decreased from 11.14 per 1,000 live births (1991) to 7.4 per 1,000 live births (2007). However, the value of this ratio is still above the values recorded in EU countries (4.6 per 1,000 live births) and the Euro-group A[1] (3.9 per 1,000 live births).

Positive trends in a number of socio-economic indicators characterized the period after the year 2000 in Montenegro, such as growth of gross domestic product (hereinafter: GDP), relative monetary stability and increase in allocations on health spending. However, low GDP and high unemployment rate are a serious limiting factors for sustainable financing of health care.

Montenegrin GDP by capita in 2002 amounted to € 2,208.00, recording afterwards a continuous increase until 2009, when it was € 5893.44 by capita, according to estimates from the Statistical Office of Montenegro (MONSTAT). It still very low.

Average (real) salaries recorded an increase in each observed year during the period 2004 - 2007. Thus, in 2008 average real net salarier reached €338.00, and in the field of health and social welfare average real net salaries were even lower and reached €296.00.

The relatively low average salaries influenced the structure of personal households' consumption by purpose. According to the Survey on Household Cosumption in Montenegro, a high share of expenditure for food and non-alcoholic beverages, up to 33.2% was typical in 2007. Expenditures for housing, water and electricity amounted to 12%. Expenditure on health care accounted for 4% in household expenditure in 2007. Almost the entire income of the household was spent due to low earnings.

According to the Labour Force Survey, the unemployment rate registered in 2009 amounted to 12.8%, which corresponds with the official data of the Employment Agency of Montenegro, while the employment rate was 51.5%. This means that the number of unemployed at the end of June 2009 was 31,516, and the number of employees was 218,609[11]. The unemployment rate is declining - in 2007 it amounted to 19.4% , and in 2008 - 18.3%. However, the unemployment rate in Montenegro is still significantly higher than the EU average (7.2%) and than in the most of neighboring countries (Croatia 9.6%, Slovenia 7.7%, Bulgaria 6.9%).

In addition to the aging population, health was also affected by negative impact of socio-economic developments in the last decade of the 20th century. The health potential of the nation has been exhausted, and therefore in times of social and economic recovery,

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[1] Euro-Group (A Eur-A) is the most prestigious out of five groups of European countries WHO Member States that are classified according to the mortality rate of children under the age of 5 years and adult males aged 15 to 59 years, given that it consists of countries with the lowest rate of deaths of children and adults. The group (Euir-A) includes 27 countries: Andorra, Austria, Belgium, Croatia, Cyprus, The Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway , Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom

[11] Source: Employment Agency of Montenegro (WWW)

with all the difficulties brought about by the state and society in transition, negative health indicators can not be stopped immediately, and their desired improvements can not be expected quickly.

Chronic non-communicable diseases are the leading causes of disease, disability and premature death (before the age of 65) of Montenegrin residents. Ischemic heart disease, cerebrovascular disease, lung cancer, affective disorders (unipolar depression) and diabetes mellitus (diabetes) are chronic non-communicable diseases, which are responsible for almost two-thirds of the total disease burden[12].

Chronic non-communicable diseases made up nearly 80% of all deaths in 2007. In the structure of mortality, heart and blood vessels diseases accounted for more than half of all the deaths (55.8%), and one in six deceased (15.8%) was the victim of a malignant tumor. Of the total number of deceased, 3.9% of deaths were caused by injury and poisoning, while 2.9% were caused by respiratory diseases.

According to available health statistics data for 2006, the share of cardiovascular diseases comes first in the overall number of diseases for which people were treated in hospitals (16.7% of all cases of hospital discharge), while diseases of digestive system with 11, 5% take the second place as a cause of hospitalizations, and respiratory diseases 11.0%. As for outpatient health service in 2006, in the most cases it registered diseases of the respiratory system (47.2%), while cardiovascular diseases were in third place (6.2%), followed by diseases of the urinary genital system (6.8%).
Participation of malignant neoplasms in the number of persons treated in hospital was very high. Accounting for 8.7% of all hospital discharges, it is the fourth most common reason for hospitalization in 2006. As for the outpatient health service burden in 2006, malignant neoplasm with an incidence of 0.53% was at the very bottom of the list of reasons for outpatient health service visit.

Smoking, hypertension, hypercholesterolemia, obesity, unhealthy diets, physical inactivity, and alcohol and psychoactive substances abuse are the risk factors for many chronic diseases, whose occurrence usually has a multifactorial etiology.

In Montenegro, 32.7% of the adult population were smoking in 2008 (26.4% of daily smokers and 6.3% of occasional smokers), about 20% of the school population were daily smokers, as well as 4% of children aged 11 to 14 years. 40.8% of the adult population had hypertension or could potentially suffer from high blood pressure, 15.1% of adults were obese, 21.2% of children and adolescents between the age of 7 - 19 years were overweight, 9.2 % of people exercised every day, and 2.3% of people did physical exercises 4 - 6 times a week, while 22.2% of adults daily or occasionally drank alcohol[13].

The basic organizational structure of the health care system consists of a network of state health institutions and privately owned health facilities.

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[12] Source: The evaluation of health care programs in Montenegro 2008 Institute for public health, 2009
[13] Source: The evaluation of health care programs in Montenegro 2008 Institute for public health, 2009

The state of Montenegro is the founder of all health facilities which deliver health services public health institutions and have been established to ensure the legal rights of citizens in the field of health care[14]. The network of health institutions and facilities are planned on the basis of standards and norms, according to the health needs of the population and health service capabilities, and in accordance with accepted principles of solidarity, accessibility and equity in accessing health care. The highest degree of decentralization has been implemented in primary health care (foundation rights of health centres were transferred to the local government).

The network of health care institutions is adopt by the GMN based on HCI, and the network of health care institutions comprises of type, size, structure, capacity and spatial distribution of health facilities. The Network of public health institutions is organized on three levels of health care. The Network of public health institutions in Montenegro in 2008 consisted of 18 community health centers and 3 health stations, 7 general hospitals, 3 specialized hospitals, The Clinical center of Montenegro (hereinafter: CC) , PHI and Pharmacy Institution of Montenegro.

The network of hospital facilities of public health institutions in Montenegro consists of dispensaries at health centers[2], general hospitals, special hospitals and CC.

The network of hospitals in Montenegro at the secondary level consists of:

- 7 general hospitals (hereinafter referred to as: GH): GH Bar (for the area of Bar and Ulcinj, GH Berane (for the area of Berane, Andrijevica, Rožaje and Plav, GH Bijelo Polje (for the area of Bijelo Polje and Mojkovac, GH Kotor (for the area of Kotor, Tivat, Herceg Novi, GH Niksic (for the area of Niksic, Šavnik, Plužine, GH Pljevlja (for the area of Pljevlja and Žabljak, GH Cetinje (for the area of Cetinje and Budva;
- 3 specialized hospitals (hereinafter referred to as SH: (SH of Psychiatry - Dobrota, SH of Orthopaedics, Neurosurgery and Neurology - Risan and SH for Pulmonary Diseases and Tuberculosis Brezovik);
- CC, which is an institution at the tertiary level of health care, but for the population of Podgorica, Kolasin and Danilovgrad it provides services at the secondary level.

A hospital bed is the base term of reference as an indicator of the stationary institutions' condition, and the functioning indicators are related to a treated patient. Hospital bed capacity in 2008 was planned based on norms of bed fund in Montenegro and determined by the Master Plan for development of Health in Montenegro for the period 2005 - 2010. Given the reform orientation to financing the needs of the population (not resources), the starting point in developing work plans for year 2008 was the rate of hospitalization and average length of treatment.

[14] Source: Health Care Law, Off.Gazette of RoM 39/04

[2] According to the Law on Health Care, a health center can not have beds because it is an institution holder of the primary health care.

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According to the data from the Reports on performance of the hospital-stationary facilities[15] as of 31/12/2008, there was a total amount of 2,422 beds, out of which 1,115 were standard beds intended for general hospital capacity, 83 beds were in health centers' stationaries[3], 509 standard beds in specialized hospitals and 715 standard beds in the CC (in the report from the field service beds located in GH Niksic and GH Cetinje were recorded in those hospitals and not in the CC. Thus provision of 385 beds per 100,000 people was achieved, which is lower than the EU average (570 per 100,000), and significantly less than the average for the European region, which amounts to 668 beds per 100,000 people.

At the end of 2008 there were 7,231 employees in all public institutions of Montenegro, out of which 5,405 medical professionals and associates and 1,826 (25.3%) of non-medical professionals. The ratio of medical and non-medical staff, employed in all public services in the health sector was 2,96:1 (i.e. 100 medical workers and associates versus 33.8 non-medical).

Table 1: Employees in all public health institutions in Montenegro in 2008

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PUBLIC HEALTH INSTITUTIONS	TOTAL EMPLOYEES	Total medical professionals associates	Medical professionals and associates														Total with low educatiom	Total non-medical staff
			TOTAL high education	TOTAL doctors + dentists	Doctors				Dentists				Pharmacists	Other with high education	Total with higher education	Total with secondary education		
					Total doctors	General medicine	On specialization	Specialists	Total dentists	General dentists	specialization	dentists specialists						
Total HS	59	39	8	8	8	1	0	7	0	0	0	0	0	0	0	31	0	20
CC CG– Podgorica	1.918	1.406	411	364	337	0	99	238	27	3	1	23	1	46	67	928	0	512
Total GH	1.630	1.180	290	281	281	0	74	207	0	0	0	0	4	5	37	852	1	450
Total SH	368	276	59	54	53	0	7	46	1	1	0	0	0	5	1	199	0	9

[15] Source: Analysis of capacity and human resources in primary and secondary health care in Montenegro in 2002, IPH 2003

[3] In 2008 there were 83 inpatient beds in use, as follows: HC Mojkovac 15 HC Rozaje 40, HC Plav 15, HC Ulcinj 8 and health station: Plužine 5;

															8			2
Total HS, GH,SH and CC	**3.975**	**2.901**	**768**	**707**	**679**	**1**	**180**	**498**	**28**	**4**	**1**	**23**	**5**	**56**	**122**	**2.010**	**1**	**1.074**
TOTAL PHI AND PAI	**7.231**	**5.405**	**1.554**	**1.357**	**1.312**	**137**	**278**	**897**	**45**	**9**	**7**	**29**	**99**	**98**	**229**	**3.616**	**6**	**1.826**

Source: Evaluation of the health care system in Montenegro for 2008. Public Health Institute, Center for Health System Development. Podgorica, May 2009

Out of 1,312 medical workers, (24.3%) are doctors (of which 67.9% specialists of various disciplines), 45 (0.8%) are dentists, 98 (1.8%) medical associates with high education, 99 (1.8%) pharmacists and 3,845 (71.2%) workers with higher and secondary education.

Compared to the year 1991, it is 5.8% more employees (Table 2), but at the same time 0.3% less than in 2003. At the same time employees' qualification structure was changed, participation of non-medical (administrative - technical) employees was reduced while participation of doctors and nurses was increased. Therefore staff provision, i.e. the number of doctors and nurses per 100,000 population improves.

Table 2: Employees in health sector in Montenegro in 1991, 2003 and 2008

Profile	**1991**	**2003**	**2008**
Doctors and specialists	917	1.139	1.312
Dentists	275	265	98
Pharmacist	120	103	99
Total medical professionals and associates	3.485	5.464	5.405
Administrative and technical staff	1.961	1.787	1.826
Total employees in health care	**6.815**	**7.251**	**7.231**

Source: Analysis of capacity and personnel in primary and secondary care in the Republic of Montenegro in 2002. Analysis of health care in Montenegro in 2003 , the Health Institute of Montenegro, evaluation of health care programs in Montenegro for year 2008, the Public Health Institute, Center for Health System Development, Podgorica, May 2009

The number of doctors in the EU countries, with 321 doctors per 100,000 population is still significantly higher than in Montenegro (204.5 doctors per 100,000 population. Participation of administrative - technical workers in total number of the

employed, although continuously being decreased was still high in 2008 In 2008 it amounted to 25.3% or 0.7% less than in 2003 (3.5% less than in 1991. The data indicate that there are no unemployed doctors, mostly due to extensive employment in health care facilities.

At end of 2008, 3,975 workers were employed in public institutions in Montenegro if only the secondary and tertiary level were observed separately (health stationaries, GH, SH and the CC. 2,901 of those were medical workers and associates and 1,074 (27.0%) were non-medical professionals. The ratio of medical and non-medical staff employed in the secondary and tertiary levels in the public service was 2.7:1 (i.e. 100 medical workers and associates versus 37.0 non-medical). Out of 697 medical workers, (24,0%) were doctors (73.3% of specialists of various disciplines), 28 (1.0%) dentists, 56 (1.9%) associates with university degree, 5 (0.2 %) pharmacists and 2,132 (73.5%) workers with higher and secondary education.

Montenegro has continually been investing in restoration and purchase of medical equipment, especially equipment of high technological value. It is estimated that public health institutions and private practice have: 2 magnetic resonance imaging (hereinafter referred to as MRI) (3.1 per million people), 11 devices for computed tomography (hereinafter referred to as: CT) (17.1 per million people), of which 1 private, 1 linear accelerator (hereinafter referred to as: LINAC) (1.5 per million people) and 10 mammograms (15.6 per million people), of which 1 privately owened.

In addition to public health institutions, private practice also provides health services to the population in Montenegro. According to the latest data of the MH, there are 529 private health care providers, including 169 pharmacies in Montenegro.

There were 1,053,317 medical examinations conducted in 2008 within the specialist service, out of which 595,709 or 56.6% were the first. 8,040 examinations were conducted by physician or 1.64 examinations per insured person.

Table 3: Number of medical examinations, first examinations in specialist service in Montenegro in 2008

	Health Centers	**Hospitals**	**Total**
Number of examinations	380.341	672.976	1.053.317
Number of first examinations	219.449 (57,7%)	376.260 (55,9%)	595.709 (56,6%)
Number of examinations/per doctor	4.754	13.196	8.040
Number of examinations/per insured	0,59	1,05	1,64

Source: Evaluation of the health care system in Montenegro for year 2008. Public Health Institute, Center for Health System Development. Podgorica, May 2009

For many years development of health centers has been characterized by the formation of specialist practices of numerous clinical disciplines, which contributed to creation of parallel polyclinic facilities - in hospitals and at health centers. According to medical examinations by the doctor and the insured, there is inefficient use of capacity – doctors in health centers.

In 2008 there were 75,033 hospitalizations registered in Montenegro. Although hospitalization rates recorded trend of increase and it amounted to 12.9 per 100 people hospitalized in 2008, it is still significantly lower than the average in the European Region (19.2) and EU (17.9). The average length of treatment in the past 13 years was reduced by 3.69 days and in year 2008 it amounted to 8.58 days, which is slightly below the average in EU (9 days). In addition, there are large differences in the average length of treatment between various types of hospitals: in GH (9.25 at internal wards, 5.95 at gynecology, 6.61 in surgery and 5.65 days in paediatrics), in SH 30.46 days (in SH Dobrota 77.29, SH Risan 15.28 and SH Brezovik 21.32 days) and the CC 6.6 days. The lowest average length of hospital treatment is health stationaries (3.74 days). The longest average treatment of patients was in the SH (Dobrota), which is consistent with chronically ill patients.

During the year 2008, the GHs recorded 164 discharged patients, the CC 115, the SHs 109 (Dobrota 92; Risan 98 and Brezovik 140) patients per physician. Number of discharged patients per physician indicates the volume of work and the workload of doctors and points out large differences between hospitals!

Average daily bed occupancy in hospitals in Montenegro ranged from 53.84% to 89.36%. The GHs had 53.84% to 74.56% (internal wards 74.56%, gynecology 55.14%, 67.82% in surgery and pediatrics 53.84%), the SHs had (SH Dobrota 104.8 %, SH Risan 80.1% and SH Brezovik 89.36%), as well as the CC with 72.62% of daily bed occupancy. Apart from special hospitals, the average daily occupancy is lower than the EU average (76.3%), as well as the European average (79.1%). Low levels of bed occupancy can not be interpreted only as a result of excess in bed capacity, but as an effect of various factors such as inadequate distribution of beds in relation to the actual needs and traditional way of financing capacity of health institutions.

Hospital case-fatality rate (deaths per 1,000 treated), as one of the indicators of healthcare quality in hospitals in Montenegro, amounted to 18.31 in year 2008 (in 2007, fatality rate was 19.96). Hospital case-fatality rates were different: 6.23 in health ceter stationaries, 18.18 in GHs, 18.04 in the CC, and the highest one as of 41.44 was in SH Risan[4].

Financing health care in Montenegro is based on the principles of Bismarck social health insurance, financed through contributions paid by employers, employees

[4] In 2008, hospital mortality rate in Slovenia was 24.98, 28.8 in OH and in UCC 23.81.

and other categories of the population[5]. LHC envisages the financing of health insurance from taxes (budget) for some marginalized groups (unemployed, refugees, displaced persons). On the basis of the LHI, entire population shall be covered by mandatory health insurance. Almost 70% of the contribution comes from employees, 25% from retirees, 3% from the unemployed and 0.1% from the farmers. The fact that 3.25% of the population are farmers, who account for 0.1% of all contributions, tells us that the principle of horizontal equity has been violated.

The above mentioned means that, as in other countries, there are groups of people who use other bases instead of gross income (as an employee), and therefore they pay less, which brings them into a privileged position in relation to the employees. Solidarity as a value is borne by employees, while other categories of the population, due to unregulated basis for health care, pay less, although their incomes are high. Prolonging such a situation affects the employees even more, as the number of population in priviledged categories is going to increase, such as self-employed and farmers. Contributions in these categories are not well regulated and may provide reduction in income due to re-categorization of the population.

In addition to MHI funds, the budget shall compensate for the funds from the reduced contribution rate for MHI, shortage in funds for the payout of salaries in the public health institutions, for financing the activities of the MH, thus causing the existence of mixed funding systemin Montenegro, especially bearing in mind that the current legislation (the Budget Law, the Treasury system) is more appropriate for the budget funding system of health care, than for the insurance system.

Additional sources of health care funding in Montenegro also include direct payment of health care beneficiaries (participation), other means of payment and funds from donations.

It is well known that the obligation and solidarity in health insurance brings certain rights to health care services and financial compensation to citizens, but the exercise of the mentioned rights is connected to the obligation to pay contributions proportionate to their financial capabilities. The MHI ensures the right to use health care to the insured individuals. The HIF is the institution where the insured exercise their rights on health insurance and which provides funds for this purpose. In addition to mandatory insurance, the LHC recognizes voluntary insurance. Voluntary insurance shall not be complementary (complementary and additional insurance analysis, what exactly each one of them implies, and in what way voluntary insurance should be introduced, is further explained within the Master Plan), but additional and voluntary and should contain a package of services that are completely separate from the MHI. Therefore, there is no need to be under jurisdiction of the public sector - the proposed

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[5] The contribution rate for health insurance of employees is 9%, of which paid by employer 5% at the expense of the insured 4% of the salary. The contribution rate for health insurance policyholders in agriculture is 9%, while the base is 12% of the average gross monthly salary in Montenegro in the previous year. For pension beneficiaries contribution rate is 19% and the base is the amount of the pension. Employment Agency pays contributions for the unemployed receiving unemployment compensation at the rate of 5% on the amount of financial compensation.

voluntary health insurance should be the responsibility of the market and private insurance companies.

In 2008, the HIF achieved mill €183.42 of revenue, which is mill €45.04, or 32.55% more than the revenues generated in 2007 (mill €138.38), as a result of the overall economic growth in Montenegro, regular revenue and increased coverage of contribution payers. Out of the stated, revenue from health care contributions amounted to mill €144.8 (78.95% of total revenue), which represents a decrease compared to previous years (2007: 90.63% 2006: 93.67%). Decline in the share of these revenues occurred due to the decrease in MHI rate from 13.5% to 12% in 2008 (10.5% in 2009), as stipulated in the Law on Social Insurance[16]. Revenues from the budget increased from mill €6.84 in 2006 to mill €11.38 in 2007, i.e. to mill €37.09 in 2008, in order to compensate for funds from the reduction of the contribution for the MHI. Therefore, the share of the budget in total revenue of the HIF increased from 5.8% in 2006 to 20.22% in 2008. In addition to funding from the MHI, another mill € 69 were allocated from public sources for funding the MH activities in 2008. In comparison to the MH budget executed in 2007, the above data represent an increase of mill €11.52 or 20%.

Total expenses of the HIF realized in 2008 were mill €172.48 million, in 2007 mill €138.52 million and in 2006 mill €117.94. The HIF expenses include funds for health care of the insured by health care levels, other rights related to health care and insurance, and other expenditures. For the secondary and tertiary level of health care expenditures in 2008 accounted for 45.21% of total expenditures[6]. In comparison with Slovenia (48.1%), the percentage is not too high. In the period since 2006 the above mentioned expenditures have been increasing, both in absolute and relative terms, because there is still no proper control and cost statistics on hospital level.

Table 5 The share of Health Insurance Fund expenditures in GDP from 2004 to 2009

Year	GDP * (in mill €)	Expenditure HIF ** (mill €)	HIF share in GDP
2004	1.669,80	95,58	**5,72**
2005	1.815,00	108,89	**6,00**
2006	2.148,90	117,94	**5,49**
2007	2.807,90	138,52	**4,93**
2008	3.085,60	172,48	**5,59**
2009	3.242,00	158,49	**4,89**

* Source Monstat (2001-2008) Analysis of the Implementation of Economic Policy of Montenegro for 9 months of the year 2009 (estimate for 2009)

** Source: Report on the Fund activities

[16] Source: The Law on Compulsory Social Insurance, Off. Gazette of MNE , No. 13/07.

[6] Due to different national definitions of secondary and tertiary levels of health care , comparison with the EU average is not possible. Comparison is also not possible on the basis of the data base OECD Health Data 2009.

Article 12 – The right to social security

With a view to ensuring the effective exercise of the right to social security, the Parties undertake:

1 to establish or maintain a system of social security;

2 to maintain the social security system at a satisfactory level at least equal to that necessary for the ratification of the European Code of Social Security;

3 to endeavour to raise progressively the system of social security to a higher level;

4 to take steps, by the conclusion of appropriate bilateral and multilateral agreements or by other means, and subject to the conditions laid down in such agreements, in order to ensure:

a equal treatment with their own nationals of the nationals of other Parties in respect of social security rights, including the retention of benefits arising out of social security legislation, whatever movements the persons protected may undertake between the territories of the Parties;

b the granting, maintenance and resumption of social security rights by such means as the accumulation of insurance or employment periods completed under the legislation of each of the Parties.

Addition to Article 12, paragraph 4

The words "and subject to the conditions laid down in such agreements" in the introduction to this paragraph are taken to imply inter alia that with regard to benefits which are available independently of any insurance contribution, a Party may require the completion of a prescribed period of residence before granting such benefits to nationals of other Parties.

Information to be Provided
Article 12, paragraph 1

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.

ANSWER

Primary legislation::

- for sickness and maternity: the Law on Health Insurance (Off. Gazette of MNE,

No.39/04) with the by-laws for its implementation; detailed answer is given in the article 11 and 13

- for benefits in case of disability: the Law on Pension and Disability Insurance (Off. Gazette of MNE, No. 54/03, 34/04, 79/04, 81/04, 47/07 and Off. Gazette of MNE, No. 79 / 08, 14/10 and 78/10), with the by-laws for its implementation;

- provisions for old age: the Law on Pension and Disability Insurance (Off. Gazette of MNE, No. 54/03, 34/04, 79/04, 81/04, 47/07 and Off. Gazette of MNE, No. 79/08, 14 / 10 and 78/10) and the Law on Voluntary Pension Funds (Off. Gazette of MNE, No.78/06 and 14/07) with the by-laws for its implementation;

- provisions for family members: the Law on Pension and Disability Insurance (Off. Gazette of MNE, No. 54/03, 34/04, 79/04, 81/04, 47/07 and Off. Gazette of MNE No. 79 / 08, 14/10 and 78/10) with the by-laws for its implementation;

- for benefits in case of occupational injury and occupational diseases: Law on Health Insurance (Off. Gazette of MNE, No. 39/04) and the Law on Pension and Disability Insurance (Off. Gazette of MNE, No. 54/03, 34/04 , 79/04, 81/04, 47/07 and Off. Gazette of MNE No. 79/08, 14/10 and 78/10) with the by-laws for its implementation;

- with unemployment benefits: Employment Law (Official Gazette of MNE, No. 29/05), with the by-laws for its implementation; detailed answer is given in Article 1 of the Report for 2011

- the one-time benefit and child benefit: the Law on Social and Child Protection (Official Gazette of MNE, No. 78/05) with the by-laws for its implementation. A detailed answer is given in Article 13, 14 and 23

Secondary legislation:

- The Rule Book on determination of bases for pension and disability insurance for employees abroad ("Off. Gazette of RoM", No. 34/2004)

- The Rule Book on unique methodological principles for keeping the records of the Pension and Disability Insurance ("Off. Gazette of RoM", No. 5/2004)

- The Rulebook on the Establishment and work manner of the second instance disability Commission ("Off. Gazette of RoM", No. 35/2007 and "Off. Gazette of MNE", No. 72/2009)

- The Rule Book on determination of the bases for pension and disability insurance for priests, clerics, monks and nuns ("Off. Gazette of MNE", No. 45/2008

- The Rule Book on determination of the bases for pension and disability insurance which can cover insured farmers according to their own choice ("Off. Gazette of RoM", No. 34/2004)

- The Rule Book on unique code system for filling data into the records of the Pension and Disability Insurance ("Off. Gazette of RoM", No. 5/2004, "Official Gazette of MNE", No. 84/2009)

- The Rule Book on the scope and content of medical records required for the procedure of exercising rights on pension and disability insurance ("Off. Gazette of RoM", No. 60/2004) The Rule book on determination of body damage ("Off. Gazette of RoM", no. 45/2004 and 50/2004

- The Rulebook on establishing occupational diseases "Off. Gazette of RoM", No. 66/2004)

- The Rulebook on establishing work posts, i.e. jobs for which the insurance service is calculated at accelerated rate and the procedure and method for their determination ("Off. Gazette of MNE", No. 71/10)

- Decree on establishing workposts, i.e. jobs in the state administration, in which the insurance service is calculated at accelerated rate ("Off. Gazette of MNE", No. 80/10)

- The Rule Book on detailed determination of work posts, i.e. jobs in public administration, in which the insurance service is calculated at accelerated rate ("Off. Gazette of MNE", No. 1/11)

- Decree on establishing duties, i.e. jobs in which the insurance service of the professional military personnel shall be calculated at an accelerated rate ("Off. Gazette of MNE", No. 35/09).

1) **Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.**
2) **Provide relevant figures, statistical data and other relevant information, if appropriate.**

ANSWERS:

By the Law on Pension and Disability Insurance it is stipulated that pension and disability insurance in Montenegro shall includes:
• mandatory pension and disability insurance based on current funding
• mandatory pension insurance based on individual capitalized savings;
• voluntary pension insurance based on individual capitalized savings

As in most other countries, the pension and disability insurance system in Montenegro is based on current funding, which means that all those who work

and earn income, based on the principle of obligation, set aside pension funds for current beneficiaries through contributions for the pension and disability insurance. In this way, today's contribution payers are entitled to have their pensions financed from funds that would be paid by future payers, on the basis of contribution payments.

Pension and disability insurance is based on the current financing (I pillar) and is funded from contributions, the state budget and other sources in accordance with the law. The liabilities of the Fund to exercising the right to pension and disability insurance, is guaranteed by the State.

Contributions for pension and disability insurance are:

- contributions of the insured;
- employer contributions;
- additional contributions for insurance service at an accelerated rate;
- contributions of other persons liable to pay contributions under this law;
- contributions or funds in case of injury or occupational disease.

Funds for the payment of pensions under the more favorable conditions as well as the difference in part between the funds raised from contributions and the missing funds for the payment of pensions provided from the state budget .

Total Income and Expense of the PDI Fund in € million, and their share in GDP

TOTAL INCOME AND EXPENSE PDI FUND IN € MILL AND THEIR SHARE IN GDP								
Year	GDP	Total income of pension system	Total expense of pension system	Income to contributions for PDI (source income)	Transfer amount (in mil. eur)	% share of total income in in GDP	% share of total expenses in GDP	% share of transfers in total income of the Fund
1999	n/a	55,20	60,66	31,55	18,90	n/a	n/a	n/a
2000	1.065,69	121,96	121,91	76,97	38,45	11,44	11,44	31,53
2001	1.295,11	141,25	132,96	73,68	56,15	10,91	10,27	39,75
2002	1.360,35	155,76	152,35	93,11	46,76	11,45	11,20	30,02
200	1.510,	166,3	161,4	105,85	38,61	11,02	10,69	23,21

3	13	5	3					
2004	1.669,78	165,84	168,48	115,98	37,72	9,93	10,09	22,74
2005	1.814,99	185,31	180,86	118,33	44,14	10,21	9,96	23,82
2006	2.148,99	205,65	196,59	139,29	54,33	9,57	9,15	26,42
2007	2.540,00	250,33	235,48	173,88	61,16	9,86	9,27	24,43
2008	3.338,00[17]	288,55	287,97	214,63	68,39	8,64	8,63	23,70

In the forthcoming period, financial sustainability of I pillar of the pension system will be conditioned on one hand by the amount of realized contributions and their participation in total income or total coverage of expenses and reduction of coverage by transfers from the budget of Montenegro, then by the ratio of the number of employees and the number of beneficiaries of the PDI, i.e. by further expected decline in unemployment as well as reducing the number of pensioners. Of course, the trends in the pension system will adversely be affected in the long term by the negative demographic trends and significant population aging, the decline in the fertility rate and the expected long life of the population and thus a longer period of exercising the pension right.

The second pillar (II pillar) of the pension system is mandatory insurance, which is based on the capital coverage or individual capitalized savings of the insured. In this system, each insured has its own private savings account with a private pension fund to which contributions are paid. These funds are invested and the income is added to the assets of individual private accounts, which is owned by its policyholders and which is available on the employee's retirement. Thus, the second pillar is organized on economic principles. Its performance is conditioned by the efficiency in organizational and administrative changes. Should the second pillar be introduced, there is likely to be structural problems related to the height of the base beneficiaries and the lack of sufficient development of the capital market in Montenegro and the region. The introduction of this pillar requires detailed financial and economic analysis (different options based on actuarial model in projected macroeconomic environment), which provide the basis for the law. Adequate institutional framework, which supports the

[17] Assessment of the Ministry of Finance

sustainability of this system, takes into account the launch of new functions (regulatory and supervisory authorities, central registry, Custodian), public campaign and the licensing of pension investment funds.

While introducing the second pillar, i.e. mandatory pension insurance based on individual capitalized savings, transition deficit was identified as the core problem, i.e. deficit that will occur in the state pension fund because of the smaller amount of contributions received. In practice of the countries that have adopted the II pillar, there are three possible options to cover this deficit, as follows:

• public debt emission;
• revenues from privatization and
• reducing the budget expenditure and / or increasing taxes.

Introduction of the second pillar in future includes the development of different options in order to create a new regulatory framework.

These analyzes - macroeconomic projections would be related to:

- projections of deficits due to the reduction in the contribution rate that finances the current system;
- plan for using accumulated funds realised on the second level;
- Time and manner of investment of realized funds in individual accounts;
- Public campaign addressing employees and affirms the principles of investment security, freedom of choice-demonopolisation;
- an institutional framework that supports sustainability, safety and efficiency of the system by establishing supervisory function, licensing the holder (funds), by allocation of private fund from the management; minimizing risk and maximizing return "binding" the profit of the management for realized profits in private funds.

The third pillar of pension system is based on the same principles, presenting voluntary insurance that is also founded , as well as the second one, on individual capitalized savings of the insured person. However, contrary to the second pillar, it is the insurance that is not mandatory, but voluntary in its character. Since the legal preconditions have been provided and the first pension funds have been established, it is to be expected an increase interest in contracting voluntary pension insurance in the forthcoming period, depending on the standard of living, earnings growth, capital market development, strong public campaign and the entry of foreign investors in this area.

Key points in functioning of the pension system in Montenegro are demographic trends and the level of economic development. Due to its financial viability caused by the corresponding ratio of the number of employees and the number of pensioners and current payments of contributions from the insured and transfers from the state budget, it makes it insufficient for future generations of retirees because they are ensured only a basic level of social security.

In order to be economically sustainable, fiscally bearable and in function of economic development, the pension system shall be adapted to the economic and demographic

structures and capacities of the society. Thus defined requirements can be realized only in the process of comprehensive reform of the pension system, that ultimately involves introducing a multi-pillar pension system.
Establishing a financially stable, transparent and efficient pension system in the future is a challenge for the Montenegrin society. Finding a model that will best meet the challenge is a very complex and demanding task.
In addition to providing high quality and accessible health care and the involvement of its members in all spheres of social and economic life, the amount of pension benefits, that is reliability and regularity of its payment will have a crucial impact on security of the population of the "the third age" in the future.

The following problems were identified by analysing the operation of the pension system in Montenegro in the last five years before the reform and conducting researches in this area:

- unfavorable ratio between the number of pensioners and the number of employees (1:1.3),
- high share of PDI Fund expenses in GDP (13%),
- generosity of the pension system,
- unfair redistribution
- negative demographic trends,
- high fiscal burden on the economy,
- avoidance of contributions for pension and disability insurance,
- weak allocation of expenses of the Pension Fund, and
- financial unsustainability in the short and long term.

The identified problems have shown that the pension system, based on current funding can not continue to regularly finance all rights under this insurance and that it is necessary to access its comprehensive reform. Reform is inevitable and urgent, and due to social and economic vulnerability, it shall be implemented gradually over a longer period of time.
In order to solve the identified problems and bring the pension system to the level of financial sustainability, the Parliament of Montenegro adopted the Law on Pension and Disability Insurance in September 2003, the Law on Pension and Disability Insurance (Official Gazette of RoM, No.54/03, 39/04, 79/04 and 47/07, and Off. Gazette of MNE, No. 79/08)

By this law:

- the existing compulsory insurance in respect of current financing (generation solidarity or the first pillar) has been reformed;
- a normative precondition for the introduction of mandatory insurance based on the capital savings of the insured (the second pillar), and voluntary insurance (the third pillar), was created.

- Reform of **mandatory** insurance under the current funding is based on:
- The gradual increase in the age limit for entitlement to old-age pension to the age of 65 for men, that is 60 years for women - which is trying to neutralize the negative demographic trends in Montenegro;
- The introduction of the point-based pension formula - thus establishing a stronger link between paid contributions, i.e. the base on which contributions are paid and the amount of the pension;
- The gradual increase in the number of years included in the calculation of the pension amount for the total period of pension insurance;
- Introduction of pension adjustments, i.e. pension value for a personal point according to the so-called "Swiss formula", which is the sum of half of the percentage of increase, i.e. decrease in the living costs and a half percent increase, i.e. decrease in gross earnings - which affects the reduction of expenses of the pension system;
- Broadening the scope of the insured and the expansion of the bases for the payment of contributions;
- Tightening of requirements for entitlement to disability and family pension, change the procedures for the exercise of disability pension, prescribing mandatory check-ups (every three years) for users who exercise their right to a disability pension according to the new law, as well as eliminating or restricted access to certain rights which by their nature do not belong to the pension and disability insurance

The main objectives of the reform of the pension system in Montenegro are:

- creating economically sustainable economic, fiscally tolerable pension system that will serve the economic development and its adaptation to economic and demographic structures and facilities of the society in order to make it acceptable to current and future generations,
- slowing down the inflow of new retirees and changing an unfavourable pensioners' structure (large share of disability pensioners in total number)
- increase personal responsibility for income in old age

The Law on Voluntary Pension Funds and by-laws for its implementation has been adopted, which has introduced the third pillar of the pension system - voluntary pension insurance based on individual capitalized savings.

In order to assess the achieved level of reform of the mandatory pension and disability insurance based on current funding (the first pillar of the pension system), the implementation of regulatory reform measures and their impact on the financial position of pensioners, in order to identify inconsistencies in the system and its upgrades and improvements related to the mentioned inconsistencies, the Ministry is making analysis on which it regularly informs the Gavernment.

In terms of further reforms to the pension system aimed at increasing the financial sustainability of the Fund and the reduction of taxes and contributions for pension and disability insurance, full support of the pensioners, employers and workers unions is given. The more projected goals of the reform are achieved and the share of costs of the pension and disability insurance in the gross domestic product is reduced and better financial sustainability of the Fund is provided, the more it is confirmed that the need for reform of the system has been justified and that the required reform measures have given the expected results.

Full implementation of prescribed reform measures after the expiry of the transitional period and the reduction in the rate of contributions for pension and disability insurance, will cause the medium-term stabilization of the pension system.

A significant issue of the continuation of reforms is possible introduction of the second pillar of the pension system - mandatory pension insurance based on individual capitalized savings. This raises a number of issues, among the most important are the way of solving transitional costs and the level of contributions to be paid for this type of pension insurance. The answer to these questions will certainly depend on the comprehensive analysis that will take into account the current reform results, future economic, demographic and social trends and other factors affecting the pension system.

A large part of the pension reforms in Montenegro was finalized and the normative and regulatory framework was completed. The Law on Pension and Disability Insurance was adopted which reformed the pension and disability insurance system based on generation solidarity (the so-called first pillar of the pension system), and by-laws necessary for the implementation of the Law on Pension and Disability Insurance.

The reform of pension administration was completed as well. Certain uneconimic business functions were closed down within the Pension and Disability Insurance Fund, new modern business processes were established (internal audit, public relations, human resources, financial management), a new integrated information system was implemented as well as the latest generation of IT technology. All stages in the reform of the pension administration implied a complete normative standardization and tendency towards automatization of business processes, thus creating conditions for transforming the Fund into a modern and efficient organization focused on providing quality service to the insured and beneficiaries.

According to World Bank criteria, one of the most important indicators of "improving administrative capacities of the PDI Fund" is the share of operating expenditures in total expenses, and a downward trend in this indicator in the PDI Fund for the past few years (2000 - 9.30%; 2,001 - 6.95 ; 2002 - 5.61%; 2003 - 4.52%; 2004 - 4.27%, 2005. - 4.24%; 2006 - 3.58%; 2007 - 2.73% and 2008 - 2.63%), is very important for the overall positive evaluation of the Project of the pension system reforms in the state of Montenegro.

As of January 2007, Tax Administration have been working intensively on the project *"Integrated registration and payment of taxes and contributions (UCG),"* which, as part

of the pension reform Project, has been funded by a World Bank loan, which should include the functionality of several institutions in a unique way.

Application of the Law on Unified Registration and Reporting System for the calculation and payment of taxes and contributions, which was supposed to take effect on 1st January, 2006, has been postponed to procure software that is supposed to provide the integration of registers and application of the Law. The Ministry of Finance has issued the *Rule Book on the Form and Content of a Single Application for Registration of Taxpayers, Contributors and Insured in the Central Register and the Rule Book on the Form, Content, Method of Filling in and Submitting the Single Form of Accrued Income Tax and Contributions for Mandatory Social Insurance.*

Law on Voluntary Pension Funds has been passed (Off. Gazette of RoM. 78/06 and 14/07) along with by-laws for its implementation, which has introduced the third pillar of the pension system - voluntary pension insurance based on individual capitalized savings. In accordance with the Law on Voluntary Pension Funds in Montenegro, three joint stock companies for voluntary pension fund management were formed and received permission to operate: ATLAS PENSION ad Podgorica, MARKET INVEST AD Bijelo Polje and NLB PENSION ad Podgorica.

ATLAS PENSIONS ad has established voluntary pension fund PENSION PLUS, while MARKET INVEST ad has established open voluntary pension fund PENSION MARKET ad. Company for voluntary pension fund management NLB RETIREMENT ad has been licensed to manage the voluntary pension fund, but they haven't founded voluntary pension fund. The management company is required to initiate the accumulation of contributions within 12 months from the date of obtaining the license, as otherwise its shall be revoked.

Voluntary pension fund PENSION PLUS had 348 memebers as of 14/08/2009, and the net asset value of the pension fund amounted to € 21,636.31.

MARKET PENSION had 29 members as of 13/08/2009/, and the net asset value amounted to € 3,803.87.

As for the introduction of the second pillar of the pension system - mandatory pension insurance based on individual capitalized savings, it is still not predicted when the law will be passed to regulate and start implementing that part of the pension system. It is necessary to resolve the question of the transition cost, and to replace the missing funds that will necessarily be provided for the Pension and Disability Insurance Fund of Montenegro due to reduced inflow of contributions for pension and disability insurance based on current funding - that will arise due to the fact that it will be paid for the second pillar for the insured persons who will be involved in the second pillar of the pension system of contributions, which is now paid only for the first pillar - into the individual account of the insured who are included in the mandatory pension insurance based on individual capitalized savings.

The reform of the pension and disability insurance based on current funding has provided its financial stability and reduce the inflow of new users. Due to the fact that the pension adjustment is done with a lower percentage than the earnings growth, it is

inevitable that during certain years, the average retirement will have slower growth compared to the average wage.

Undertaken activities have contributed to increasing number of beneficiaries of pension and disability insurance, i.e. an increasing number of persons have been involved in the legal flows of the economy which causes a better structure of pensioners, mainly due to reduction in the number of disability pensioners, as a result of the new disability definition which is defined by the concept of general disability, as well as the introduction of regular revision of disability pension

These changes, as well as the measures and actions undertaken in order to enhance collection of contributions for pension and disability insurance, through intensive and good cooperation with the authorities responsible for the control and collection of public revenue, have had a significant impact on increasing the income of the Fund and have contributed to a larger share of contributions income in total revenue.

Therefore, the reform of the first pillar of the pension system in the short and medium term gives positive results. However, despite the positive effects of the reform measures implemented so far, high pension costs result in dificult funding, and increasing the participation of budgetary transfers in the total income of the Fund. In the long term, negative demographic trends and the aging population will in future lead to a deterioration in the relationship between the pension system and the labor market, which means that it will cause an approaching in the number of retirees to the number of employees. Therefore, further reform of the pension system is needed, aimed at ensuring its long-term financial sustainability, diversification of the pension sources, involvement of the individual in decision making on allocations for retirement, and, finally, encouraging citizens to timely extra savings for their old age.

The total expenditures of the Fund (pension and disability insurance based on the current contributions funding - I pillar) in 2008 amounted to mill. €287.97, or 8.63% of GDP, while revenues from contributions amounted to mill. €214.63, or 74.38% of the total income of the Fund.

"**Pay as You Go" (hereinafter: PAYG) pension system of generational solidarity, which has been in use in Montenegro for almost half a century, is a result of high social consciousness of society, but insufficient for the future generations of retirees, because they are provided only a basic level of social security. Key determinants of functioning of such a pension system are demographic trends and economic development level. On the other hand, this system, built on an appropriate ratio of the number of employees and the number of pensioners has proven to be inefficient and financially unsustainable, as it relies only on the current contribution payments.**

Social and economic circumstances in which the RAYG system was applied were favourable and ensured its efficient operation as long as the ratio between the number of employees - those who earn and pay contributions and the number of beneficiaries was favorable, in times when the growth of GDP was relatively high

and demographic trends were positive. However, in the late 80s, social and economic environment were completely changed, which affected the operation of the applied pension system, i.e. the exercising of rights within the stated system.

Income provided by the PAYG system, despite the high rate of contributions, were not sufficient to cover the increased expenditures for approximately 90,000 retirees. The foundation of the Generational solidarity system (PAYG) functioning and sustainability lies in an appropriate ratio in number of employees and retirees, i.e. the number of contributors and those whose incomes are financed from those contributions funds. Disruption of key indicators of the pension and disability insurance (number of employees, number of retirees), has caused arisen difficulties and permanent disbalance in terms of collecting revenues from contributions and the need for the operation of the pension system. For these reasons, without radical reform, the existing system of intergenerational solidarity was unable to ensure the financial sustainability of the pension system and the safety of the insured anfer retirement.

The above mentioned weaknesses of the PAYG system have forced the State to accede to the reform of traditional approaches in this area, in order to adjust to the new demographic conditions and avoid larger potential system disruptions in the future.

To solve the identified problems and bring the pension system to the level of financial sustainability, on the recommendation of, and in cooperation with the World Bank, the Government of Montenegro has opted for the concept of three-pillar pension system, which is widely applied pension reform concept in the world.

In September 2003 the first step towards financial sustainability of the system was made and the first phase of pension reform was conducted by passing the Law on Pension and Disability Insurance and its coming into forse as of 1st January 2004. A gradual increase in the retiring age, changing the pension formula, increasing the number of years included in the calculation of pension, by using a new method of pension adjustment and other reform measures led to the results that justify the short-term projections and to a slight decline in the share of pension expenditure in the GDP.

Along with these reform measures, the reform of the pension administration has been completed. Certain uneconimic business functions were closed down within the Pension and Disability Insurance Fund, and new modern business processes were established (internal audit, public relations, human resources, financial management), a new integrated information system was implemented as well as the latest generation of IT technology.

Undertaken activities have contributed to increasing number of beneficiaries of pension and disability insurance, i.e. an increasing number of persons have been involved in the legal flows of the economy which causes a better structure of pensioners, mainly due to reduction in the number of disability pensioners, as a result of the new disability definition which is defined by the concept of general disability, as well as the introduction of regular revision of disability pension

These changes, as well as the measures and actions undertaken in order to enhance collection of contributions for pension and disability insurance, through intensive and good cooperation with the authorities responsible for the control and collection of public revenue, have had a significant impact on increasing the income of the Fund and have contributed to a larger share of contributions income in total revenue.
Therefore, the reform of the first pillar of the pension system in the short and medium term gives positive results. However, in the long term, negative demographic trends and the aging population will in future lead to a deterioration in the relationship between the pension system and the labor market, which means that it will cause an approaching in the number of retirees to the number of employees. Therefore, further reform of the pension system is needed, aimed at encouraging and creating a challenging work opportunities for older employees in order to motivate them to work longer. Despite the positive effects of the reform measures implemented so far, high pension costs result in difficult funding, i.e.increasing the participation of budgetary transfers in the total income of the Fund.

Pension reform is an integral part of comprehensive and systemic reforms implemented to improve fiscal and social sustainability of the pension system, and as such has a positive impact on the labor market and the increase in employment in several ways:

- The new pension calculation as a measure of the Law on Pension and Disability Insurance provides the insured who work longer, have higher earnings and higher contribution paid, the larger amount of pension. The introduction of a point-based pension formula establishes a stronger link between paid contributions, i.e.the base on which contributions are paid and the amount of pension. In this way, the insured are encouraged to work longer and keep the average income, which is important not only for the standard of future retirees, but also for the stability of the pension system. Since the formula for calculating pensions ensures larger amount of pension for longer work period, it thereby encourages people to work longer.
- Tightening of requirements for entitlement to disability and family pension, change the procedure for the exercise of disability pension, prescribing mandatory check-ups (every three years) for users who exercise their right to a disability pension according to the new law, as well as eliminating or restricted access to certain rights which by their nature do not belong to the pension and disability insurance . In accordance with the new definition of the term disability, in addition to the term complete loss of ability, the Institute of partial loss of ability has been set up. A beneficiary who has been determined a partial loss of earning capacity can be employed up to ¼ of full time, which aims to ensure a longer retention of the insured in the process of work, or in their operations.
- One of the important measures carried out by the reform of the I pillar of the pension system is the contribution rate reduction. Over the period of ten years, up to 2004, the contribution rate was not changed, but in 2004 it was reduced to 22.80%.

Implementation of the pension reform led to a further reduction of the contribution rate. Contributions for pension and disability insurance in 2008 amounted to 21% of gross salary (employer pays 9% and employees pay 12%), and since 2009, the contribution rate has been reduced to 20.5% (employee pays 12%, while the employer pays 8.5%). Downward trend in rates will continue in 2010, when reduction to 20% is planned, also on behalf of the portion of the contribution paid by the employer (the employer will pay 8%, employees 12%).

The effects of reduced contribution rate have significantly influenced the improvement in the labor market and the positive changes in the pension system. The main consequence of this measure is decline in the field of gray economy, as employers resorted to greater employee registration and payment of contributions at a reduced rate. In order to encourage employment of persons with low employability (occupational invalids, older categories of unemployed persons, long-term unemployed persons and other hard-to-employ people), the Decree on Tax Incentives for the Employment of Certain Categories of Unemployed Persons was adopted ("Off. Gazette of MNE", no. 29/2008).

Since the beginning of 2004, there has been a rapid increase in the number of registered employees in Montenegro mostly due to decrease in the tax burden on labor, which has primarily been reflected in the reduction of contribution rate paid by employer for pension and disability insurance. This has initiated work offer of the Montenegrin labor market, increased inflow of domestic and foreign investment, has led to directing a part of gray economy activities in legal channels, thus increasing the rate of employment and reducing the unemployment rate, simultaneously giving an incentive for long-term growth of the wages and earnings. Also, the positive rates of growth in employment was driven by the favorable macroeconomic situation in Montenegro and reducing barriers to business, which resulted in the inflow of foreign direct investment in infrastructure, tourism and financial sectors. As a result of this and other projects, unemployment was reduced and the number of registered employees in the country was increased, thus increasing the amount of paid contributions for pension and disability insurance.

It should be noted that continuation of reforms, particularly the reform of the existing pension system has influenced the increase in employment and a lower number of registered unemployed persons. The previous pension system was not stimulative for employers in regard to new employment, while workers were motivated to use the generosity of such a system and take an early retirement. New reform measures that have been planned to reduce the taxes paid by employers regarding the rate of contributions for pension and disability insurance, have contributed to decrease in unemployment rate in Montenegro over the past few years.

Prescribing the minimum pension, as a special form of social protection, which is realized through the pension and disability insurance in order to guarantee the necessary level of financial and social security of pensioners, emphasizes the social redistributive elements in favor of the insured with a lower earnings. When determining

the amount of pension, the length of insurance coverage has a crucial role in its amount, which encourages the users to work longer and retain their average income as long as possible.
Also, retirees are entitled to employment or self-employment without suspension of pensions, and they are entitled to re-evaluation of the amount of pension, under the condition of being insured (on that basis) for a period of at least one year.

Article 12, paragraph 2

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.

Answer provided under paragraph 1. 1

2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.
3) Provide relevant figures, statistical data and other relevant information, in particular on the extent to which branches of social security in your country meet (or meet over it, or fail to meet) the requirements of the European Code of Social Security.

ANSWER:

The provisions of Article 16 of the Law on Pension and Disability Insurance provides for the right to pension and disability insurance:
1) for elderly to an old age pension;
2) in case of disability to a disability pension;
3) in case of death:
- The right to family pension;
- The right to compensation for funeral expenses;
4) in the event of physical damage caused by occupational injury or disease, the right to compensation for physical injury.

In accordance with the provisions of Article 9 of the said law the insured are:

1) employees;
2) any self-employed person
3) workers in agriculture (hereinafter referred to as: the insured farmers).

If the person simultaneously meets the requirements for insurance on several grounds referred to in paragraph 1 of this Article, the base of insurance is determined in such a

way that the existence of insurance base in previous item excludes the insurance base from the next item.

Obligations to pay contributions in respect of insurance shall be determined in accordance with this Law.

According to the Tax Administration of Montenegro as of June 2012 , the number of insured persons in Montenegro was as follows:

- employees **157931**
- insured self-employed **3376**
- farmers in **1987**

The total cost of the pension system in 2011 amounted to mill €361.14 and accounted for 11.03% of GDP.

According to the Fund for Pension and Disability Insurance of Montenegro's data - April 2012

The total number of pensioners-120 158
Paid in Montenegro -113 777
Paid outside of Montenegro - 6381
Detailed view in the following table:

	Number	**of beneficiaries of PDI for month of payment (payment base)**							
2012	**January**	**February**	**March**	**Aprile**	**May**	**June**	**July**	**August**	**Septemb.**
Number of old age pensioners	52.385	52.734	53.013	53.202					
Number of disability pensioners	23.880	23.814	23.793	23.795					
Number of family pensioners	28.424	28.410	28.431	28.463					
I Total number of pensioners	**104.689**	**104.958**	**105.237**	**105.460**	**0**	**0**	**0**	**0**	**0**
Other rights									
Physical damage	6.058	6.038	6.021	5.999					
Assistance and care	1.270	1.261	1.255	1.246					
Reimbursement for occupational disability	1.221	1.216	1.208	1.199					
Addition to the memorial	59	57	56	56					
II Total other rights	**8.608**	**8.572**	**8.540**	**8.500**	**0**	**0**	**0**	**0**	**0**
I + II MONTENEGRO	**113.297**	**113.530**	**113.777**	**113.960**	**0**	**0**	**0**	**0**	**0**

Other countries										
Serbia	Pensions	3.076	3.125	3.194	3.256					
	Oth.rights*	110	110	110	110					
Macedonia	Pensions	263	263	264	266					
	Oth.rights*	2	2	2	2					
B and H	Pensions	1.496	1.508	1.524	1.534					
	Oth.rights*	0	0	0	0					
Croatia	Pensions	1.182	1.185	1.193	1.205					
	Oth.rights*	32	31	31	31					
Foreign countries	Pensions	63	63	63	63					
III Total other countries	**Total pensions**	6.080	6.144	6.238	6.324	0	0	0	0	0
	Total oth.rights*	144	143	143	143	0	0	0	0	0
	Total pens.and oth.rights	**6.224**	**6.287**	**6.381**	**6.467**	**0**	**0**	**0**	**0**	**0**
TOTAL PENSIONS		**110.769**	**111.102**	**111.475**	**111.784**	**0**	**0**	**0**	**0**	**0**
TOTAL OTHER RIGHTS		**8.752**	**8.715**	**8.683**	**8.643**	**0**	**0**	**0**	**0**	**0**
I+II+III TOTAL		**119.521**	**119.817**	**120.158**	**120.427**	**0**	**0**	**0**	**0**	**0**
Aver.pension in Mne		**279,55 €**	**279,55 €**	**279,47 €**	**279,54 €**					
Aver. Paid pension		**270,12 €**	**269,99 €**	**269,75 €**	**269,65 €**					

*Other rights – physical damage, assistance and care, reimbursements and addition to the memorial.

Article 12, paragraph 3

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.

Answer provided under paragraph 1. 1

2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.

3) Provide relevant figures, statistical data and other relevant information on improving the social security system, as well as any measures taken to limit the system.

ANSWER:

ANSWER to 2 and 3:
Law on Pension and Disability Insurance ("Official Gazette of RoM", no. 54/03, 39/04, 61/04, 79/04, 14/07 and 47/07 and "Official Gazette of MNE", No. 79/08 and 14/10) was adopted by the Assembly the Republic of Montenegro as of 24th September 2003, and has been in force since 1st January 2004.

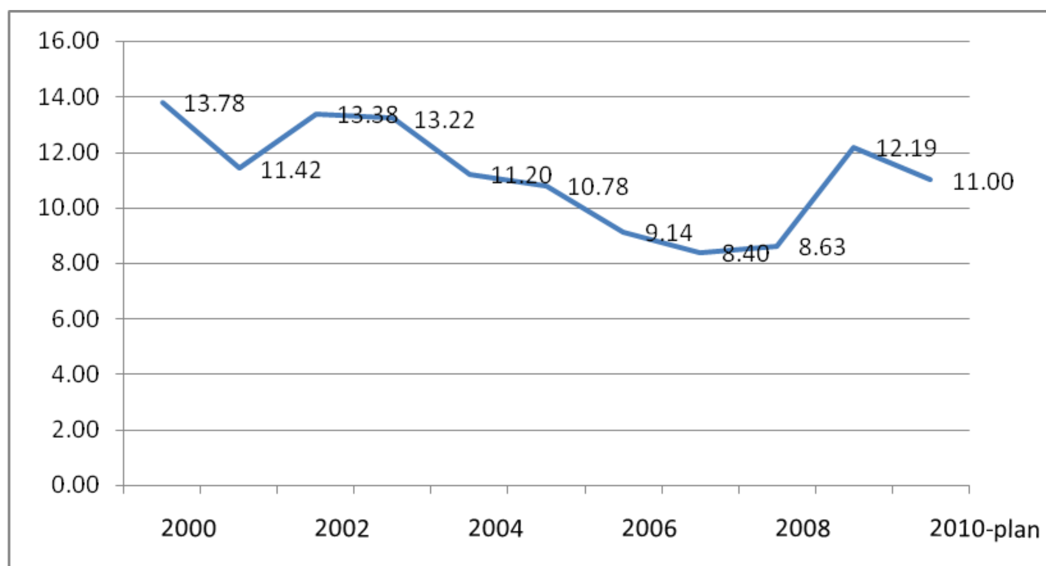
The main reason for proposing amendments to the Law on Pension and Disability Insurance is a continuation of the reform of pension and disability insurance, equalization of women and men in relation to eligibility for retirement, raising the age for entitlement to pension, the introduction of the institute of early pensions, as well as the need for harmonization of certain of its provisions with other provisions dealing with particular issues affecting the trends in the field of pension and disability insurance, ensuring equality of military pensioners in respect of exercising the pension and disability insurance after complying with the judgments of the Administrative Court of the Ministry of Labour and Social Welfare and the Pension and Disability Insurance Fund of Montenegro, as well as the improvement of certain solutions.

Seven years after commencement of a comprehensive reform of the pension system in Montenegro, and taking into account all the challenges the pension system is facing, it is time to continue the reform started back in 2003. The challenges which the pension system in Montenegro is facing can be divided into three main groups:

- financial sustainability of the system in the short and long term,
- low activity in the labor market
- negative demographic trends.

Although the pension reform from 2005 had a positive impact on the sustainability of the system in the short-term period, that is it led to a reduction in total expenses of the pension system, it was noticed that under the influence of external shocks, such as the global financial crisis, the pension system was inflexible and could jeopardize its financial viability and sustainability of public finances in Montenegro. Thus, in 2009 pension expenditures increased by approximately 4 percentage points of GDP, from 8.6% to 12.2% of GDP, compared to 2008. Although the projected pension expenditures for 2010 amounted to approximately 10.5% of the projected GDP (excluding expenditures for health insurance retirees who make an average of 1.1% of GDP), execution data indicate that the total expenditure of the pension system could reach 11% of GDP.

Graph 1 Total expenditures of the pension system as a% of GDP



These data suggest that the expenses of pension systemare characterized by unpredictability, since the factors, which affect pension adjustments in accordance with the current legislation, can not be controlled - average earnings and inflation rate. In addition to unpredictability regarding the movement of earnings and inflation, there are doubts about the quality of statistical data, particularly data on earnings, on the bases of which adjustments are done. Adjustment of the level of pensions has the greatest impact on financial sustainability of the pension system in the short term, as well as on its (un) predictability of the most influential right. For these reasons, and in accordance with the prevailing practice in the EU, it is necessary to 'tie' pensions for the inflation, since it would thus manage to maintain the standard of living of pensioners and ensure the adequacy of pensions. Also, if we observe the countries in the region and the European Union, the implementation of the so-called "Swiss" formula in a way that has been implemented in Montenegro, is rare. Adjustment of pensions in the EU can be summarized in three basic models: harmonization with inflation, adjustment with inflation and earnings levels, and the government's decision on the basis of the increase / decrease of revenue.

Among these models, adjustment with inflation is dominant (ten states apply this model - Italy, Belgium, France, Greece, Spain, Ireland, Luxembourg, Poland, Portugal, Romania), where in some countries the adjustment is conditioned by the height of the inflation rate, for example if it it exceeds 2% or 5%.

In addition to the way of harmonization, financial sustainability in the short and especially long-term is highly influenced by the current situation of the labor market, characterized by relatively low activity rate of working-age population, as well as the comparatively low employment rate. Since the activity rate has not changed significantly in over the last 20 years or so, one of the reasons for this situation on the labor market

is a generous social welfare system, including the pension system, considering the fact that about 1/6 of total population of Montenegro are users exercising some rights from the pension protection.

The most important challenge to the pension system, which affects the financial sustainability and the level of activity in the labor market, as well as need for the reform are reported negative demographic trends. Similar to other European countries, Montenegrin population is aging. According to demographic projections of MONSTAT, Montenegrin population will grow, but the aging trend is evident. Accordingly, it is necessary to continue adjusting the pension system to demographic trends, in order to ensure the sustainability of the pension system, as well as providing financial and social security of pension and disability insurance.

The Law on pension and disability insurance does not stipulate rights on the basis of remaining ability (second and third categories of disability), but, in accordance with the principle of the protection of acquired rights and special protection for occupational invalids, it has been stipulated that the beneficiaries of financial compensation in respect of the remaining working capabilities shall continue to exercise this right even after the application of the new law to the same extent. In order to provide gradual transition to the new legislation, Article 22 stipulates, as an interim solution, extension of deadline within which such persons are calculated the period of receipt of the above mentioned into the insurance coverage at the expense of budget funds, i.e. the period of working part-time is calculated as full-time work, until the end 2014.

In accordance with the Law on Amendments to the Law on Pension and Disability Insurance, the Pension Fund has conducted transition of the existing amounts of military pensions to personal points as of 15th August 2007, when they are introduced into the pension system of Montenegro. Dissatisfied with these solutions, a number of military pension beneficiaries entered administrative court proceeding in the Administrative Court, which ordered by its judgements the Ministry of Labour and Social Welfare and the Pension and Disability Fund to apply dinar-euro exchange rate published by the Central Bank of Montenegro when transiting "the existing amount of" personal pensions to personal points for the beneficiaries who exercised the right according to military rules applied until 15th August 2007, as well as to apply previous adjustment they were entitled to according to the Law on Yugoslav Army, at the moment of calculation of their "existing amount".

After the Ministry of Labour and Social Welfare and the Pension and Disability Insurance acted in accordance with the Administrative Court decisions, a certain number of beneficiaries was put in an unequal position regarding the exercise of pension and disability insurance rights, and therefore the government, as the body responsible for creating and managing the policy of development of the pension and disability insurance activities, proposed to solve this problem. The proposed decree shall provide the public interest, respect of the principle of equality of beneficiaries who are entitled to insurance under the equal conditions, as well as the equal position of

military pension beneficiaries and other beneficiaries in the pension and disability insurance system.
Also since 2006 Montenegro has legislation that allows the establishment and development of additional private pension insurance systems, as part of a voluntary pension insurance based on individual capitalized savings (the third pillar of the pension system). The Law on Voluntary Pension Funds ("Official Gazette of MNE", no. 78/06 and no. 14/07) was adopted by the the Assembly as of December 2006 and entered into force on 31st December 2006. On the basis of this Law, Commission for Securities issued all by-laws necessary for the establishment and operation of voluntary pension funds. As these by-laws entered into force, the companies for pension funds management were able to begin procedures for obtaining a work permit, and then the procedure of forming a voluntary pension fund.
Up to the present, the Commission has completed procedures for establishing two voluntary pension funds of open type that have already been operating. These are the ATLAS PENSION ad established by the voluntary pension fund PENSION PLUS and MARKET INVEST ad established an open voluntary pension fund MARKET PENSION.
The voluntary pension fund "Pension Plus" had 2040 members as of 6th November 2011, and voluntary pension fund "Market Pension" had 205 members. .

The legislation allows for the establishment of closed pension funds, which are suitable for the establishment and development of professional and supplementary pension insurance, and so it is expected in the near future as part of the third pillar of the pension system.
According to the Law on Voluntary Pension Funds, membership and payment of contributions to the open voluntary pension fund, is not conditioned by residential status in Montenegro, because the open pension fund can be accessed by all individual persons. This means that the fund member who move to another country and remain a member of the open voluntary pension fund, can continue to pay their contributions to the fund under the conditions specified in the agreement on membership.
When it comes to closed voluntary pension fund, the rights and obligations in case of moving abroad shall be determined by the Decision of the employer on the establishment of the pension fund. As it does not contain any restrictions on the payment of contributions, the law provides cross-border payments of contributions in order to facilitate the unlimited exercise of the freedom of movement of workers and self-employed persons.

The minimum amount of contributions to voluntary pension funds is not stipulated by law, but it is determined by the membership agreement between the management company and the fund member.

Article 12, paragraph 4

1) Please describe the general legal framework, in particular provide a complete list of bilateral and multilateral agreements or other means such as unilateral, proposals of regulations, or adopted legislation or administrative measures and indicate the way the application of the principles set forth in subparagraphs a) and b). Is provided, in terms of various social benefits.

Answer provided under paragraph 1. 1

2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.

3) Provide relevant figures, statistical data and other relevant information. In addition, specify the length of stay, should condition related to the length of stay be applicable.

Subject to the provisions as interpreted by the European Committee of Social Rights

*Paragraph 1**:*** Establishment and maintenance of the social security system against the traditional (normal) risks (health, disease, unemployment, old age, occupational injury, family, maternity, disability, and outlive of family member; regulations and persons eligible to the right to social security; social security (contributory and non-contributory) benefits and their adequacy.

Paragraph 2: Maintaining the social security system at a satisfactory level at least to the extent necessary for the ratification of the European Code of Social Security.

Paragraph 3: Upgrading / improvement of the social security system. When reforms cause restrictions in the social security system, such restrictions must be justified, including in terms of sustainability, and must maintain at least basic obligation and social security system wide enough.

Paragraph 4:

a. Equality of treatment of nationals of other Member States who are or were once lawfully or regularly working on the territory of a Member State, in respect of social security benefits; ban of direct (provided at the national level) and indirect (conditions relating to residence and length of stay, provided that the person is employed) discrimination in terms of contributory benefits; the condition according to which the user is not allowed to stay over a certain period, and related to the length of stay, for non-contributory benefits; such as family allowances: refugees and stateless persons, self-employed and those who were sent to work in another Member State, to the exclusion of long-term cases / risks, which continue to be insured in the country of origin are persons to whom this provision applies

The right to hold collective (acquired-binding, addition) rights, irrespective of where the user is located, moving (disability, age, outlive, occupational injurie, illness); obligations

to be observed by means of bilateral agreements or other means, such as one-sided (unilateral), legislative and administrative (administrative) measures;

b. the right to retain the acquired rights (collective) through the addition period of insurance and the length of insurance coverage (work period) acquired abroad, obligations are to be respected by means of bilateral agreements or other means, such as one-sided (unilateral), legislative and administrative (administrative) measures;

ANSWER

The objective of concluding bilateral international agreements on social security is to ensure, on the basis of reciprocity, social insurance rights to the citizens of the parties based on work and residence in one of the contracting countries, which include the right to health insurance, the pension and disability insurance, the right to unemployment benefits, the right to child support and administrative and legal assistance, which is in accordance with the European Code of Social Security
The provisions of Article 9 of the Law on Pension and Disability Insurance ("Official Gazette of RoM" No.54/03, 39/04, 61/04, 79/04, 81/04, 14/07 and 47/07 and Official Gazette of MNE, No.79/08, 14/10 and 78/10) **stipulate** that foreign citizens, stateless persons, have access to pension and disability insurance under the same conditions as the citizens of Montenegro. This means that the law on pension and disability insurance recognizes category of the insured, regardless of the fact whether he is a citizen or a person without a citizenship.
Therefore, the fact that is the basis for mandatory insurance is not citizenship, but employment or other basis for pension and disability insurance (private or agricultural activity) after a foreigner meets the requirements of the regulations on the residence, according to the labor law regulations (or by the regulations on the self-employment). Based on the status of an employee, a self-employed person or a farmer, a foreigner shall acquire all the rights and obligations from social security, including the right to pension and disability insurance, without limitation, in the same manner and to the same extent as those employees who are citizens of Montenegro.
The insured in Montenegro as of June 2012 -Tax Administration of Montenegro data

- employees **157,931**
- self-employed insured **3376**
- insured farmers **1987**

The fact that we particularly underline is that regarding collecting the insurance periods acquired in the country of origin with Montenegrin insurance periods, it shall be applied only to workers who come from the countries which have concluded bilateral agreements with Montenegro, such as bilateral international agreements on social security that Montenegro has concluded with the following countries:.

A. After the independence as of 3rd June 2006, Montenegro has concluded and apply

agreements on social insurance with the following countries:
Republic of Serbia, the Grand Duchy of Luxembourg, the Republic of Hungary, the Republic of Macedonia and Slovenia.

Also, Agreements between Montenegro and the following states have been concluded and ratified: the Republic of Austria, the Kingdom of Belgium and the Swiss Confederation, but have not yet come into force because the other party have not submitted information whether domestic legal procedures, necessary for the entry into force of the agreement have been completed.

B. Agreements concluded by the former Yugoslavia and the State Union of Serbia and Montenegro, which Montenegro has undertaken and implemented on the basis of succession:
Republic of Austria, the Kingdom of Belgium, Republic of Bulgaria, the Kingdom of the Netherlands, the Czech Republic, the Kingdom of Norway, the Federal Republic of Germany, the Republic of Poland, the Kingdom of Sweden, the Republic of France, the Republic of Italy, the Republic of Macedonia, the Republic of Romania, Libyan Džamahiria, the Republic of Croatia, the Kingdom of Denmark, Great Britain, the Swiss Confederation, Bosnia and Herzegovina, the Republic of Turkey.
C. The negotiations for the conclusion of agreements with the following countries are on-going:
- The Republic of Croatia, Bosnia and Herzegovina and the Republic of Turkey
D. Initiative for the conclusion of agreements with the following countries has been launched:
- The Slovak Republic, the Republic of Romania, Greece, the Republic of Bulgaria, the Republic of France, Ukraine and the Republic of Italy.
Conclusion of Administrative Agreement with the Kingdom of Belgium is expected.
Most of these agreements include all types of social security benefits, all of which are based on the principles of gathering period required for entitlement to benefits if there is no individual right to benefits by national legislation (subsidiary application of agreements; also based on the principle of avoiding overlapping rights, equal treatment of citizens of the contracting parties, as well as the preservation of acquired rights and rights to acquire.

This large number of agreements is the result of the Montenegrin interest to protect the rights of its workers employed in foreign countries.

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1 to ensure that any person who is without adequate resources and who is unable to secure such resources either by his/her own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his/her condition;

2 to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

3 to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;

4 to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

Addition to article 13, paragraph 4

Governments not Parties to the European Convention on Social and Medical Assistance may ratify the Charter in respect of this paragraph provided that they grant to nationals of other Parties a treatment which is in conformity with the provisions of the said convention.

Information to be submitted

Article 13, paragraph 1

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.

Answer

The Law on Health Protection has established the priority health care measures that, among other things, cover health care for children and young people by the end of the prescribed regular education, the protection of women in connection with family planning, pregnancy, childbirth and motherhood, for physically and mentally disabled (handicapped persons), raising the level of mental health, treatment and rehabilitation of mentally ill persons who are not otherwise insured, health care (preventive and curative) of people over 65 years of age, as well as emergency accommodation and treatment of persons whose state of health is in immediate danger due to illness or injury.

2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.

3) Provide relevant figures, statistical data and other relevant information, in particular: the evidence that the level of social support is adequate, ie. an assistance should enable anyone to meet their basic needs and level of benefits should not be below the poverty line. Therefore there should be provided

information on the basic benefits, additional benefits and poverty line in the country, which is defined as 50% of the averaged equalized income callculated on the basis of value of risk poverty line published by Eurostat.

Article 13, paragraph 2

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.
2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.
3) Provide relevant figures, statistical data and other relevant information,if appropriate.

Article 13, paragraph 3

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.
2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.
3) Provide relevant figures, statistical data and other relevant information,if appropriate.

Article 13, paragraph 4

1) Please describe the general legal framework. Please specify the nature, reasons in favour of reforms and extent of reforms, if any.
2) Specify measures taken (administrative arrangements, programmes, action plans, projects, etc.) for the application of legal framework.
3) Provide relevant figures, statistical data and other relevant information,if appropriate.

Subject to the provisions as interpreted by the European Committee of Social Rights

Paragraph 1: Social assistance – appropriate benefits shall be payable 'to any person' on the sole ground that he/she is in need. The assistance is considered to be appropriate if it enables any person to meet his/her own needs, i.e. the amount of assistance benefits is not below the poverty treshhold. Medical assistance – everybody who lacks adequate resources must be able to obtain free of charge ' in the event of sickness the care necessitated by his/her condition'.

The right to assistance shall be individual, stipulated by the law and supported by an effective right of appeal to an independent body.

Paragraph 2: Persons receiving assistance must not suffer as a result any diminution of their political or social rights. Any discrimination against persons receiving assistance that might result from an expressed provision must be eradicated.

Paragraph 3: Providing appropriate public or private services such as advice or individual/personal help to persons without adequate resources, which may be required to prevent, remove or alleviate personal or family want.

Paragraph 4: An emergency social or medical help for everyone who is lawfully or unlawfully present (but he/she is not a resident) in the stated territory. Member States are required to provide for those concerned to cope with an immediate state of need (accomodation, food, emergency care and clothing).

Law on Social and Child Protection ("Off. Gazette of RoM", No. 78/05) stipulates the basic rights to social protection and basic rights of the child protection system, which protect financially and medically vulnerable individuals and families in accordance with the State possibilities. The following laws have been passed in the field of social welfare, the Law on Privilege to Travel for Persons with Disabilities ("Official Gazette of MNE", No. 80/08), Law on the Movement of Persons with Disabilities with the Help of a Trained Dog ("Official Gazette of MNE", No. 76/09), and the Law on Prohibition of Discrimination of Persons with Disabilities ("Official Gazette of MNE", No. 39/11).

‘ The following strategic documents have been adopted: the Strategy for the Social and Child Protection Development in Montenegro for the period 2008-2012, Development Strategy of Protection of the Elderly 2008-2012, the Strategy for the Integration of Persons with Disabilities in Montenegro 2008-2016, the Strategy for Protection against Domestic Violence 2011 -2015, Development Strategy of Foster Care in Montenegro, with the Action Plan for the period of 2012-2016. Activities in progress include the creation of the National Plan of Action for Children, which will present a comprehensive study of planning strategic objectives in all areas of life regarding the protection of children

Ministry of Labour and Social Welfare, in collaboration with the Ministry of Education and Sport and its partner organizations UNDP and UNICEF, has nominated the Project "Reform of Social and Child Protection: Improvement of Social Inclusion" to the Delegation of the European Commission, for which funds have been provided under the IPA 2010 Fund, in the amount of 3 million euros. The implementation of of this project will produce long-term and sustainable solutions for the social welfare and education systems in Montenegro

The project consists of three components: the First component of the project includes activities related to the inclusion of Roma children and children with special needs in the education system and its implementation is the responsibility of the Ministry of Education and Sports. The implementation of the second and

third component of the project shall be coordinated by the Ministry of Labour and Social Welfare, with full technical and administrative support tof the UNICEF and UNDP.

The Component 2, conducted by the UNDP in collaboration with the Ministry of Labor and Social Welfare, provides activities to be implemented at national and local level. Activities required to strengthen the capacity of the Ministry of Labour and Social Welfare in the field of planning, directing and managing the processes of decentralization and the establishment of social services at the community level (such as day care centers for people with disabilities, the elderly, social enterprise etc..), and that respond to the needs of vulnerable people, will be implemented at the national level. The objective of Component 3, conducted by the UNICEF in collaboration with the Ministry of Labor and Social Welfare, is to facilitate the access of vulnerable families to overall, inclusive and sustainable services, based on family and community, as an alternative to institutionalization of vulnerable children.

The main activities under Component 3 will be directed towards the establishment of political, legal and institutional framework to support the vulnerable and excluded children and their families in exercising their rights. The activities can be divided into three components:

The adoption of the new Law on Social and Child Protection in accordance with international standards is predicted within the sub-components of "political, legal and institutional framework", as well as the drafting of bylaws that will support the new law.

Within the sub-component "Building and prevention of institutionalization of children", the capacity of the social welfare sector will be strengthen through the reorganization of performance of the local centers for social services, which will include the provision of training on case management and family counseling. In addition, it will strengthen the capacity of the health sector to support vulnerable mothers in order to prevent the separation from a child and placement in institutions. Besides, support will be provided to the education sector by strengthening the capacity of the Commissions for the assessment and guidance of children with disabilities into the education system

By the implementation of sub-component "Alternative services in family and community," all the children residing in the Institute Komanski most will be de-institutionalized, as well as the percentage of children living in the institution "Mladost" Bijela. Also, two small group homes will be established, and the network of day care centers for children with disabilities will be improved. The foster care will be promoted through the National Strategy on Fostering, as well as by creating programs for the identification and recruitment of foster families. Finally, an extensive campaign on the reform process will be conducted, along with the media campaign "Every child is in need of a family."

The Government of Montenegro passed the Draft Law on Social and Child Protection as of January 26th, 2012. The adoption of the Law is planned for the second

quarter of 2012. The reasons for the adoption of this law are comprised in compliance with international standards and commitments overtaken by ratifying international agreements, above all those relating to the guarantee of human rights and freedoms and the rights of the child.

Decisions implemented by the adoption of the new Law include, among other stimulating the development of various services and the implementation of new services of social and children's care in the community and the involvement of as many different participants as possible in the provision of services. The Law has extended and specified number of services including: assessment and planning, support for community living, counseling and therapy, social and educational services, accommodation and urgent reaction. The Law stipulates the minimum standards for the provision of social care. Minimum standards enable the unified manner of the services' development and provision on the territory of Montenegro. This means that the service in all the places of provision, must meet the same minimum standards. Standards are the basis for the introduction of a licensing system for providers. Standards also give incentive to improving the offer and quality of all the services for beneficiaries. The Law stipulates the inspection supervision of performance, realized by social and child care institution and other service providers, through inspectors in social and child care, in order to establish better control in the field of social and child welfare.

The Law on Social and Child Protection stipulates that social and child care shall be performed by social and child care institution. It may be established as a public or a private institution. Certain jobs of social and child care can also be performed by other types of organizations, as well as individuals, in accordance with the Law. Ten Centers for social services have been organized In order to carry out social and child care, with departments that cover all twenty one municipalities in Montenegro. In addition to the Centers for social services, six facilities for accommodation of beneficiaries have been organized, in order to accommodate the following categories: children without parental care (1 facility), the elderly and adults with disabilities (2 facilities), children with behavior disorders (1 facility), people mentally disordered (1 facility), and for resting and recreation for children and youth (1 facility). Day care centers have been established for children and youth with disabilities and special needs in accordance with the Strategy for the Integration of Persons with Disabilities for the period 2008 - 2016. Day care centers are being established with the help of the Government and the NGOs. So far, five day care centers have been opened in Bijelo Polje, Pljevlja,Niksic, Herceg Novi, Ulcinj and Plav, and activities have been undertaken on opening day care centers in other local communities, as well. Beneficiaries' accommodation is financed from the state budget, for those who are unable to cover the accommodation costs. According to the Law on Social and Child Care, the costs of accommodation and transport for children with disabilities who attend educational institutions under special regulations shall be paid. In the field of education, three institutions for education of children with disabilities have been established.

Centres for Social Services are the authorities responsible for the exercising rights in social and child care at the first instance of administrative proceeding. The Ministry of Labour and Social Welfare shall make decisions in proceedings on appeal, as the second instance body. Administrative Court of Montenegro decides upon the complaint to the second instance decision. Beneficiaries may contact the Ombudsman for human rights and freedoms regarding the protection of their rights, in accordance with regulations.

Rights under the Law on Social and Child Protection can be exercised by Montenegrin citizens residing in the territory of Montenegro. Foreign citizens and stateless persons may exercise the rights on social and child care as stipulated herein, in accordance with international agreements and conventions.

The above mentioned Law stipulates that all the citizens shall be equal in exercising social and child care, regardless of their nationality, race, sex, language, religion, social origin, or other personal characteristics.

According to Law on Social and Children Care, basic rights on social protection include:

1. family allowance, the amount of compensation for the family without income per month is:

- for a single-member family €63.50€
- for two-member family €76.20
- for three-member family €91.50
- for four-member family €108.00
- for a family of five or more members €120.70

Number of families beneficiaries as of April 2012 was 14 451, with 43 954 members

2. Care and assistance of another person amounts to €63.00 and the number of beneficiaries in April 2012 was 7,693

3 Personal disability benefit amounts to € 108.80, and the number of beneficiaries in April 2012 was 1,714.

4 Foster care for children is €200,00 with a € 60,00 payable to person with whom the child is placed and the number of beneficiaries in April 2012 was 392.

5 The right to health care is provided to a beneficiary : of material support, personal disability, placement in an institution or in another family, if this law is not exercised on any other ground. The right is exercised by 1980 persons.

6. A family or an individual who, due to special circumstances affecting the housing, financial and health status, finds himself in need of social assistance may be entitled to the right to one-time financial assistance.

The basic rights arising from child care:

1. Children allowance, the amount of compensation:

- for beneficiary of financial provision € 19;
- for those with physical, mental or sensory disability, who can be trained to live and work independently € 25.50;

- for those with physical, mental or sensory disability, which can not be trained to live and work independently € 31.80;
- for children without parents € 30.25;
The number of families is 10,716 with total of 20,606 children.
2. Allowance for a newborn child is paid once and amounts to € 105, the number of beneficiaries is 477.
3. Compensation based on the child's birth for a person who is registered with the State Employment Agency and for a full-time student is € 26.20 per month. The number of beneficiaries is 3,099.
4. Refund of earnings reimbursement on the ground of maternity leave. The employer pays the employee earnings compensation in the amount of compensation of earnings that an employee makes in the workplace. The employer can realize refund of the fee paid to an employee by the competent center for social service. In April 2012 this right was used by employers for 1863 mothers.
5. The right to rest and recreate is entitled to a child of a family allowance beneficiary and a child placed in an institution or in another family, in order to practice sports and recreational, cultural, entertainment and educational activities, by referral to a facility for recreation of children. During the period 2010-2011, this right was used by 2,600 children in 7 day duration shifts. Also, rest and recreation for 500 children was provided during the winter season. During the winter in 2011 this right was used by 600 children.

Children from families of family allowance beneficiaries, children without parental care and children of parents casualties in the 1991-92 war, who attend the first three grades of primary school, have been provided for funds of € 40 for the purchase of textbooks, for 3,667 children in the total amount of € 146,680.

In order to protect the most vulnerable groups, the Government adopted a new Program for subsidies of the electricity bills for to the most vulnerable categories of population in April 2012.

Article 14 – The right to benefit from social welfare services

Law on Social and Child Protection specifically protectes: those unable to work and without financial security, children without parental care, children with physical, mental or sensory disability; abused and neglected children, children with behavioral disorders; persons with disabilities, elderly; individuals and families who due to special circumstances require an appropriate form of social protection.

The Law on Social and Child Protection stipulates that social and child protection shall be performed by a social and child care institution. It may be established as a public or a private institution. Certain jobs of social and child care can also be performed by other types of organizations, as well as individuals, in accordance with the Law. Ten

Centers for social services have been organized In order to carry out social and child care, with departments that cover all twenty one municipalities in Montenegro. The Centres employ 290 professional and administrative staff. In addition to the Centers for social services, six facilities for accommodation of beneficiaries have been organized, in order to accommodate the following categories: children without parental care (1 facility), the elderly and adults with disabilities (2 facilities), children with behavior disorders (1 facility), people mentally disordered (1 facility), and for resting and recreation for children and youth (1 facility). Day care centers have been established for children and youth with disabilities and special needs in accordance with the Strategy for the Integration of Persons with Disabilities for the period 2008 - 2016. Day care centers are being established with the help of the Government and the NGOs. So far, five day care centers have been opened in Bijelo Polje, Pljevlja,Niksic, Herceg Novi, Ulcinj and Plav, and activities have been undertaken on opening day care centers in other local communities, as well. Beneficiaries' accommodation is financed from the state budget, for those who are unable to cover the accommodation costs. According to the Law on Social and Child Protection, the costs of accommodation and transport for children with disabilities who attend educational institutions under special regulations shall be paid. In the field of education, three institutions for education of children with disabilities have been established.

Service of accommodation in a social and child protection institution shall be exercised by institutional care and ensuring the accommodation allowance. Accommodation is realized as a daily, temporary, casual or permanent. The right to placement in an institution shall be given to: a child without parental care and children whose development is hindered by family circumstances, up to the completion of regular education in high school, but no longer than six months after graduation; children and youth with physical, mental or sensory disability; a child with behaviour disorders; individuals with physical, mental or sensory disability, who, due to housing or health, social or family life, can not be provided protection in other ways; adult disabled person and old person who, due to housing or health, social or family life, can not be provided care in any other way.

In the field of social and child welfare, following institutions have been established dealing with the issue of accommodation: Public Institution for children and youth without parental care and children whose development is hindered by family circumstances (140 beneficiaries), Public institution for children and youth with behavioral disorders (20 beneficiaries), Public Institution for people with mental disabilities (120 beneficiaries). Public Institution for rest and recreation, the right to annual benefits in 2600 children, Home for the Elderly "Grabovc" Risan "(about 270 beneficiaries) Home for the Elderly in Bijelo Polje (120 beneficiaries).

The right to accomodation in another family, in addition to the persons who are entitled to placement in a social and child care institution, shall be granted for pregnant women and single parent with a child under three years of age , who is in need of care due to social conditions. Families in which the person is placed are entitled to special reimbursement. Accomodation in another family is exercised by 392 persons.

Beneficiary's accommodation is financed from the state budget, for those who are unable to cover the costs of accommodation.

Centres for Social Services are the authorities responsible for the exercising rights in social and child care at the first instance of administrative proceeding. The Ministry of Labour and Social Welfare shall make decisions in proceedings on appeal, as the second instance body. Administrative Court of Montenegro decides upon the complaint to the second instance decision. Beneficiaries may contact the Ombudsman for human rights and freedoms regarding the protection of their rights, in accordance with regulations. In the exercise of rights to social and child protection, a center will obtain evidence on behalf of an ignorant, or a person with disability, as well as in all other cases where it is deemed expedient and cost-effective.

In addition to the exercise of rights on social and child protection, centers deal with issues of counseling in the field of social and child care and as a guardianship body in family care, according to the Family Law Montenegro. The centers organize professional teams dealing with children with behavioral disorders, children without parental care, domestic violence, family relations, guardianship, adoption, and others. All the citizens are entitled to the right to social services. Social work services include preventive activities, diagnosis, treatment, counseling and therapeutic work. Services are based on the application of technical and scientific knowledge in order to provide professional assistance to individuals, families and community groups in addressing life's difficulties, or assistance in organizing local and other communities to help prevent social problems and mitigate the consequences. Services provided by the center are free of charge.

The Project " Home Care Services" is implemented in collaboration with the Employment Agency and local self-government. In this project, 16 municipalities employ 170 gerontological housewifes, caring for about 1,200 elderly people. It is a model of help at home for the elderly, who can not be provided protection otherwise, primarily reflected in the physical care and social-psychological support to the elderly, with the aim of improving the quality of life in the old age.

Decisions implemented by the adoption of the new Law on Social and Child Protection (in relation to the answer to question 13) include, among other stimulating the development of various services and the implementation of new services of social and children's care in the community and the involvement of as many different participants as possible in the provision of services. The Law has extended and specified number of

services including: assessment and planning, support for community living, counseling and therapy, social and educational services, accommodation and urgent reaction.
The Law stipulates the minimum standards for the provision of social and child care services. Minimum standards enable the unified manner of the services' development and provision on the territory of Montenegro.

Article 23 – The right of elderly persons to social protection

In the area of social protection of the elderly, a series of documents that deal with protection and promotion of the rights of the elderly has been passed: the Law on Social and Child Protection (2005), the Law on Travel Benefits of People with Disabilities (2008), the Law on Ratification of the UN Convention on the Rights of Persons with Disabilities and its Optional protocol (2009), Strategy for Suppression of Poverty and Social Exclusion (2007-2011), the Strategy for Social and Child Welfare (2008-2012) the Strategy of Social Protection of the Elderly in Montenegro (2008-2012).

Law on Social and Child Protection stipulates that all the citizens are equal when exercising the rights on social and child protection, regardless of nationality, race, sex, language, religion, social origin or other personal characteristics. There has not been any objections in the area of social protection, indicating the existence of discrimination against the elderly in terms of age or gender, as well as on the ground of other characteristics (nationality, disability, etc.).

Law on Social and Child Protection stipulates the basic rights of social protection, which, according to prescribed conditions, may be used by the elderly persons as follows: family allowance (the number of the elderly beneficiaries 1,999, 587 men and 1,412 women), disability benefits, care and support of another person, placement in an institution, accommodation in another family, funeral expenses and one-off financial assistance. The elderly provide assistance in the area of counseling. The new Law on Social and Child Protection, the adoption of which is planned for 2012, will enhance the social protection system in the field of protection of the elderly, especially in the improvement of services in this area (daily stay, home care, personal assistance, etc.)..

Enforcement of the right is implemented by competent centers of social services. Ten centers for social service have been established in the territory of Montenegro, which with their departments cover the entire territory of the country, so that these forms of protection are available to all old persons. Also, in the exercise of rights to social and child protection, a center will obtain evidence on behalf of an ignorant, or a person with disability, as well as in all other cases where it is deemed expedient and cost-effective.

The Government of Montenegro adopted the Strategy for Development of Social Protection of the Elderly in Montenegro for the period 2008 – 2012, in November 2007. The Strategy for Social Protection of the Elderly in Montenegro aims to achieve better

protection of older persons in all areas of life, respecting the principles established by the European Union in the fight against social exclusion.

The strategy envisages, among other things, that municipalities within their Action Plans shall develop activities for the protection of the elderly in the municipality. Local self-governments in several municipalities in Montenegro are conducting activities on the construction of accommodation facilities for the elderly, which would create the conditions for accommodation and care of the elderly who can not be provided any other form of protection.

Two Nursing Homes for adult-disabled and the elderly people have been established in Montenegro, in Risan (270 beneficaries) and Bijelo Polje (120 beneficiaries). An appropriate institution of social welfare, Public Institution "Komanski Most" in Podgorica (120 beneficiaries), has provided accommodation for the elderly who are mentally disabled and who can not provide accommodation in the family. The Nursing Home "Grabovc" based in Risan, has been working since 1947 as a public institution. Staff structure: one doctor, 37 nurses, 4 gerontology nurses, 3 physiotherapists, 1 social worker, 1 psychologist, 1 occupational therapist, 1 occupational therapist, 1 coordinator of the afternoon shift, 1 BA lawyer, 1 graduate economist and technical services , kitchen, laundry room, tailor's room, hairdressing and other support staff. A Nursing Home provides institutional care to: the elderly, the disabled adults, chronically - mentally ill elderly people and people who find themselves in a state of acute social needs. Caring includes: complete care and health care for individuals living in the dormitory, complete professional and social counseling, legal advice and assistance in administrative - financial matters that are of the user's concern. Each beneficiary in the facilities for accommodation is provided an individual plan of care by an expert team, which is periodically reviewed and adjusted to the changes.

Center for Social Service, as a guardianship body pursuant to the Family Law of Montenegro, provides protection to the elderly in the area of custody, in order to protect their status and property rights and interests. The Law on Local Self-Government lays down the responsibilities of municipalities that, in accordance with financial possibilities, shall solve housing issues of beneficiaries of social protection and persons with disabilities.

The Ministry of Labour and Social Welfare is implementing The Project " Home Care Services" in collaboration with the Employment Agency and local self-government. In this project, 16 municipalities employ 170 gerontological housewifes, caring for about 1,200 elderly people. It is a model of help at home for the elderly, who can not be provided protection otherwise, primarily reflected in the physical care and social-psychological support to the elderly, with the aim of improving the quality of life in the old age. A pilot project related to daily stay of the elderly is implementing in collaboration with the Centre for Social Welfare and UNDP in the municipality of Niksic.

In addition to statutory rights, the Government of Montenegro is conducting a program of subsidizing for electricity consumers. The program includes a group of beneficiaries of social protection rights. The program also encompasses the elderly, who are beneficiaries of social protection rights: family allowance, care and support of another person, disability benefits and accomodation in another family.

In addition to the State, the Law on Social and Child Protection gives the opportunity to municipalities and other legal entities or individuals to deal with forms of care of the elderly.