Keywords

DELIVERY OF HEALTH CARE
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MONTENEGRO
The Health Systems in Action series

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• provide core information and data on health systems succinctly and accessibly
• outline the country health system context in which WHO’s European Programme of Work is set
• flag key concerns, progress and challenges health system by health system
• build a baseline for comparisons, so that Member States can see how their health systems develop over time and in relation to other countries.

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The Insights follow a common template that provides detailed guidance and allows comparison across countries. The series is publicly available on the websites of the WHO Regional Office for Europe and the European Observatory on Health Systems and Policies (eurohealthobservatory.who.int).

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Acknowledgements

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This edition of the Health Systems in Action Insight for Montenegro was written by Ilaria Mosca, Natasa Terzic and Florian Tille.
HEALTH SYSTEMS IN ACTION: MONTENEGRO

Key points

- In 2022, Montenegro switched to a fully tax-funded health insurance system.

- Revisions to the health insurance law in 2017 made residency an additional basis for entitlement to health benefits, extending population coverage to close to 100%.

- Out-of-pocket payments are high, accounting for 39% of current spending on health in 2019, and almost 10% of all households experienced catastrophic health spending in 2017.

- Most out-of-pocket payments are for outpatient medicines and dental services, but informal payments for health services also exist. However, the country has made progress in reducing unmet needs for medical examination.

- Montenegro lacks an operational monitoring and evaluation system. To date, data collection is fragmented, statistics are often not publicly available, and data are not sufficiently used for decision-making purposes.

- The limited scope of primary care providers in risk detection, smoking cessation and mental health services is one of the reasons for high referral rates to specialist services, even for conditions that could be easily addressed in primary care.

- Montenegro suffers from outmigration of health professionals. Important push factors are low earnings, lack of protocols and work standards, underdeveloped continuous medical education, and provider payment mechanisms that are not linked to performance and quality of care.

- Coverage of routine vaccination for children has generally declined over the past 10 years. The COVID-19 pandemic has disrupted vaccination programmes, and many other health services.

- Noncommunicable diseases (NCDs), such as stroke, ischaemic heart disease, lung cancer and cardiomyopathy (disease of the heart muscle), are the main drivers of death and there is limited access to prevention activities both within and outside the health sector.

- Unhealthy diets, tobacco and alcohol consumption, and relatively poor air quality are the main public health threats in Montenegro, leading to premature deaths. Factors outside the health sector – poverty and unemployment – contribute to ill health and unmet needs.

- The COVID-19 pandemic led to substantial excess mortality, exceeding the WHO European Region average.

- Montenegro has a well-developed AMR action plan, but rates of antimicrobial consumption are high.

This report looks at the action Montenegro is taking to strengthen its health system; to achieve the Sustainable Development Goals; to address the priorities of the European Programme of Work; and to ensure that no one is left behind.
ORGANIZING THE HEALTH SYSTEM

Montenegro’s publicly funded health system is highly centralized

The Ministry of Health is the primary administrative, regulatory and governing authority in the health sector. The Health Insurance Fund (HIF) is the single purchaser of health services. The Institute for Medicines and Medical Devices is responsible for pharmaceutical policy. Health services are provided through the network of publicly owned health facilities and contracted private facilities. The network of certified providers aims to ensure equal geographical access to health care.

The main documents regulating health care are the Health Care Law (2021) that stipulates that everyone has equal access to health care; the Health Insurance Law (2021) that sets out that everyone has the right to health services under statutory health insurance; and the Master Plan for the Development of the Health System in Montenegro 2015–2020 that defines the strategic priorities for health.

The Health Care Strategy 2022–2026 that is currently being developed has three key objectives: moving towards universal health coverage (UHC), protecting against health emergencies, and promoting health and well-being – reflecting the priorities of the WHO European Programme of Work 2020–2025 (WHO, 2021a).

In 2015 Montenegro adopted the 2030 Agenda for Sustainable Development with the 17 Sustainable Development Goals (SDGs), with health being at the heart of the development agenda, reflecting today’s interlinkages of health, development and the economy.

The health system is largely centralized, without substantial involvement by local self-government in health service provision and planning.

Montenegro’s strategic plans emphasize the role of primary care

The Master Plan for the Development of the Health System 2015–2020 emphasized the important role that primary care plays in improving population health and lowering health costs. In practice, however, primary care is not being exploited to its full potential (WHO, 2020). High use of hospital services and payment mechanisms not linked to performance limit the potential of primary care.

Health care providers are predominantly public. Primary care services are delivered by the “chosen doctors” (family medicine specialists, medical doctors, paediatricians, gynaecologists, general or emergency medicine specialists, internists, dentists or occupational medicine specialists). The chosen doctor acts as the main entry point to the health system. There are 18 primary health care centres (called dom zdravlja) in Montenegro that deliver primary care services and other services provided by support centres (diagnostic and prevention centres, home visits and patient transport units, centres for lung diseases and tuberculosis, mental health...
centres, centres for children with special needs, day care centres, and primary level physical therapy units).

Access to publicly funded secondary care requires a referral from the chosen doctor. However, people often bypass primary care through the emergency department of the clinical centre. The current model of primary care and payment mechanisms of the chosen doctors and nurses is conducive to referrals to specialist services, even for conditions that could be easily addressed in primary care, such as pneumonia; angina; chronic obstructive pulmonary disease (COPD); ear, nose and throat infections; diabetes complications; and hypertension. This is in contrast to the government’s ambition since 2005 that primary care should be organized to meet up to 85% of the population’s health needs (Government of Montenegro, 2022).

Montenegro switched to a fully tax-funded health insurance system in 2022

Montenegro has made major progress towards UHC by increasing the share of the population that is entitled to publicly covered services. Since revisions to the health insurance law in 2017, population coverage increased from about 95% to almost 100%, as residency became an additional basis for entitlement to health benefits. Since 1 January 2022, financing of health services has changed from a combination of payment of insurance contributions and government transfers to fully tax-based funding. However, the practical implementation of this new funding model still lacks clarity at the operational level and there are concerns on the long-term financial sustainability of the current health financing system that appears to lack a sound fiscal space analysis.

The benefits package is relatively comprehensive but out-of-pocket payments are high

The basic benefit packages for primary (2005) and secondary and tertiary health care (2013) define the benefits people are entitled to, together with positive lists of medicines and medical products. Publicly funded health services are delivered by public facilities that are part of the health network and private facilities contracted by the HIF. Coverage of health services has expanded over time. Patients pay (part of) some services out of pocket, particularly for outpatient medicines and dental services. Dental care in primary care is not covered for most adults. People (unless exempted, such as children, older people or patients with chronic conditions) pay a fixed co-payment (€0.36) for each prescription for outpatient medicines, as well as the price difference (varying from 5% to 48%) between the Basic List of Medicines and the Supplementary List of Medicines, which was introduced in 2018 and includes therapeutic alternatives to medicines from the basic list to increase people’s choice of alternatives. Outpatient visits are subject to percentage co-payments (20% in primary care and 40% in secondary and tertiary care).

Public spending on health is in line with the South-Eastern European average

In 2019, public spending on health amounted to 5% of Montenegro’s gross domestic product (GDP). This was below the European Union (EU) average (6%), but in line with the average of South-Eastern Europe (SEE) (5%), and above the average for upper-and-middle income (UMIC) countries in the WHO European Region (3.4%) (Fig. 1).

Current public spending on health per person is lower in Montenegro than in SEE overall: US$ 1,207 (adjusted for purchasing power) compared with US$ 1,630 in 2019. Private spending, mostly in the form of out-of-pocket payments, accounted for US$ PPP 765 per person in 2019, which was a larger amount than in the EU and in UMIC countries (Fig. 2).

About 39% of current health spending is paid out of pocket

Out-of-pocket spending as a share of current spending on health fluctuated between 2011 and 2019 (the years for which internationally comparable data are available). In 2019, 39% of current health spending was paid

Box 1

The efficiency of the health system could be improved

In 2019, Montenegro spent 11% of its government budget on health and people also faced high out-of-pocket payments, representing 39% of current spending on health (Fig. 3). This suggests inefficiencies in the organization of health services delivery and in the use of public funds in the health system. In fact, most public funding goes to hospitals and the current model of primary and specialized care is conducive to high rates of people accessing outpatient specialized care. Quality assurance systems and health technology assessment are underdeveloped and payment systems do not incentivize performance and quality of care.
out of pocket, the same level as in 2011 (Fig. 3). The heavy reliance on out-of-pocket payments, and the relatively low level of public spending on health per person, can lead to households becoming impoverished (Fig. 4) and to unmet needs for health and dental examinations (section 4). In Montenegro, cost is the main reason for unmet needs both for health care and dental care.

Informal payments are not monitored but present

There is no monitoring of informal payments for health services. Habibov & Cheung (2017) estimated that about 21% of respondents using publicly funded health services in the preceding 12 months had to pay informally. This share is higher than in neighbouring countries except for Albania (65%). The effects of informal payments in health care are well documented: they are detrimental to accessing health services and can push people into poverty and financial hardship (Stepurko et al., 2015).

**Fig. 3**
Out-of-pocket payments as a share of health spending are higher in Montenegro than in the EU and SEE overall

**Fig. 4**
Share of households with catastrophic health spending by risk of impoverishment and out-of-pocket payments as a share of current spending on health

**Notes:** OOP: out-of-pocket; EU: European Union; SEE: South-Eastern Europe; UMIC: upper middle-income countries in the WHO European Region.

**Source:** WHO, 2022b.
Health financing statistics by level of care should be further disaggregated to help determine opportunities for improvement

In 2019, curative care and medical goods accounted for 42.6% and 8.9% of current health spending, respectively (WHO, 2022b). The share spent on preventive care was only 1.2% in the same year. However, there was a large share of spending (40.9%) not classified elsewhere, suggesting scope for improving health financing statistics.

High out-of-pocket payments lead to high levels of catastrophic health spending, particularly for poor households

The high levels of out-of-pocket payments for health services contribute to catastrophic health spending in Montenegro. In 2017, nearly 10% of households reported catastrophic health spending (Fig. 4), which is particularly problematic for poorer households and can lead to further impoverishment. However, catastrophic spending in Montenegro is lower than in some other countries that have lower levels of out-of-pocket payments.

3 GENERATING RESOURCES, PROVIDING SERVICES AND ENSURING ACCESS

There remains scope for efficiency gains in the hospital sector

Montenegro has seven general hospitals, three specialized hospitals, and the Clinical Centre of Montenegro in the capital Podgorica. Most diagnostic services are provided in hospitals due to high levels of referrals from primary care providers (WHO, 2020).

The number of hospital beds per 100 000 population decreased slightly from 393 in 2008 to 386 in 2019, well below the EU average of 532 in 2019 (Fig. 5). Despite this slight reduction in the ratio of beds, the bed occupancy rate also fell, from 74% in 2012 to 65% in 2019 (Eurostat, 2022). In line with trends in many other European countries, the average length of stay (ALOS) in hospitals declined, albeit slightly, from 9 days in 2015 to 8 days in 2019 (Eurostat, 2022), but this was still among the longest ALOS recorded in Europe. In Montenegro, there seems to be scope for efficiency gains through rationalizing hospital services, shortening the ALOS and making greater use of outpatient services or day care.

The number of doctors has increased, but Montenegro has fewer doctors and nurses than most other countries in Europe

The number of physicians increased from 200 per 100 000 population in 2010 to almost 275 in 2020, while the number of nurses remained relatively stable, at around 480 nurses per 100 000 people throughout the same period (Fig. 6). These numbers are well below the averages of the EU, the WHO European Region and SEE overall.

The relative scarcity of human resources for health in Montenegro is partly due to outmigration, particularly of doctors. Official numbers are not available but estimates from the Medical Chamber of Montenegro and the Montenegrin Trade Union of Physicians indicate that around 7% of all doctors emigrated in the past 5 years. Push factors are higher earnings abroad, lack of protocols and work standards in Montenegro, and the absence of continuous medical education. The COVID-19 pandemic seems not to have halted the outmigration of doctors (Golubovic, 2021).

Montenegro has improved access to essential health services, but lags behind the WHO European Region average

The UHC service coverage index – a global indicator that monitors progress towards SDG 3, target 3.8.1, on coverage of essential health services – increased in
Montenegro scored lower on the UHC service coverage subindex on noncommunicable diseases (NCDs) (51 versus a WHO European Region average of 59 in 2019) and the subindex on service capacity and access (82 versus 93).

Unmet needs for medical and dental examination dropped significantly over time

Since 2013 the share of people facing unmet needs for medical and dental examination has fallen substantially in Montenegro. European Union Statistics on Income and Living Conditions (EU-SILC) data show that unmet needs due to cost, distance and waiting time for medical and dental examination in Montenegro fell between 2013 and 2018, but slightly grew again in 2019. In 2020, 3.1% of people self-reported unmet needs for medical examination (compared with 4.5% in the EU) and 3.3% for dental examination (compared with 4.8% in the EU). The relatively low share of people with unmet needs for dental examination may be due to dental care being publicly financed for children and certain groups of people (pregnant women, people younger than 26 years and older than 65 years, and people with certain medical conditions). Cost is the main reason for unmet needs both for medical and dental examination.
In 2020 unmet needs for medical examination due to cost were higher for poor people than rich people. Income inequality in access to health services is an issue. Unmet needs for dental examination due to cost was about 6.5 times higher for the poorest quintile than for the richest quintile in 2020, while there was almost a twofold difference in unmet needs for medical examination due to cost in that same year. However, the difference was smaller than in some other countries of SEE (Fig. 8).

Coverage for routine childhood vaccinations has declined over the past 10 years and the COVID-19 pandemic has led to further disruptions. The share of children vaccinated against tuberculosis (BCG), polio (POL3), measles (MCV1) and hepatitis B (HEPB3) has declined since 2010. The COVID-19 pandemic has resulted in an even larger drop, particularly for BCG, MCV1 and HepB3 vaccines, with BCG vaccination coverage declining from 93% in 2018 to 67% in 2020 (Fig. 9). Moreover, UNICEF and WHO estimated that by February 2022 only 12% of all children born in 2020 had received the first dose of the vaccine against measles, mumps and rubella. This means that most of these children have not been vaccinated.
are at risk of hospitalization or even death should a measles epidemic break out (UNICEF, 2022).

The COVID-19 pandemic also disrupted all screening programmes, including those for colorectal, breast and cervical cancers. Screening activities stopped at the beginning of the pandemic in 2020, resulting in a coverage rate of only 30% among the eligible population groups (WHO, 2022d) and a general drop in the number of visits to primary care.

4  IMPROVING THE HEALTH OF THE POPULATION

Life expectancy at birth has improved, but a marked difference between the sexes exists

Life expectancy at birth increased from 74.1 in 2000 to 75.6 years in 2009 (Fig. 10). While newer data have not been reported to WHO, according to the National Statistical Office, life expectancy stood at 75.9 in 2020. This was on a par with the average for SEE countries in 2017 and below the WHO European Region average (78 years in 2017).
Although life expectancy at birth has improved, there is still a marked difference in life expectancy between the sexes. In 2020, females lived on average over 5 years longer than males (78.8 and 73.2 years, respectively), although this gap was below the average in the WHO European Region (6.3 years in 2017).

Improvements in perinatal and paediatric care have contributed to a significant reduction of infant mortality

Maternal mortality is comparatively low, declining from an estimated 7 per 100 000 live births in 2010 to 6 in 2017, lower than the averages of the EU (6.3), SEE (11.7) and the WHO European Region (12.7) (WHO, 2022e). Infant mortality is also very low, and decreased from 6 per 1 000 live births in 2010 to 2 in 2020. The decline in infant mortality is partly due to improvements in antenatal, perinatal and paediatric care, with the share of live births attended by skilled personnel at almost 100% (UNICEF, 2021).

NCDs are the leading causes of death in Montenegro

Cancer, stroke and ischaemic heart disease were the leading causes of death in 2009, the latest year for which the country reported data to WHO (Fig. 11). Preliminary national data suggest that circulatory diseases and cancers were still the two top causes of death in 2019.

NCD prevention outside the health sector is limited

However, in Montenegro, preventive strategies for addressing NCDs focus on health service interventions aimed at behaviours, rather than the underlying determinants of behaviour and lifestyles, such as education, work and working conditions, poverty and housing (UN, 2020). Preventing NCDs requires an intersectoral approach involving the health sector and other sectors, with strategies such as increasing taxes on high-sugar beverages, enforcing advertising bans or restrictions on tobacco and alcohol; media campaigns targeting behavioural health risks; and law enforcement.

COVID-19 led to substantial excess mortality

The COVID-19 pandemic presented unprecedented challenges to the health system in Montenegro. The country responded timely and effectively at the beginning of the pandemic by adopting measures such as physical distancing, self-isolation and quarantine. The pandemic had a negative impact on access to health services due to cancellations of regular specialist consultations and elective surgeries, restrictions in movements due to lockdowns, financial barriers linked to loss of jobs, and fear of becoming infected when seeking care (UN, 2020). Estimates of excess mortality indicate rates far above the WHO European Region average (Fig. 12).
Access to health services declined during the pandemic

An opinion survey carried out by the United Nations (UN) in Montenegro found that almost 40% of respondents who sought medical care in the last 6 months did not have their needs met, especially people above 60 years of age. Of the respondents who incurred costs in private medical facilities due to the limited access to publicly funded health services during the pandemic, 63% were not able to pay for their food and utilities (UN, 2021).

Groups of people already at risk were impacted heavily by the pandemic

Vulnerable groups of people were greatly affected by the pandemic. They include victims of gender-based violence who suffered from the so-called “shadow pandemic” that led to the growth of violence against women. The government was slow in recognizing victims of violence as a vulnerable group, delaying assistance and support to victims (UN, 2021). Other groups impacted negatively by the pandemic include the Roma and Egyptian communities and other marginalized groups, in particular those not receiving social assistance (UN, 2021).

Unhealthy diets, tobacco and alcohol consumption are the main public health threats

Behavioural risk factors, including tobacco use, physical inactivity, alcohol consumption and unhealthy diets, all increase the risk of suffering and dying from NCDs. Tobacco use in Montenegro is very high, with an estimated prevalence among people aged 15 years and over of 32.8% in 2020, compared with 25% in the WHO European Region, 29.8% in SEE and 24.7% in the EU. In contrast to almost all other countries in Europe, smoking prevalence is higher among females (33.9% in 2020) than among males (31.6%) (WHO, 2022c).

Total alcohol consumption per person and year for people aged 15 years and above was estimated at 9.9 litres of pure alcohol in 2019, which was down from 10.4 in 2006 but much higher than the 2019 WHO European Region average of 7.8 litres (WHO, 2022c). Alcohol consumption in 2018 was much higher among males (18 litres) than among females (5 litres) (World Bank, 2022).

A 2018 WHO study on health determinants also highlighted dietary issues such as sugar consumption and salt intake as behaviours that should be addressed to reduce NCDs (D’Elia et al., 2019).

Tobacco and unhealthy diets are major risk factors for mortality

Mortality attributable to high systolic blood pressure was estimated to account for almost 34% of all deaths in 2019, with tobacco being the second major risk factor for mortality (Fig. 13). Improved detection and management of biological risk factors and chronic conditions in primary care could go a long way in improving the health status of the population.

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**Fig. 13**
Almost two thirds of deaths are due to high systolic blood pressure and tobacco

<table>
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<td>Tobacco</td>
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<tr>
<td>Dietary risks</td>
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<tr>
<td>High fasting plasma glucose</td>
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<tr>
<td>High body mass index</td>
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<tr>
<td>High LDL cholesterol</td>
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<tr>
<td>Air pollution</td>
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<tr>
<td>Kidney dysfunction</td>
</tr>
<tr>
<td>Alcohol use</td>
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<tr>
<td>Non-optimal temperature</td>
</tr>
</tbody>
</table>

**Notes:** LDL: low-density lipoprotein. Shares overlap and therefore add up to more than 100%.

**Source:** IHME, 2019.
Poverty levels are high, particularly in rural areas

Almost one quarter of the population in 2018 was living below the national poverty line (World Bank, 2022), with people in mountainous and rural areas at greater risk of poverty than those in urban areas (WHO, 2017). It is estimated that more than 45,800 children live below the at-risk-of-poverty threshold, surviving on €2.14 per day. More than 65% of those children do not receive a child allowance (Carraro et al., 2020). The COVID-19 pandemic has exacerbated inequalities and poverty, particularly among already vulnerable groups of people such as children and women; refugees, asylum-seekers and stateless persons; Roma and Egyptian communities; and people with disabilities (UN, 2021).

In 2018, 640 premature deaths were due to relatively poor air quality

Air quality in Montenegro is, according to WHO guidelines, “moderately unsafe”, with an annual mean concentration of PM2.5 of 21 µg/m³, exceeding the WHO-recommended maximum of 10 µg/m³. In 2018, the exposure to high concentrations of PM2.5 caused an estimated 8600 years of life lost to Montenegro’s population and 640 premature deaths (EEA, 2020). The Government of Montenegro is exploring options to use renewable energy sources to reduce air pollution and the dependence on fossil fuels (Spasić, 2021).

WHO has also supported programmes on health promotion and health literacy. The WHO European Food and Nutrition Action Plan 2013–2020 recommends that countries adopt comprehensive salt-reduction strategies and Montenegro has included the goal to reduce salt/sodium consumption in its national nutritional policies. However, it is not clear how far these policies are being implemented and the monitoring and evaluation of national policies is in general underdeveloped.

To address environmental health risks, WHO has supported the ratification of the Protocol on Water and Health, by facilitating a multisectoral national consultation and supporting its implementation.
5 SPOTLIGHT ON ANTIMICROBIAL RESISTANCE

Montenegro is among the countries in Europe with the highest consumption of antibacterials

In 2018, Montenegro recorded the fourth highest antimicrobial consumption rate per capita in the WHO European Region, after Greece, Türkiye and Cyprus. As yet, the country has not met the WHO national monitoring target of at least 60% of total antimicrobial consumption being from the Access category in 2018, indicating the need for stronger antimicrobial stewardship (Fig. 14). Montenegro is part of the CAESAR (Central Asian and Eastern European Surveillance of Antimicrobial Resistance) and the Antimicrobial Medicines Consumption (AMC) network established by the WHO Regional Office for Europe in 2012 and has a well-developed national AMR action plan that was built with relevant data and lessons learned from all sectors.

Rates of antimicrobial resistance are lower in Montenegro than in many other countries in Europe

In 2020, the rate of bloodstream infections due to methicillin-resistant Staphylococcus aureus (MRSA) in Montenegro was lower than the EU/EEA average (Fig. 15). However, as a result of limitations in the data quality, the reported percentages of resistance should be interpreted with caution and are not necessarily generalizable to any one patient presenting with invasive infection in Montenegro, especially patients with community-acquired infections.

Montenegro successfully implemented activities to fight AMR, but involvement of animal health authorities has been limited

Data from the TrACSS survey (2020/21) show that Montenegro has adopted guidelines and practices to assure appropriate antimicrobial use in some health care facilities. Laws and regulations are in place for the

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**Fig. 14**

Montenegro has one of the highest rates of antimicrobial consumption in the WHO European Region

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**Notes:** DDD: daily defined dose; EEA: European Economic Area; EU: European Union. Access, Watch and Reserve (AWaRe) classification system of antibiotics. Access group antibiotics: first- and second-choice antibiotics that should be widely available in all countries. Watch group antibiotics: antibiotics that only should be used for a specific, limited number of indications. Reserve group antibiotics: last-resort antibiotics for cases where other antibiotics have failed or for infections of multi-resistant bacteria. Unclassified group antibiotics: antibiotics which are not yet classified (WHO, 2019b). Countries for which hospital sector data were not included.

**Source:** European Centre for Disease Prevention and Control, WHO Regional Office for Europe, 2022.
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prescription and sale of antimicrobials for human and animal health and on the use of antimicrobials for growth promotion. However, no AMR training for veterinarians and veterinary paraprofessionals, farming (animal and plant), food production, food safety and the environment sectors are currently available. There is no national monitoring system for animal health, unlike human health with records of antimicrobials sales and use.

The COVID-19 pandemic hampered the development and implementation of the AMR National Action Plan

As a result of the COVID-19 pandemic, government funding to address AMR was reduced, the AMR National Action Plan Committee meetings were deferred, and awareness campaigns were postponed. Montenegro, however, developed timely guidelines for the treatment of COVID-19 patients in primary care to reduce antibiotic use and educational seminars were organized to achieve good compliance with guidelines.

6 EUROPEAN PROGRAMME OF WORK (EPW)

Moving towards universal health coverage

The WHO Regional Office for Europe is supporting Montenegro’s efforts to build back better health services after the COVID-19 pandemic. The work on UHC focuses on improving the quality of primary care services by enhancing people-centredness and integrating health services across the continuum of care for communicable diseases, NCDs and mental health conditions. To improve access to and enhance the quality of mental health care, WHO and UNICEF are supporting the country in a 10-year collaborative effort (Box 3). During the COVID-19 pandemic, WHO has contributed to national activities providing psychosocial support to persons with severe mental health conditions and developing guidelines on multidisciplinary community mental health teams. Furthermore, WHO supports Montenegro’s efforts of strengthening financial protection and making health financing more sustainable. An ongoing study on financial protection in Montenegro will provide support for the next steps towards UHC.
Protecting against health emergencies

Since the outbreak of the COVID-19 pandemic, WHO has provided comprehensive support to Montenegro’s response, including through increasing surveillance, diagnostic and rehabilitation capacities, improving the clinical management of COVID-19 cases, building primary care capacity across the country, and rolling out the vaccination programme. The pandemic has highlighted the challenges associated with workforces commuting across borders and the need for effective investment in and management of human resources for health. WHO will continue to support forecasting the need for health professionals, retain health workers in the country, and promote digital solutions.

Promoting health and well-being

WHO is supporting the Ministry of Health in addressing behavioural risk factors for ill health. WHO has provided technical assistance for implementing the Framework Convention on Tobacco Control, with a focus on setting up a regulatory framework to protect tobacco control policies and programmes from industry interference. WHO has also provided technical assistance to reduce the salt content in bread and bakery products. To improve water, sanitation and hygiene in health care facilities, WHO has supported Montenegro in assessing facilities and building capacity. These areas, together with the consumption of alcohol, deaths due to road traffic injuries, and air pollution, will remain a high priority in the coming years.

COUNTRY DATA SUMMARY

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</thead>
<tbody>
<tr>
<td>Life expectancy at birth,</td>
<td>75.9</td>
<td>76.7</td>
<td>78.3</td>
<td>80.9</td>
</tr>
<tr>
<td>Estimated maternal mortality</td>
<td>6</td>
<td>11.7</td>
<td>12.7</td>
<td>6.3</td>
</tr>
<tr>
<td>per 10000 live births</td>
<td>(2017)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated infant mortality</td>
<td>2</td>
<td>5.2</td>
<td>6.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Population size, in millions</td>
<td>0.6</td>
<td>57.7</td>
<td>927.2</td>
<td>447</td>
</tr>
<tr>
<td>GDP per capita, PPP$</td>
<td>23 097</td>
<td>27 355</td>
<td>35 818</td>
<td>44 421</td>
</tr>
<tr>
<td></td>
<td>(2020)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty rate at national</td>
<td>24.5</td>
<td>22.6</td>
<td>14.9</td>
<td>17</td>
</tr>
</tbody>
</table>

Notes: EU: European Union; GDP: gross domestic product; PPP: purchasing power parity; SEE: South-Eastern Europe.

Source: WHO, 2022e.
References


WHO Regional Office for Europe

WHO is the authority responsible for public health within the United Nations system. The WHO Regional Office for Europe (WHO/Europe) covers 53 countries, from the Atlantic to the Pacific oceans.

To support countries, WHO/Europe seeks to deliver a new vision for health, building a pan-European culture of health, where health and well-being goals guide public and private decision-making, and everyone can make healthy choices. WHO/Europe aims to inspire and support all its Member States to improve the health of their populations at all ages. WHO/Europe does this by providing a roadmap for the Region’s future to better health; ensuring health security in the face of emergencies and other threats to health; empowering people and increasing health behaviour insights; supporting health transformation at all levels of health systems; and by leveraging strategic partnerships for better health.

European Programme of Work ‘United Action for Better Health in Europe’

The European Programme of Work (EPW) sets out a vision of how the WHO Regional Office for Europe can better support countries in our region in meeting citizens’ expectations about health.

The social, political, economic and health landscape in the WHO European Region is changing. United action for better health is the new vision that aims to support countries in these changing times. “United”, because partnership is an ethical duty and essential for success, and “action” because countries have stressed their wish to see WHO move from the “what” to the “how”, exchanging knowledge to solve real problems. The WHO European Region’s solidarity is a precious asset to be nurtured and preserved and, through the EPW, WHO/Europe supports countries as they work together to serve their citizens, learning from their challenges and successes.

The European Observatory on Health Systems and Policies

The European Observatory on Health Systems and Policies supports and promotes evidence-based health policy-making so that countries can take more informed decisions to improve the health of their populations. It brings together a wide range of policy-makers, academics and practitioners, drawing on their knowledge and experience to offer comprehensive and rigorous analysis of health systems in Europe. The Observatory is a partnership hosted by WHO/Europe. Partners include the governments of Austria, Belgium, Finland, Ireland, Norway, Slovenia, Spain, Sweden, Switzerland, the United Kingdom, and the Veneto Region of Italy (with Agenas); the European Commission; the French National Union of Health Insurance Funds (UNCAM), the Health Foundation; the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). The Observatory is based in Brussels with hubs in London (at LSE and LSHTM) and at the Berlin University of Technology.