



THE RIGHT TO HEALTH IN SERBIA

“The Right to Health – a Multi-Country Study”, University of Aberdeen School of Law

<http://www.abdn.ac.uk/law/hhr.shtml>

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INTRODUCTION

In order to examine the matter of implementing the right to health in Serbia, or human rights in general, one should first be introduced to a short overview of the context inside of which the country has been developing during the recent time.

The sustained period of struggle in the 1990s, including participation in war, strict and devastating economic sanctions and embargoes, as well as the armed intervention undertaken by the NATO forces in 1999, has drastically affected the Serbian economy and industry, the standard of living and major social values. The year 2000 witnessed some measure of political and social change, in the form of so-called “democratic revolution” during which the socialist government was replaced by the political coalition of democratic parties.

The unfortunate series of events has had a crucial influence on the establishment of standards in Serbian society and politics. Protection of human rights is among those delicate and high priority matters that were most brutally neglected and affected.

The standard of population's health, quality and availability of health protection as well as the environmental determinants has, with no surprise experienced direct consequences of the society's rapid degradation in almost every possible way. Lingering political, economic and social factors stemming from the '80s and the '90s have continued to impact standards of human rights as well as human health levels in Serbia.

Since the year 2000, a certain amount of progress can be recognized. In principle, a more sizable percentage of resources has been allocated towards health care system (other socially determining areas were not so fortunate). Progress has also been made with regard to specific conditions and the health of certain population groups, such as the Roma, women, persons with disabilities and others, although only to a limited extent. The data contained in this study will show whether the extent of the progress is sufficient in terms of complying with the duties under the right to health.

Concerning the legal framework, a number of relevant laws have been issued, introducing relatively new policies and an approach to human health protection and preservation. Although other additional improvements may also be acknowledged regarding Serbia's implementation of the right to health, various systematic problems still exist, which shall be addressed in following chapters.

The Serbian population numbers 7.5 million people, 52% of which is the urban population.¹ According to the 2002 Census, around 82% of the general population is of Serbian nationality. The remaining percentage is divided by national minorities (above 1%: the Roma, Bosnians, Hungarians, and those declared as Yugoslavienian) and undefined, undeclared and unknown.² As for the age of the population, people of age between 15 and 65 years account for 67%, while those over 65 years of age amount to

¹ 2007 estimate by the World Bank

² Serbian institute for statistics, at: <http://webrzs.stat.gov.rs/axd/Zip/SN31.pdf>

14.7% of the general population.³ UNDP reports that around 10% of the population is living with some kind of disability.

Serbia is a member of the Council of Europe since the year 2003. In 2010, the Serbian Government submitted the initiative for the candidate status with the European Union.

INTERNATIONAL COMMITMENT TO THE RIGHT TO HEALTH

Serbia is party to a number of international and regional instruments protecting human rights, including the right to health. Amongst them are several of those most significant to the protection of health-related rights: the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Rights of the Child. Serbia also joined the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families and the Convention on the Rights of Persons with Disabilities. Furthermore, beginning in 2009 Serbia ratified the Revised Social Charter (Council of Europe), and is party to a number of other international and regional human right instruments issued by the UN, WHO, the Council of Europe.

The UN Millennium Declaration introducing Millennium Development Goals (MDG) targets certain important health-related issues. These would include poverty reduction (important health determinant), reduction of child mortality (through immunization coverage, higher quality of pre- and post-natal care), improvement of maternal health (prevalence of contraception, pre- and post-natal care, maternal health, access to skilled staff at birth), and battles against a number of diseases (HIV/AIDS, malaria, tuberculosis). It also includes goals connected to environmental health, quality of sanitation and water, environmental protection. Serbia has been dedicated to achieving these targeted goals. In 2004, the Serbian Government created a Task Force, whose main functions are monitoring the implementation process of the goals and plans under the UN

³ World Bank statistics on health, nutrition and population in Serbia, at: <http://ddp-ext.worldbank.org/ext/DDPQQ/report.do?method=showReport>

Millennium Declaration, as well as defining national development goals that are to be realized by the year 2015. The Task Force is comprised of Ministries, representatives of municipalities and cities, State organs and UN agencies in Serbia, with a strong emphasis on co-operation with the NGO and civil sectors. Since there is indeed an expectation of MDG becoming further specified and adjusted to the national and local factors and circumstances, the Task Force has so far defined national development goals. In terms of the human right to health, some of the most relevant specific national targets would be: “Reduction of the unemployment rate of persons with disabilities by at least 20%”; “Combating the chronic poverty of the Roma, with poverty reduction of at least 30%”; “Increasing the coverage of women in natal care during the first trimester of pregnancy to 85% by 2015”; “Increasing the coverage of women attended by a polyvalent nurse at least once during pregnancy to 95% by 2015”; “Increasing the average number of visits by a polyvalent nurse to the new mother and newborns in the first five days after childbirth to five by 2015”; etc.

OVERVIEW OF THE HEALTH CARE SYSTEM

Some of the most critical components of the health care system in Serbia derive from the very nature of the system’s organization and history. The Serbian health care system is mainly financed through a network of employee contributions to the centralized social security fund⁴ (comprising around 90% of General government expenditure on health), while general government expenditure on health (as the percentage of total exp. on health) is very high (more than 70%).⁵ The level of total expenditure on health care (as a percentage of GDP) has been rising during the 2000s (2005: 8.0%; 2006: 8.2%; 2007: 8.4%).⁶

⁴ “Serbia: discrimination and corruption, the flaws in the health care system” (Alternative report in the application of the ICESCR), International Federation for Human Rights, 2005, p.4, accessed on 15/01/2010 at: <http://www.ifhhro.org>

⁵ World Health Organization: Country Estimates – Serbia, accessed on 10/11/2009, at: <http://www.who.int/nha/country/scg.pdf>

⁶ *Ibid.*

The system is affected by a deep neglect of infrastructure and equipment, as a result of the influencing factors of the past decades. Reform of the health care system initiated by the creation of new health-related laws, introduced a wide guarantee of health rights, followed by even greater financial demands, while the investment in maintenance and functioning of the system remained relatively low. As a result, a visible disproportion exists between the right to health (care) and the actual capability to implement it.⁷

Research demonstrates that the emphasis (expenditure wise) has been put on secondary and tertiary health care levels, but the greatest need remains at the primary health care level.⁸ A larger number of doctors have become specialists, while the number of generalists is still at an unsatisfactory level, (more than 80% of doctors are specialists). Furthermore, their access to modern training has been rare.⁹

National legal framework

Since the year 2000, a more serious dedication to reforming the health system has been announced by the new government officials. New laws regarding the health care system and insurance were issued, though these did not fully succeed in creating a set frame for the expected reform. While not intended to make a core change in the system's organization or methods of finance, these laws did, however introduce some novelties to the system, such as patient-oriented health services, insisting on patients' rights for the first time in such form. In recent years, a more pronounced and focused effort can be acknowledged (national policies concerning vulnerable groups and particular public health issues, legislation concerning public health, donation and transplantation, reproductive rights, etc.), but these activities demonstrate at the same time the limitations that are placed upon the decision-making bodies and the society itself with regard to meeting the new standards in human rights law and in this case – human health issues.

⁷ UNDP “Human Development Report Serbia 2008”, accessed on 10/11/2009 at: http://www.undp.org.rs/download/nhdr2008_eng.pdf

⁸ UNDP

⁹ UNDP

National Health Goals were adopted in 2002, with underlining principles of preservation and improvement of health, equal and equitable access to health services for all, special protection of vulnerable social groups, patient-oriented services, decentralization of resources and financing, higher quality of services, defining of the private health sector, etc. Subsequently, a number of specialized strategies and action plans have been put into effect.

Health expenditure

In comparing the total expenditure on health (as a % of GDP) in recent years, the percentage has been slowly increasing – from 8.0% in 2005 to 8.4% in 2007, which puts Serbia at a medium level compared to regional countries. The public (government) share in total expenditure on health fluctuates between 70% and 80% (74% in 2007), which represents between 13% and 14% of annual General government expenditure.¹⁰

When it comes to a measure of specific currency amounts, the total expenditure on health per capita (int.dollar rate) amounts to \$899 (2007), from which the General government expenditure per capita is \$665 (2007). This shows that the private sector expenditure as % of the total expenditure on health has not exceeded 30% in the last 10 years. At the same time, the percentage of out-of-pocket payment (as % of private sector expenditure) is quite high – just above 86%.¹¹ As such, while the public share in total health expenditure is high, a significantly large amount of private health expenditure comes out-of-pocket from private consumers. An obvious discrepancy in the relation between the public and the private health sector in terms of regulation, monitoring, accessibility and insurance coverage is also one of the problems that requires serious reform and attention. Such a state indicates low availability (and quality) of certain services within the public sector.

¹⁰ WHO

¹¹ WHO

Nevertheless, the involvement of the public sector remains high in comparison to the direct provision of services by the private sector.

Relation between public and private health services

As it has been stated, health services for the population of Serbia are primarily financed through a public fund at the national level (with smaller, district-based offices). Services that are paid for by the public health insurance fund are exercised within public health institutions at several levels of health care. Thus, a connection between the public and the private health sector (both are regulated by the same health acts), in terms of service and financial equality is non-existent.

Namely, the only possibility for covering private health services from the central fund occurs when a patient cannot be taken onto an ongoing waiting list within a prescribed period of time, and therefore must seek medical help outside the public health system.

Simultaneously, the private sector, although required to meet basic criteria prescribed by the law, is not covered with regard to certain procedures that are considered common in the public sector (patients' ombudsperson, for instance). Consequently, people often have to suffer through waiting lists that are usually very long, or they have to make an out-of-pocket payment directly to private practices for a medical service to which they are entitled in the public sector. In the area of labour and occupational health (e.g. sick leave), approvals and interventions by the private institutions are not accepted by employers, as current practice norms corroborate.

The same dismissive trend is witnessed in the evaluation of medicine prescriptions issued by the private sector that are not recognized in public pharmacies, while prescriptions issued by the public health services that are not recognized by private pharmacies. This situation is primarily a repercussion of the slow pace of developing relations between the public insurance fund and private health practices, in which the inclusion and coverage of

practices under the insurance scheme is not proportional to the needs of the health care system, its patients and capacities.

Furthermore, some specific health services (interventions) are only available (or are of a better quality, or are available without waiting) within the private health sector. For instance, magnetic resonance imaging (MRI) can be performed at any equipped private clinic on the same day as requested, without any waiting, whilst in order to perform the same diagnostic procedure at authorized public-funded institutions, the waiting lists often require the patient to wait up to 6 months. However, a process has been initiated (through tender offering) by the public insurance fund to provide patients with an opportunity to avoid overly long waiting lists for some health services by visiting a privately owned practice.

These discrepancies have led and can continue to lead to a deprivation of certain rights, and no doubt contribute to a worse overall standard of health care, particularly when taking into account both the unsatisfactory state of the public sector in certain medical areas and the size and growth of the private sector in Serbian health care.

In examining the position of private health insurance coverage and availability in Serbia, these institutions have not yet been widely adopted by the general population. Only over the last year has the public insurance fund issued statements that are aimed to promoting this option among its users. The options of additional and/or private health insurance would not replace the system of mandatory public health insurance, as announced in one of those statements, but would rather enable the users to approach certain services within both public and private health institutions at any time. Services that are already available within the public health sector and those that are not would both be included to a degree. Research has shown, contrary to the wide presumption that wealthier social groups primarily enjoy the private health insurance options that the highest number of users actually belongs to middle-income class. Nevertheless, private insurance coverage is still shown to be an exception rather than a common practice spreading among the general population.

HEALTH OF THE POPULATION (general observations)

A large proportion of persistent health problems of the Serbian population are in some way life style related (smoking, nutrition, alcohol consumption), which implies a low level of health promotion and preventive medicine. There is a consistently high presence of cardiovascular and malignant diseases.¹² As previously noted in several sources, such tendencies reveal demographic and epidemiological social transitions.¹³ At the same time, the mortality caused by life style choices is declining in the EU countries. In 2007 life expectancy among the Serbian population averaged just above 73, or approximately 5 years shorter than the EU average.¹⁴

The rate of mortality caused by certain illnesses remains significantly higher than in more developed countries. For instance, while streams of campaigns consciously directed towards raising awareness raising in developed countries have resulted in a decrease of mortality rates among frequently occurring gender-related conditions, the respective numbers in developing countries are stagnating (e.g. ovarian cancer is the second leading cause of female mortality from malignant diseases, with 27 cases per 100.000, or approximately 6 times more than in Finland).¹⁵

A visible disproportion in living conditions, health quality and protection exists between the general population and marginalized, vulnerable and minority groups, such as Roma. The majority of Roma inhabitants (app. 500.000 of whom reside in Serbia) live in inadequate conditions and poverty, with no sanitation, proper housing, registration or identification documents, thereby making it almost impossible to include them in official surveys and statistics. However, it can still be concluded that negative indicators apply to the Roma minority (esp. women and children) in a greater measure than to the general

¹² UNDP

¹³ UNDP

¹⁴ UNDP

¹⁵ UNDP

population, with an unbalanced implementation of health objectives within this minority group.

WOMEN'S HEALTH

General Comment no.14 on Article 12 of ICESCR puts an emphasis on several critical points that must be particularly addressed when understanding States' duties under the right to health, and when implementing this right. One of them concerns the health of women, as a vulnerable group. The Convention on the Elimination of all Forms of Discrimination against Women (to which Serbia is a party) also commits its member states to securing access to health care and services for women, underlining pregnancy-related health care, including prenatal and postnatal care, availability of free services and adequate nutrition. The UN Millennium Development Goals introduced „improvement in maternal health“ as one of the main objectives for the projected period.

Reproductive health services and information

With regard to unlimited access to contraception, as well as contraception use among women, statistics shows that while 74% of women age 15-24 used contraceptives in their last risk-holding sexual intercourse (2006), while the adolescent birth rate (per 1.000 women) comes to around 25.¹⁶ Use of contraceptives among married women (age 15-49, year 2005) varies from 41% (any method of contraception), to 18% (modern methods), to 8% (condom use).¹⁷ This seems to be an obvious fall in use compared to the year 2000 (any: 58%; modern methods: 31%; condom: 17.7%). General information about reproductive health is in principle available, which could be said for the information on HIV/AIDS as well.¹⁸ In 2005 around 42% of women (age 15-24) had comprehensive

¹⁶ Millennium Development Goals (MDG) – Data on Serbia, accessed on 10/12/2009, at: <http://unstats.un.org/unsd/mdg/Data.aspx?cr=688>

¹⁷ MDG

¹⁸ MDG

correct knowledge about HIV/AIDS. From 2005 to 2010 the fertility rate did not experience radical changes, and remains at 1.6 live births per women.¹⁹

Pregnancy related health services

States' duties regarding maternal health occupy a special place in international and regional human rights instruments. Some of the indicators through which we can observe and evaluate the trends in this particular field are care during the prenatal period, attendance of skilled staff during birth and the maternal mortality ratio. Others factors that might be included are facts concerning maternity leave, the number of midwives/specialists per a chosen number of women (people), availability of adequate facilities and services regarding pregnancy and birth.

The percentage of pregnant women receiving prenatal care in 2005 (at least one visit) climbed to 98.2% in Serbia.²⁰ The proportion of births attended by skilled health personnel measured high in 2005 – 99.2%, with a maternal mortality ratio of 14.48 per 100,000 live births in 2008 (this figure is, while a reflection of the average regional value, still a slight increase in comparison to previous years).²¹ The density of midwifery personnel per 100,000 people was 33 in 2007.²²

The number of fetal deaths per 1,000 births was 4.97 in 2008 (5.39 in 2007).²³ , Additionally, the number of abortions performed per 1,000 live births was 349 in 2008 (presenting higher numbers than non-EU members neighbour countries).²⁴

Abortion is legal in Serbia. The related services are available in medical institutions that practice gynecological expertise and have adequate facilities and conditions. Abortion can be performed upon the request of a pregnant woman of 16 years of age and above,

¹⁹ MDG

²⁰ MDG

²¹ WHO Europe – European Health for all Database (HFA-DB), accessed on 10/13/2009, at: <http://data.euro.who.int/hfadb>

²² HFA-DB

²³ HFA-DB

²⁴ HFA-DB

until the 10th week of pregnancy. Exceptionally, a termination of pregnancy may be performed between the 10th and the 20th week, or after the 20th week of pregnancy, according to reasons prescribed by law, and upon approval by the authorized organs. The reasons for late termination include serious danger to a woman's health that cannot be eliminated through medical intervention; certainty that the child will be born with serious physical or mental disadvantage, and cases in which procreation is the result of a criminal act. In such cases involving the late termination of pregnancy, the existing conditions will be examined by a committee of physicians, or, in a situation where a pregnancy has exceeded its 20th week, the evaluation of the conditions will be made by an ethical board of the health institution.²⁵

CHILDREN'S HEALTH

As noted, Serbia is also a party to the UN Convention on the Rights of the Child (CRC). According to the Article 24 of CRC, children have the right to the highest attainable standard of health and to health and rehabilitation facilities. In order to progress towards the full implementation, several specific goals are addressed within the provision: diminishment of child and infant mortality, provision of necessary, especially primary medical care, adequate nutrition and safe drinking-water, appropriate pre- and post-natal care of the mothers, health-related information and education, preventive health care and support, as well as the abolishment of hurtful traditional practices.

In addition, the UN Millennium Development Goals include a reduction in child mortality – Goal 4 (of half in the age category 0-5; of half in the age category <19 from external causes; an increase in mandatory immunization to 99%, as well as in the percentage of breastfed children age <6 months, by 2015).

UNDP reports that the number of children deaths under the age of 5 per 1,000 births is at the average level of recently joined EU member states – 7.8 (2008).²⁶ The value of this

²⁵ Serbian Law on the procedure of pregnancy termination, Sl. Glasnik RS br. 16/95, 101/2005

²⁶ UNDP

indicator is, however higher than the EU average (5.5). It is also reported that the mortality is higher for children of male sex, and that the most common causes are those that appear within the perinatal period and congenital anomalies. Observing the constant fall in these indicators (12.7 in 2000), it is expected that the goal of reducing child mortality under the age of 5 to appropriate standards will be met by 2015.²⁷

It is of a great importance to underline the discrepancies in values between children from the general population and those of the Roma minority. According to research from UNICEF, child mortality under the age of 5 within the Roma population peaked at 29 per 1,000 live births in 2005, drastically higher than the general population ratio.²⁸ The National Institute for Statistics, in contrast, reports that the child mortality of Roma children does not deviate significantly when compared to that of children from the general population. More reliable data is not available, however, and the statistical information on the Roma minority is not collected in a regular manner. Despite these inconsistencies, numerous initiatives on the national and regional level has been introduced. These include national strategies focusing on the Millennium Goals, as well as special activities for the improvement of health services and care for the Roma population, especially children.

In 2008, the number of deaths from external causes of children under the age of 19 was 10 per 100,000 children, again higher for the male gender. The most frequent causes include traffic accidents, suicide and violent attacks.²⁹ According to the same source, regardless of a slight decline of mortality in this area, the projected goal of a 50% reduction of death rate from external causes (MDG 4, Target 3) cannot be estimated to be achieved. Efforts to address the unfortunate causes of such mortality have been initiated through national policies on youth development and health. In this process, several national programmes concerning the prevention of violence in schools have been introduced, as well as programmes devoted to the prevention of youth suicide, all of which have been undertaken by official ministries and institutions.

²⁷ UNDP

²⁸ UNDP

²⁹ UNDP

Recommendations issued by UNICEF and World Health Organization encourage exclusive breastfeeding for children up to six months of age. UNDP reveals obvious positive developments – the percentage of children breastfed in the first 6 months after birth has increased from almost none in 2000 (UNICEF) to 15% in 2005. Nevertheless, it is still considered insufficiently high. The national programme on encouraging early breastfeeding and ensuring adequate conditions for securing the activity, has contributed to the promising trend.

UNDP reports on high immunization coverage in Serbia. According to this source, the immunization of children under the age of 18 months has surpassed 95% since the year 2005. The high coverage rate is attributed to the long tradition of immunization in Serbia. However, a certain discrepancy exists with regard to regional and social coverage. UNICEF has concluded a causality between the development of the region, social and educational status and immunization access. Therefore, children in urban areas are under greater coverage than those in rural regions, and parents with higher education are more diligent when it comes to regular child immunization. Also, child vaccination coverage is lower within the Roma population, due to the lack of personal medical documents and information, as well as personal attitudes towards immunization.³⁰

Within the national programme for protecting people from infectious diseases, a special emphasis is put on increasing coverage of certain vaccinations, including the introduction of special methods to increase coverage among Roma children.

HIV/AIDS

UNDP reports on positive trends regarding HIV/AIDS incidence and mortality in Serbia. It is reported that AIDS incidence in 2008 was 5.1 per 1,000,000 people (10.4 in 2000), while the AIDS mortality rate was 3 (5.6 in 2000). HIV incidence in 2006 was 12 per 1,000,000 people (European Health for all database), while the prevalence of HIV among adults is 79 per 100,000 people (2007, WHO). The largest percentage of incidence still

³⁰ UNDP

remains with intravenous drug consumers, with an increase of occurrence due to unprotected sexual intercourse. However, a positive movement should be acknowledged in terms of condom use within young age groups (from 2000 to 2007, the percentage of people age 15-24 using condoms during risky intercourse more than doubled – according to the Serbian Ministry of health).

A number of positive actions has been taken to reduce HIV/AIDS prevalence and mortality, as well as to raise awareness and protection among risk groups and the general (mainly younger) population. In 2005, National strategy on HIV/AIDS was adopted, while financial and systematic support from UN agencies and other international sources has been constant in 2000s.

Even though it has been reported that Highly Active Antiretroviral Therapy is available to patients in Serbia (with 100% availability, as these medications were placed onto the white list of the Republic Insurance Fund, and are therefore either covered entirely by public insurance or require only a participatory payment of a small percentage), it has also been documented that the factual application of such therapy depends highly on the actual availability of the drugs within the health care system.³¹ Namely, in cases of temporary unavailability of the treatment, the therapy would either have been paused or performed through a different set of drugs for a period of time. The medications are usually prescribed by the Republic Institute for Infectious Diseases in Belgrade, for the duration of a month.³²

MENTAL HEALTH

The International federation for human rights notes, in its Report on Serbia's health care system³³, that 10% of the general population in Serbia (800.000) is handicapped. Of this

³¹ "HIV Treatment Access, Delivery and Uncertainty: A qualitative study in Serbia and Montenegro", UNDP, accessed in September 2010, at: <http://www.undp.org.rs/index.cfm?event=public.publicationsDetails&revid=FD534BD3-3FF2-8C75-25BDD68F9CDB1B61>

³² UNDP

³³ IFHR

number, 200.000 people are afflicted with mental deficiency. It also stated that the majority of households with a member possessing some kind of handicap are living a life of poverty (61.2%).³⁴ The services in mental health institutions are reported to be inadequate, with nearly a third of the people suffering from a mental condition placed in institutions.³⁵ As expected, a noticeable occurrence of persons suffering from *post-conflict stress* is noted, causing health problems not only among the direct participants in the conflict, but among the general population as well. Insufficient and inadequate care has been provided for such persons, with only a small number of professionals receiving the necessary training and expertise in the field.³⁶ UNDP reports a satisfying coverage of mental health protection as well as qualified personnel in this area, but notes that a relatively small percentage of patients has been hospitalized. Furthermore, large-scale psychiatric hospitals often serve as a sort of asylum for the socially endangered, and patients' rights protection is not implemented in all the phases of the treatment. The therapy offered to this group of patients is not based on progressive and modern principles, as reported.³⁷

In its controversial report on treatment of adults and children with mental disabilities in Serbia³⁸, Disability Rights International declared that Serbia has failed to comply with adopted international human rights standards. Of particular concern was the lack of effort to include individuals with disability into the community, thereby creating serious segregation while breaching numerous human rights – to live, to work and to receive treatment within the community, all of which are defined in numerous international norms.³⁹ MDRI has also recognized the urgency for Serbia to enable proper social inclusion of children with disabilities, thus terminating the breach of norms contained in the UN Convention on the Rights of the Child.⁴⁰ What has also been acknowledged, measured by the ICESCR and ECHR standards regarding to the right to life and the right

³⁴ IFHR

³⁵ IFHR

³⁶ IFHR

³⁷ UNDP

³⁸ "Torment, not treatment: Serbia's Segregation and Abuse of Children and Adults with Disabilities", Mental Disability Rights International (MDRI), at: <http://www.disabilityrightsintl.org/wordpress/wp-content/uploads/Serbia-rep-english.pdf>

³⁹ MDRI, pp. 21

⁴⁰ MDRI, pp. 22

to health, is the failure to ensure adequate living conditions and proper health care for those with disabilities, mainly people placed in a mental institution.⁴¹ As a result, a number of life- and health- threatening factors have appeared and may continue to appear. Serious cases of degrading and inhuman treatment have been reported, most noteworthy being physical restraint and placement of patients in inadequate facilities.⁴² MDRI investigators also documented instances of children and adults with mental disabilities being kept in permanent, lifetime restraints, which was classified by the WHO as a cruel treatment often leading to permanent physical and mental consequences, and providing a platform for torture of bodies and health of the persons in question.⁴³ The creators of the Report have expressed their satisfaction with the legal framework of Serbia, which enables proper inclusion of the people with disabilities while prohibiting discrimination against them, but at the same time demand reorganization and detailed supervision of a number of health institutions that provide care for adults and children with disabilities.

PERSONS WITH DISABILITIES

Serbia is party to a number of instruments prohibiting discrimination on the grounds of disability and enabling social inclusion and equality of this vulnerable social group. Of particular note among these instruments is the UN Convention of the Rights of the Persons with Disabilities, which entered into force in 2008. Article 25 of the Convention proclaims the right of persons with disabilities to the enjoyment of the highest attainable standard of health, without discrimination on the basis of disability. The norm obliges States to provide persons with disabilities with the same range, quality and standard of *free and affordable* health care as provided to other persons, accompanied by disability-sensitive health care. It further requires territorial accessibility of services, non-discrimination in health and life insurance for the people with disabilities, as well as the

⁴¹ MDRI, pp. 22

⁴² MDRI, pp. 24

⁴³ MDRI, pp. 25

prohibition of discriminatory denial of health care, foods and fluids on the basis of disability.⁴⁴

At the national level, the Constitution provides an explicit prohibition of discrimination. Furthermore, a Law on the prohibition of discrimination against persons with disabilities was adopted in 2006, introducing amongst its general principles the rule of absolute equality and respect of integrity of those persons, as well as their complete and far-reaching social inclusion. According to this law, one of the cases qualifying as a serious violation would be any case of discrimination against people with disabilities in regard to their access and enjoyment of full health care. This particular legal act was positively evaluated by the European Disability Forum.⁴⁵ 10% of the population is reported to be living with some kind of disability, and over 60% of households with a disabled member live in poverty.⁴⁶ The above mentioned Report by an independent organization for human rights of persons with disabilities (DRI/MDRI) claimed a number of serious violations of human rights that are protected by several international documents. Those would mostly include the right to life and the right to health, the prohibition of torture and discrimination, as well as other rights that were internationally proclaimed. It has been reported that children and adults with mental disabilities are being placed in institutions that do not provide for adequate care and living conditions and employ methods of treatment and restraints that pose a threat to their lives and health.⁴⁷ Cases of arbitrary detention and lack of social inclusion have as well been reported. Further information on other disability-related indicators were not available from the official databases that were employed in this report.

THE ELDERLY

As a socio-demographic group with specific health-related needs, older persons were mentioned specifically in the General Comment no.14, the follow-up document of the

⁴⁴ UN Convention on the Rights of the Persons with Disabilities 2006, at: <http://www.un.org/disabilities/default.asp?navid=13&pid=150>

⁴⁵ UNDP

⁴⁶ IFHR

⁴⁷ MDRI Report on Serbia

ICESCR dedicated to the right to health. The Committee for Economic, Social and Cultural Rights insisted once again on an integrated approach, including preventive, curative and rehabilitative health treatments for the elderly. The dynamics, extent and content of care should provide for autonomy and functionality of older persons. Persons with chronic and terminal diseases need special attention that would spare them avoidable pain and allow them to die with dignity.⁴⁸

Research shows that poverty among people above 65 years of age is almost twice as common as among those younger than 65 (2002: 14.7% vs. 9%). Furthermore, women are slightly poorer than men of that age (15.2% vs. 14.2%).⁴⁹ It has been reported that 4 out of 5 persons older than 65 suffer from some sort of chronic disease, with cardiovascular conditions occurring at the greatest frequency. 16% of those with some chronic condition report that they do not enjoy or consume regular therapy for their conditions.⁵⁰

The elderly population in Serbia is by default among the most endangered social categories. Their pensions are far below the average income, their inclusion is significantly hampered and their overall health condition is bad.

Their living conditions are often below acceptable standards, even more so in rural areas, where proper sanitation and water supply are lacking. Life expectancy in Serbia averages 73 years (2007, female: 76, male: 70)⁵¹. It has been observed that while a slow increase in life expectancy is obvious, it still falls well under the EU average.⁵²

⁴⁸ General Comment no. 14 on the Right to Health (CESCR), 2000

⁴⁹ NGO Report on non-institutional protection of the elderly (Sataric/Rasevic, 2007), supported and published by UNDP Serbia, p. 27-35 at:

<http://www.undp.org.rs/index.cfm?event=public.publications&pg=2>

⁵⁰ *Ibid.*

⁵¹ World Bank statistics on health, nutrition and population, Report on Serbia, accessed in September 2009, at: <http://ddp-ext.worldbank.org/ext/DDPQQ/report.do?method=showReport>

⁵² UNDP

SAFE WATER AND SANITATION

The regional office of WHO Europe reports sufficient water resources for the population in Serbia (potential equivalent to 60.000 to 90.000 litres per second), with groundwater aquifers and open reservoirs serving as the primary sources of drinking water.⁵³ A discrepancy between urban and rural access to water supply is significant and visible (rural: 64% access to improved water supply system, urban: 97% access).

The quality of water varies from region to region. While waters in some regions show a strong presence of ammonia, nitrates, sulfides, and minerals oil, the most worrying quality problems of waters throughout Serbia are turbidity, iron, manganese and arsenic.⁵⁴ Additionally, surface water of bad quality can cause serious skin and other organ irritation, together with the condition of Balkan endemic nephropathy, which is usually connected with the quality of drinking water.⁵⁵ It has also been reported that Serbia is facing challenges with wastewater management, especially in rural areas (ENHIS).

ENVIRONMENTAL HEALTH

The Serbian Constitution (2006) proclaims the right of everyone to a healthy environment and environmental health related information, and holds official instances accountable for control and observance, as well as for acting on the protection of environmental health. WHO estimates that the environmental burden of disease for Serbia and Montenegro in 2004 was 27%.⁵⁶

Regarding air quality, it has been reported that in some Serbian cities a poor quality of air exists due to the emission of sulfur dioxide, nitrogen oxides, carbon monoxide and

⁵³ WHO Europe “Summary overview of the environment and health performance reviews for Estonia, Lithuania, Malta, Poland, Serbia and Slovakia”, accessed in February 2010, at: http://www.euro.who.int/_data/assets/pdf_file/0019/114922/E93533.pdf

⁵⁴ WHO Europe

⁵⁵ WHO Europe

⁵⁶ WHO Europe

particulate matter (urban areas in particular). Possessing four cities with a concentration of PM10 at 55 µm/m³, Serbia has a relatively high number of polluted cities in comparison with the European region.⁵⁷ Motor-vehicles emissions (poor quality of engine fuel, low technical standards) contribute in large part to this pollution.

As for the indoor pollution, the main source lies in tobacco smoke (71% of people between 15 and 19 years of age are exposed to smoking in their homes).⁵⁸

One of the environmental problems that was highlighted in Serbia is inadequate waste management systems, which could lead to serious consequences for public health.⁵⁹ Of foremost concern is hazardous waste, which is not being collected separately, nor are permanent and adequate disposal sites being provided for that purpose. Furthermore, numerous temporary or illegal dumpsites (especially in rural areas of the country) are being burned oversight and left out of public management, increasing harmful emissions to air, soil and underground waters.⁶⁰

The Serbian Government includes a particular Ministry dedicated to environmental protection and urban planning. Together with the Ministry of health, it holds the jurisdiction over the environmental-related areas. Some of the national laws in this field would include: The Law on Public Health (2009), The Law on Environmental Protection (2009), The Law on Health Care, and a number of national laws, strategies and plans for environmental protection (general population, children), food safety, sanitary surveillance, occupational health and safety, water/air/soil protection, fisheries, waste management and other.

Though a number of separate actions were undertaken by the Ministry of environment under the project „Let’s Clean Serbia“ in certain areas of the country, a need still exists

⁵⁷ WHO Europe

⁵⁸ WHO Europe

⁵⁹ WHO Europe

⁶⁰ WHO Europe

for long-term planning and regulation with regard to direct and indirect environmental protection and preservation.

CORRUPTION IN THE HEALTH CARE SYSTEM

In its „Country procurement Assessment Report on Serbia“, the World Bank declared that the health sector is the epicentre of corruption financing in Serbia. The International Federation for Human Rights reports on several causes of corruption in health care. The underpaid and overloaded corpus of health workers appears to be easily susceptible to bribery. In many instances, patients offer money or gifts, or are asked to provide them, in order to either gain access to certain medical services beyond the formal procedures of the system or to access them more quickly, thereby bypassing any significant period of waiting. Furthermore, systematic corruption in health was found in the insufficiently differentiated relationship between public and private health practice. In such an ambiguous situation, patients are often redirected by a physician in the public practice to physician’s own private practice, or to someone that he or she cooperates with. This way, a patient would most likely have to pay for the service from his or her own pocket.⁶¹

A primary contributing factor of corruption can be also found in the sheer size and organization of the health care system and the health insurance fund. The International Monetary Fund has urged the Government to facilitate mechanisms and reduce barriers (corruption and informal payments), as such actions would lead to a reduction in out-of-pocket payments for health services and allow for reallocation of public expenditure.⁶²

The corruption, however, is not present to a significantly greater extent than in other public areas.

Some recent media scandals in Serbia have shown strong connections between heads of important health institutions, their close collaborators and professionals, and foreign pharmaceutical companies, resulting in major violations of procedure and ethics, such as manipulations in treating cancer patients, especially children.

⁶¹ IFHR

⁶² IFHR

In a recent survey among the Serbian population, it was concluded that people in Serbia perceive the health system as the most corrupt by a large margin, placing it ahead of both political parties and customs authorities in their answers.

CONCLUSIONS

Even though Serbia is party to all of the primary human rights instruments proclaiming health-related human rights, the level of their implementation can still be considered problematic and insufficient, particularly in certain areas. Some indicators have undoubtedly shown progress compared to previous years, but values typically fall significantly short of the EU, or even smaller regional, averages.

Social, political and economic circumstances have not provided favourable ground for the advancement of human rights in Serbia in general.

The health care system has suffered greatly from long time of neglect, a lack of investment and restricted technological and bureaucratic progress. Major health determinants are also compromised, especially those connected to poverty, sanitation, housing and environment. The living standard of the Serbian people is, although increasing, one of the lowest in the Balkan region, and greatly influences the standards of health. Some social groups or profiles suffer from multiple sources and grounds of discrimination.

Reports claim that the subjective perception of people in Serbia towards public institutions indicates a high level of corruption in the health care system (78% perceive health sector to be most corrupted)⁶³. In one of the previous “Country Procurement Assessment Reports”, the World Bank stated that the health sector is the epicenter of corruption in Serbia.⁶⁴

⁶³ TNS Medium Gallup – Serbia Corruption Benchmarking Survey 2009 (UNDP supported publication)

⁶⁴ IFHR

Despite noticeable hindrances, official bodies seem to be putting significant efforts towards improving health determinants in recent years. Greater numbers of national strategies, action plans and statutes are being issued and implemented every year and higher amounts of resources are being allocated towards health protection in general. Nevertheless, true reform and progressiveness is absent, and these absences combined with the derelict systems of the past are critically impacting the standard of service and health in general.

It has been shown that most problematic health issues of the Serbian general population could be solved and systematically treated through better-organized means of prevention and health education. Furthermore, long-term planning mechanisms of the health system do not seem to be sufficiently integrated – certain components of the system continue to be inadequate.

In terms of achieving Millennium Development Goals, certain indicators clearly show visible progress, and predict successful realization of particular aspects. Other areas projected within the MDG, however, are stagnating and require more serious dedication and activity.

In comparison to other societies going through similar processes of serious transition, Serbia is experiencing somewhat expected troubles. Nevertheless, independent reports consistently show the Serbian health care system to be one of the sectors in greatest need of reparation and core reform.

Furthermore, some critical health factors continue to demonstrate a significant potential of endangering human health (air/soil pollution, sanitation, drinking water, health awareness and education, discrimination, access to health care, life style choices, minority rights).

When analyzing the right to health in Serbia according to the four main standards of implementation and evaluation of a state's dedication as set in the International Covenant (availability, accessibility, acceptability and quality), the following conclusions should be drawn.

General Comment no.14 explains the notion of availability as the overall existence of essential health determinants and adequate health services, equipment and programmes at all times and in a sufficient quantity. In addition to the health care services, this availability also includes access to safe drinking water, proper sanitation, medical personnel, hospitals and basic medicaments. Even if at this point the ability of state resources to meet such standards may come into question, the availability of certain determinants of health (food, shelter, water, essential drugs, basic health care) is strongly connected with the notion of the minimum core of the right to health, as proscribed in the General Comment.

The Serbian health care system provides for medical services that are, in principle, available. There is a fairly sufficient number of primary, secondary and tertiary health institutions across Serbia, with a satisfactory number of medical personnel. However, the number of specialists overwhelms the number of general medicine practitioners. Furthermore, the equipment, methods and available means of health protection are dated and far beyond their advisable reparation/replacement date.

The standard of *accessibility* necessitates a need for just access to health services for all, a health system that is physically accessible and affordable, with free and easy access to health related information. Within the framework of such a definition, several problems in the Serbian health care system can be recognized.

Certain social groups holding a special level of vulnerability lack access to basic health care. For the Roma minority, a number of reasons account for their unfortunate situation regarding health rights – invisibility in registration, their overall marginalization, poor standard of living and social habits, etc. For others, such as persons with disabilities, access to health care may be problematic for other reasons, e.g. lack of adequate experts for their conditions or improper conditions of institutionalization, to name a few. Geographic accessibility of health care services, safe drinking water, improved sanitation or satisfactory environmental conditions is also a significant issue for some areas or/and groups in Serbia.

The requirements of *acceptability* and *quality* are violated foremost by means of aging,

insufficiently up-to-date equipment, facilities and medical methods. Cases involving dated infrastructure being updated to newer forms, or the introduction of progressive diagnostic and therapeutic methods into the system, are still of an incidental nature, being supported mostly through foreign or private donations. The system itself is in serious need of more critical reform, which should include a transformation of the system of health payments, insurance structure, higher inclusion of vulnerable groups, suppression of corruption, better quality health-related education, greater environmental health and pollution control, inclusion of the private practice within the insurance scheme on the national level and in all medical areas, and firmer resistance to any form of discrimination in health care.

Proofread by Mr. Andrew Wiesike

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