TOWARDS EQUAL ACCESS TO HEALTH SERVICES IN SERBIA

By: Vesna Bjegovic-Mikanovic, Milena Vasic, Dejana Vukovic, Janko Jankovic, Aleksandra Jovic-Vranes, Milena Santric-Milicevic, Zorica Terzic-Supic and Cristina Hernández-Quevedo

Summary: Serbia has a comprehensive universal health system with free access to health care, but there are inequities in the utilisation of health services. Some vulnerable groups, such as those living in poverty or Roma people in settlements, have more barriers in accessing health care. Financial constraints are the main reason for unmet needs, in particular for the less educated and the poorest. Although citizens are generally satisfied with public and private health care services, a significant number of patients are on waiting lists. Therefore, reaching equal access to health services should be one of the leading health policy goals.

Keywords: *Universal Health Coverage, Health Inequalities, Financing, Serbia*

Vesna Bjegovic-Mikanovic is Full Professor, **Dejana Vukovic** is Full Professor, **Janko Jankovic** is Professor, **Aleksandra Jovic-Vranes** is Professor, **Milena Santric-Milicevic** is Professor and **Zorica Terzic-Supic** is Professor, Centre School of Public Health, University of Belgrade, Belgrade, Serbia; **Milena Vasic** is Associate Professor, Institute of Public Health of Serbia "Dr Milan Jovanovic Batut", Belgrade, Serbia; **Cristina Hernández-Quevedo** is Research Fellow, European Observatory on Health Systems and Policies, London School of Economics and Political Science, London, UK.
Email: bjegov@med.bg.ac.rs

Introduction

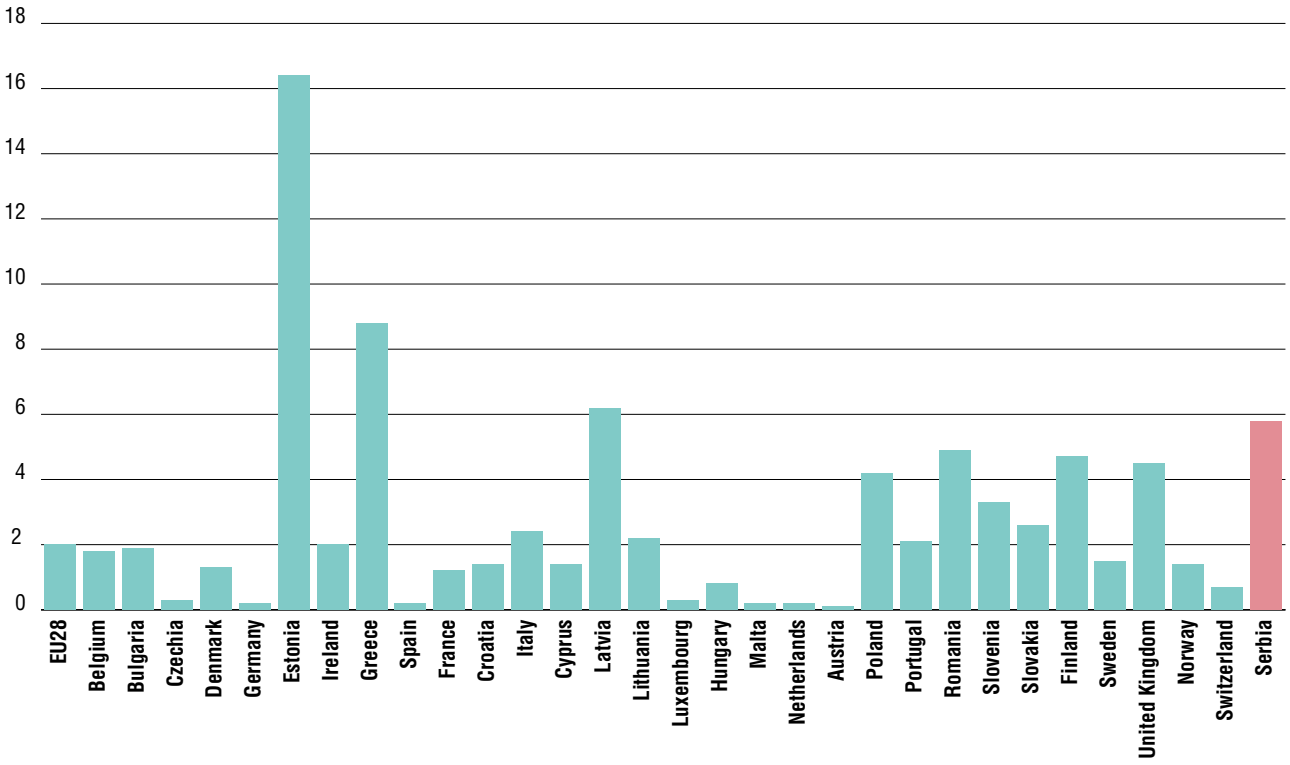
Access to health care and persistent inequalities in health due to socioeconomic conditions are key policy issues faced by countries in the WHO European Region. There is increasing concern that progress regarding health systems' performance has reversed in some countries because of the economic crisis, and reducing inequalities in health and inequities in access remains high on the political agenda.

Serbia is no exception. Since 2000, significant progress has been made in the development of health policy in the country, and this has translated into favourable trends in health status and morbidity rates, such as a decrease in the incidence of tuberculosis and an increase in life expectancy at birth (although it remains five years below the average across European Union (EU) countries).[1,2] However, barriers to health care remain, which increase inequalities in health status across socioeconomic groups.

Financial barriers to access persist and good health is enjoyed by the better-off

Serbia has a comprehensive universal health system with free access to health care services at the primary level. There are, however, inequities in the utilisation of health services, with some vulnerable groups such as people living in poverty, and Roma people in settlements, experiencing more barriers in accessing adequate care. In 2018, 5.8% of the Serbian population reported unmet needs for medical care due to cost, travel distance or waiting lists, well above the EU28 average of 2.0% and much higher than in neighbouring countries such as Bulgaria (1.9%), Croatia (1.4%), and Hungary (0.8%), but closer to those reported in Romania (4.9%) (**see Figure 1**).

Figure 1: Self-reported unmet needs for medical care in EU countries and Serbia (due to cost, travel distance or waiting lists) in %, 2018



Source: [2]

> Some vulnerable groups have more barriers in accessing adequate care

Financial constraints are reported to be the main reason for unmet needs for medical care, with those with lower educational attainment and the poorest being more likely to report them. The percentage of people that forewent medical care due to lack of financial resources in 2018 was higher in Serbia (3.1%) than the average across EU Member States (1.0%) and in neighbouring countries.[2] According to the latest National Health Survey in the country, in 2013, women (33.1%), the lower educated (35.9%), and the poorest (40.1%) were significantly more likely not to be able to meet their health needs.[3] Additional analysis is needed to estimate other obstacles in addressing unmet needs for medical care (i.e. geographic, cultural and informational).

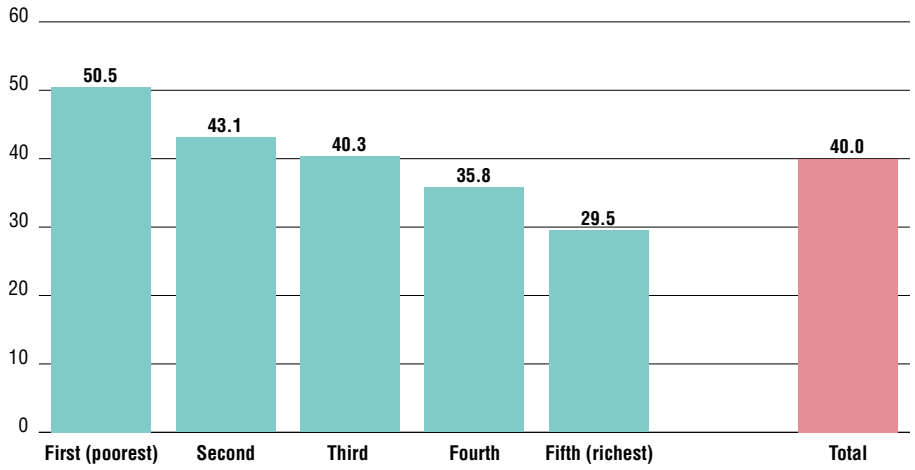
Long waiting times also impede the accessibility of health services in Serbia. Although the National Health Survey (2013) shows that citizens are generally satisfied with public and private health care services, a significant number of patients who underwent treatment in 2013 had to go on a waiting list.[3]

Regarding health inequalities, several studies show a clear association between sociodemographic determinants and health status in Serbia, and they confirm the existence of socioeconomic inequalities in morbidity.[4,5] Compared to people with higher levels of education, the lower educated have a 4.5 times higher chance of reporting poor health status. The unemployed, economically inactive individuals, and the most deprived people are also more likely to report poor self-perceived health than employed persons and those in the highest income group.[4] Women, people with basic or lower levels of education and those in the lowest wealth index quintile are more likely to report having a chronic disease or long-standing health issue (**see Figure 2**). The high prevalence rates for chronic disease risk factors such as smoking, alcohol consumption and hypertension are concentrated among men, individuals with low income and people with lower educational level, which contributes to health inequalities.[3]

National initiatives have targeted health inequalities and access to the health system

Recent reforms aimed to improve the performance of health care institutions in Serbia in order to address regional inequalities and disparities in the accessibility of health care services.[1] The main reform in service delivery introduced the concept of the "chosen doctor" in primary care in 2005 with the Health Care Law, which was further supported by the 2019 Health Care Law. The "chosen doctors" are general practitioners (GPs) or specialists in general medicine, specialist paediatricians, specialist gynaecologists, and dentists.

Figure 2: Population in Serbia who reported having some long-term disease/health problem by wealth index quintile (%), 2013



Source: [3]

Box 1: Interventions to improve health and access to health care for the Roma population in Serbia

Roma in Serbia are more than twice as likely as non-Roma to report poor health.[5] Infant mortality and under-five mortality rates in Roma settlements (12.8 and 14.4 per 1,000 live births in 2014[7]) are more than two times higher compared to the national average in 2018 (5 and 5.5 per 1,000 live births).[8] Also, smoking prevalence among Roma is higher than in non-Roma communities. A study conducted in 2010 by the United Nations Population Fund among 1,000 respondents living in Romani settlements showed that 53.8% of Roma are smokers, which is significantly higher than in the general population (34.7%).[9]

In the field of health, interventions to reduce inequalities are directed to reducing the differences in general health conditions between the Roma and the rest of the population through: a) the provision of quality health care to Roma, especially to children and women, of preventive care and social services under the same conditions under which they are available to the rest of the population; b) the inclusion of qualified Roma in health programmes (Roma health mediators) that affect their community, wherever possible (based on the Strategy for Social Inclusion of Roma for the period 2016–2025).[10] The introduction of Roma health mediators responsible for linking Roma with primary health care providers presents an example of good practice in Serbia. The impact of this intervention is already visible in the reduction of infant and under-five mortality in the Roma population.[11] Furthermore, the life expectancy of Roma has improved, vaccination coverage among children has been increased and the majority of Roma men and women have been covered by mandatory health insurance.

The reform process also facilitated the set-up of counselling services both for vulnerable groups of the population and specific diseases such as diabetes. In practice, counselling services addressed a range of health risks and behaviours (e.g., nutrition, physical activity, substance use, prevention, mental health).[1]

National initiatives aiming to identify and reduce inequalities in health in Serbia started with the adoption of the 2003 Poverty Reduction Strategy. The main goal of this intersectoral strategy was to reduce poverty by half between 2003 and 2008.[6] In 2009, the government established the Social Inclusion and Poverty Reduction Unit (SIPRU) mandated to strengthen government capacities to develop and implement social inclusion policies based on good practices in Europe. The SIPRU provides support to the government to coordinate, monitor and report on efforts in the field of social inclusion. Successful interventions to reduce health inequalities have been implemented, including social welfare and health (particularly for vulnerable groups, i.e., Roma, people living with disabilities, migrants, and people living in poverty), education, economic development and employment, and human rights (for details see: http://socijalnoukljucivanje.gov.rs/en/).

The European integration process – the main mechanism for leading a dialogue on the priorities of Serbia in the field of social policy and employment – is contributing to the reduction of inequalities in health.[6] However, although the formal start of Serbia's EU accession negotiations was on 21 January 2014, Chapter 28 on health has still not been opened in the negotiation process. The Employment and Social Reform Programme (ESRP) was officially launched in September 2013 by the government and covered the issues of the labour market and employment, human capital and skills, social inclusion and social welfare, and pension and health systems, with a specific focus on tackling high youth unemployment. More recently, the most relevant cross-sector strategies which tackle social inclusion and, hence, inequalities are the 2013 Strategy for Prevention and Protection against Discrimination, the 2016 Strategy for Social Inclusion of Roma for the period 2016–25, and the 2009 National Strategy for Improving the Position of Women and promoting Gender Equality.[1] Successful interventions linked to the Roma population in Serbia have also been implemented (**see Box 1**).

Improvements in prevention may lead to better performance of the health system

The leadership and governance of the health system are focused on improving health and reducing health inequalities in the Serbian population.[12] For that purpose, all self-government authorities in Serbia (158 in total) are expected to establish municipal health councils as multidisciplinary bodies to support

health.[13] This policy has recently been adopted (2018) and its implementation is pending.

Broad, comprehensive, health promotion and disease prevention strategies take into consideration the many risk factors and determinants of ill health, which disproportionally affect already vulnerable groups, often leading to cases of multiple and cumulative disadvantages. In other words, health inequalities are an important dimension of prevention and promotion; it remains a fundamental objective for targeted strategies to tackle health inequalities and under no circumstance exacerbate them.[14]

> National initiatives are in place to increase access to the health system

In the area of preventive services, while investments supported by European projects have improved cancer treatment, national screening rates are still very low. The problem appears to be that the level of investment in organised screening programmes is still too low, and consequently, implementation and response remain insufficient. Stepping up prevention efforts to deal with lifestyle factors such as tobacco use, alcohol consumption and obesity will also be essential going forward to help improve health more generally and to contribute to reducing health inequalities.

Conclusions

Serbia has a comprehensive universal health system with free access to health care services at the primary level, but inequities in the utilisation of health services persist, with vulnerable groups being disproportionately affected. Financial constraints are the main reason for unmet needs for medical care, which are reported more frequently by the lower educated and the poor. Although citizens are generally satisfied with public and private health care services in the country, waiting lists challenge their prompt access to health care.

It is expected that Serbia will continue to develop policies focused on reducing barriers to accessing health care and improving the efficiency of the health system, supported by international organisations and in the context of Serbia's continuing EU accession negotiations.

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