Welfare in the Mediterranean Countries

SERBIA AND MONTENEGRO

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Introduction

Serbia and Montenegro were the two republics that comprised the Federal Republic of Yugoslavia (FRY) after the break up of the Yugoslav federation during the 1990s. In March 2003, the remnants of the federation were finally dissolved when the two republics agreed to enter an arrangement. This arrangement provides for a federal assembly and president, and joint handling of defence and foreign affairs, will remain in existence for three years, after which it will be reviewed. The Republic of Serbia includes Central Serbia, Vojvodina and Kosovo. In 1999 Kosovo came under UN administration following the terms of UN Security Council Resolution 1244. According to the International Crisis Group\(^1\), the agreement on a new union takes no account of the status of Kosovo, notionally still an autonomous province of Serbia, but in practice a UN protectorate. As long as Kosovo’s future remains unresolved, the territory and the constitutional make-up of Serbia, and of the joint state of Serbia and Montenegro, remain undefined. The agreement between Serbia and Montenegro only partially addresses the future of the defunct Federal Republic of Yugoslavia and the EU’s determination to press Montenegro into retaining the joint state was largely driven by its fear that early Montenegrin independence would force an unready international community to address Kosovo’s status prematurely. Consequently the EU and the wider international community have opted for interim, inherently unstable solutions for Serbia, Montenegro and Kosovo alike, rather than tackling the causes of instability.

A decade of conflicts in the Balkans has gravely impacted the health of its citizens and their healthcare system. During the decade of armed conflicts, mass migrations, and political and economic instability, healthcare system in the Region became overwhelmed.

This paper focuses on a sector of the welfare reform - the health service. In order to analyse current status and reforms of the health care system, the paper will look at Serbia and Montenegro separately, because of the administrative autonomy within the Yugoslav Federation and of two Ministries of Health. Moreover, even if Kosovo is part of the Republic of Serbia, the UN Security Council Resolution 1244 accords it “substantial autonomy and meaningful self-administration of FRY”. This is the reason why the Kosovo health sector will be treated separately.

The main points of the analysis will be health service and its problems, financing sources and health reform.

1. Serbia

Internal political instability and external pressures, including sanctions and embargoes throughout the 1990s, have severely destabilized the health system infrastructure in Serbia. The structural devastation and social disruption caused by the North Atlantic Treaty Organization air campaign (23 March - 09 June 1999) dealt a further blow to the crippled healthcare system in Belgrade and throughout Serbia. The results of 10 years of conflict were perilous economic decline and severe under-funding of the ailing healthcare system. The effects of these changes on the Serbian population are reflected by a substantial decline in health indices over the last 10 years. At present, the healthcare system in Serbia remains without the functional facilities, supplies, equipment, and economic infrastructure to support necessary healthcare reforms in the public and private sectors.

Renewed hope came with the election of a new Serbian administration in September 2000-rewarded by the international community with the lifting of remaining sanctions and with a promise of international aid for development. As a greater sense of stability returns to the region, focus can be turned to restructuring and developing the struggling healthcare system of Serbia. However, developmental assistance from the international community must be offered with caution and forethought. System-wide program improvements often fail due to inadequate planning, funding, or long-term commitment. Ineffective initiatives for health system reform can leave an already damaged system burdened with sustaining inappropriate programs at various stages of development. Initiating health system reforms in the post-conflict setting, is fraught with difficulties. Common mistakes made by relief organizations during post-conflict restructuring result from an inadequate “carbon copy” of a Western healthcare system without sensitivity to the unique local needs and cultural dimensions.

1.1 Health service structure and provision

Public health services are provided by the National Institutes of Public Health (IPH) which are supported by a network of regional IPH facilities. Primary care services are provided via a network of Health Houses, responsible for local public health, primary care and the administration of smaller ambulantas (which provide limited primary care facilities).

3 Ibidem
Primary healthcare in Serbia is delivered through a well established network of primary health centres (*domovi zdravlja*) and smaller primary health stations (*zdravstvene stanice*). Each of Belgrade’s 16 municipalities has a primary health centre - a limited-capacity outpatient facility that provides services such as general medicine, paediatrics, obstetrics and gynaecology, occupational medicine, dentistry, home care, preventive care, and laboratory services. In large municipalities, primary health centres also provide public health surveillance, tuberculosis-control programs, physical and occupational therapy, and, occasionally, limited specialty services in municipalities without a general hospital. Complementing the primary health centres is a network of smaller, satellite, primary health stations, which brings services further into the community⁴.

**Secondary and tertiary care** is provided in general hospitals, university clinical centres and specialised institutions that target specific groups such as women and children, or treat specific diseases such as TB and cerebral palsy. Each region has at least one general hospital and, in many cases, several inpatient facilities providing specialized or tertiary care. Although health facilities are relatively well staffed, with doctor-to-nurse ratios in the region of 1:3, the quality of care is often poor, because services are not patient-centred, there is a lack of audit or independent monitoring, and equipment and buildings are in bad condition. Many doctors are unemployed, there are 8,500 unemployed nurses, although there are many unfilled nursing posts at tertiary care level, and 9,300 unemployed physiotherapists. Measures have yet to be taken to match the health sector workforce to health need. Rates of pay for health professionals are low by European and even national standards. The average monthly salary is €130 for doctors and €90 for nurses, compared to a national average gross salary of €176. The low rates of pay for health sector staff are widely believed to exacerbate the pressure on patients to make informal payments to access health care. Many health sector staff are believed to work in the grey economy to increase their income⁵.

**Private health care** is not well developed and is not incorporated into the national health system. The utilization of private sector health care is not known.

Existing **health legislation** has also contributed to problems in the health care sector. The Health Care Act and the Health Insurance Act of 1992 failed to provide appropriate solutions for many problems; in addition, a certain number of very good solutions were never applied in day to day practice.

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⁵ Debra Stevenson *Serbia and Montenegro Health Profile June 2003* www.dfidhealthrc.org
In addition to the financial and legislative problems, there are many other weaknesses in the area of organization and functioning of the health care sector:

- Rigid standard regulations in the health care system;
- Centralized and bureaucratic management with limited autonomy for managers who lack the necessary management skills;
- Undeveloped information system for health care and health insurance;
- An undeveloped health sector “market”, with deprivation of private health care providers and a “passive” approach by the government to privatization in the health care system;
- The development of health facilities beyond the economic level feasible for the society; duplication of facilities and the lack of coordination of activities according to levels of health care organization, together with poor maintenance of equipment and buildings;
- Over-extensive but poor quality education of health care professionals with overspecialization of physicians and an oversupply of health personnel;
- Little professional satisfaction for health professionals resulting from low salaries and consequently little motivation for the provision of effective and quality health services;
- Cure-oriented health care system with priority given to the development of secondary (hospital) and territory (sub-specialized) levels of care despite formal support for primary health care orientation;
- Lack of any policy for high-technology assessment and quality assessment, lack of clinical practice guidelines, no monitoring of drug prescriptions and so on.

1.2 Health service financing

The publicly funded health sector is based on a system of compulsory social health insurance, financed by salary contributions paid by employees and operated by the Health Insurance Fund (HIF). Transfers from the republic budget are meant to cover health care provision for uninsured, including unemployed, refugees and IDPs (International Displaced Person). Budget funds also finance some capital investment, training and public health programs. The main weaknesses of the system are low coverage for uninsured people, lack of transparency in budgeting, evasion of contributions and arrears between the fund and institutions6.

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6 Ibidem
Public spending on health was estimated at close to 7 percent of GDP in 2001. Once estimates of private expenditure are added, total health expenditure would range between 9 and 11 percent of GDP, among the highest in the region.

**Total Expenditure on health as percentage of GDP, 2001 in the Balkan area**

![Bar chart showing total expenditure on health as percentage of GDP in 2001 for various Balkan countries.](chart.png)


Patients are required to make official co-payments to access health services. However, there is a significant problem with patients having to make unofficial, or informal, payments in order to receive health care. In Serbia and Montenegro it is estimated that out-of-pocket expenditure on health care is around 49% of the total expenditure on health care, compared to Bosnia-Herzegovina where it is estimated at 31% and Croatia where it is 15%.

### 1.3 Health reform

Health reform has been delayed because of a lack of continuity in ministerial leadership and fragmentation of responsibility for health policy and planning, and because health policy has not yet attracted high priority attention from the Government. Some initial progress has been made in tackling the problems of the sector, primarily in reducing arrears in health sector revenues and controlling HIF expenditure via contracts with public healthcare providers, though there are concerns that blunt expenditure control may have reduced patient access to care. In addition, extensive analytical work and consultation over health policy and strategy has taken place.

In February 2002 the Government of Serbia adopted the ‘Health Policy of Serbia’, which identified six aims:

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8. Debra Stevenson *Serbia and Montenegro Health Profile* June 2003 www.dfidhealthrc.org

9. Ibidem
1. Safeguarding and improving the health of the population in Serbia and strengthening its potential for better health
2. Equal access to health care of all the citizens of Serbia, and improvement of the health care for vulnerable population groups.
3. Sustainability of the health care system, while ensuring transparency and a selective decentralization in the field of resources management, with diversification of sources and methods of financing.
4. Improvement of the efficiency and quality of the health care system, with the development of specialized national programs related to human resources, institutional networks, technology and medical supplies.
5. Defining the role of private sector in provision of medical services to the population.
6. Improvement of the human resources for health care.

In implementing this policy, the Government has identified a number of immediate priorities:

- Improved access to drugs – despite some activities to improve the situation, patients are still deprived of essential drugs, especially in hospitals, and some drug costs are prohibitively high for certain population groups
- Increasing the supply of perishable items of medical equipment, which are in short supply and often have to be bought by patients
- Rehabilitation of selected health institutions
- Development of a Health Master Plan to define optimal use of available human and physical resources
- Reform of health financing mechanism, with procedures to improve the effectiveness and efficiency of the contracting process, including private sector participation.

Tomica Milosavljević, Minister of Health, underlined that the period to realize the reform will include several years (the Health Strategy of the Ministry is from 2003 to 2015). As a priority it is important to reorganize the Ministry, to introduce an ombudsman for patent rights, to define what kind of services the hospitals have to provide and to put side by side public system and private insurance. Regarding low salaries, he said that the subject is included into the priorities, but for now people must be patient.

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10 Ibidem
11 Reform In The Health Care System In Serbia Won’t Be Easy 09/07/2002 www.seeurope.net
2. Montenegro

The health care system of Montenegro represented part of the health care system of the former SFRY, which was characterized by irrational and inefficient organization while promoting access to all health care rights. In that way a picture was formed that citizens have rights to any kind of health care service, regardless of necessity, but without previously developing the conscience of citizens that every health care service has its price and that health care is not free.

The reasons for health care reform should be looked for in the inefficiently functioning health care system and a number of identified problems, from inadequately organized health care services, methods of collecting and allocating resources, absence of an adequate system that monitors and controls different segments of the health system and insufficient quality of the service provided. All of these problems have been present for many years in the health care system.

2.1 Health service structure

The Health Care and Health Insurance Law\(^\text{12}\), which has been in force since 1990, was passed because of a system of socio-economic relations founded on self-management. The values of this system were public property, self-management and state decentralization, and the general characteristics of its relation to health care was the absence of all State controlled mechanisms in conducting health policy, social principles that allowed the largest volume of health care rights and public property that did not commit subjects in health care deficiency and as consequence of this it had a long financial crisis.

The lack of clear objectives and development strategies on a Republic level have made it possible for hospital care to dominate capacities and resources because consumers mostly received services in hospital care, as primary health care was not able to solve most health care needs\(^\text{13}\).

During the transition period, health care, like the whole of Montenegro, was exposed to hardship: sanctions and war in its surrounds. Contrary to the traditional method in which ownership of health care institutions was exclusively publicly owned, in accord with social changes, all public institutions were proclaimed state owned, and simultaneously private practice was introduced. Financing health care has remained predominately in the domain of public financing and citizen participation.


\(^{13}\) Ibidem
With regard to management, focus was given to a centralized model by centralizing resources and decision-making. It should be emphasised that in spite of the numerous problems, basic health care resources were preserved, the material basis for operations were considerably advanced, and health services provided health care to citizens of the republic and numerous displaced persons appropriately. However, lack of adequate mechanisms in management of the health system, firstly institutional mechanisms, influenced the variance between resources and the requirements for health care\textsuperscript{14}.

The health care system is \textbf{organised as an unique health care region} and is \textbf{based dominantly on the public sector}. Public health care institutions are organized through a network of primary, secondary and tertiary health care consisting of eighteen medical centres, seven general hospitals, three special hospitals, the Clinical Centre of Montenegro, the Institute for Health and the Pharmaceutical Institute of Montenegro. The \textbf{private sector}, not yet integrated in the health care system, comprises a larger number of medical centres, dental centres, wholesale medicines and pharmacies.

The existing health care resources, within the framework of the public sector indicate that the accessibility and development of health care infrastructure, especially with regard to the number of beds and number of doctors is at the same level as more developed countries. The average monthly salary for doctors is between €250-350 and for nurses is €120\textsuperscript{15}.

\textbf{2.2 Financing health care}

Organization and financing health care in Montenegro is founded on the \textbf{dominant role of the public sector} to provide and ensure resources for health care and services. Namely, financing health care is based on the method of \textbf{compulsory health insurance} (German – Bismarck method). Contributions are paid according to employee gross earnings, according to present legal regulations in the amount of 15\% of employee earnings (proportional 50:50 employee and employer), as well as the self-employed\textsuperscript{16}.

Public and total health expenditures are high (public expenditure was 7 percent of GDP in 2001 and estimated total health expenditure about 10 percent of GDP). The level of expenditure per capita at around US$150 in 2002 is low, although it is higher than in Serbia, Bosnia-Herzegovina, or FYR Macedonia. The current public health financing and delivery system is not financially sustainable due to problems of inadequate revenues, arising from

\textsuperscript{14} Ibidem
\textsuperscript{15} Debra Stevenson \textit{Serbia and Montenegro Health Profile} June 2003 www.dfidhealthrc.org
contribution waivers, difficulty of collecting contributions from small businesses, farmers and the informal sector, and lack of adequate budget transfers for the uninsured, including refugees and IDPs. In addition, there has been a failure to adjust the generous benefits package and capacity to reduced economic circumstances. Pharmaceutical expenditure has grown rapidly in recent years and now stands at a very high almost 30 percent of HIF expenditure, plus widespread out-of-pocket payment\(^\text{17}\).

In Montenegro, the lack of national medicines’ policy, as well as irrationality in view of procurement, prescription and consumption of medicines, effectuates the pronouncement of that regulations should regularize pharmaceutical work.

### 2.3 Health reform

By adopting the **Health policy in the Republic of Montenegro until 2020** in January 2001, Montenegro has joined an unique international process implementing papers of the World Health Organization 'Health for all in XXI Century' and '21 objectives for the 21st Century'.

The general objectives are:

- Developing health policy that shall guide citizens to become aware of their own decisions and health responsibility and consequences thereof;
- Improving health care in the most acceptable and equal manner;
- Developing a health care system, harmonized with European health care development trends;
- Increasing efficiency of the health care system through rational and accessible resources;
- Improving quality of services;
- Application of modern health care technology;
- Creating a financially stable system.

The Ministry of Health shall, by using instruments of health policy, provide conditions for\(^\text{18}\):

1. Strengthening primary health care
2. Sources of financing and development of a new health insurance system,
3. Advancement of the payment system for health services and programs through the system of contract services based on capitation, budgeting and other payment methods,
4. Developing the health information system
5. Guaranteeing patients’ rights,
6. Regulating national medicine policy,

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\(^{17}\) World Bank, *Serbia and Montenegro Recent progress on Structural Reforms*, November 11, 2003


\(^{18}\) Ibidem
1) Strengthening preventative and primary health care may considerably influence and decrease the numbers of persons who are ill from the most common diseases and by doing so significantly influence the positive state of health of the population.

2) It is necessary to prevent increased expenditure, prevent creation of new losses, in the Health Insurance Fund as well as in health institutions, accelerate payments and strictly control contribution payments, establish an incentive system and regular payments for health services and assessment of work performance, establish management principles in health care in order to stimulate independent activities of the most important health institutions.

3) It is necessary to consider new methods for financing health institutions. This particularly refers to resources that the Montenegrin Budget has to provide for health care of non-insured persons. The Fund for Health Insurance has to undertake the function of controlling the contribution payment for health insurance in order to secure collection of resources in the assigned framework. It is necessary to clearly divide the relations between the Budget and Fund resources for health insurance. Key to success of reform is that all persons settle their obligations.

4) The health information system in Montenegro is insufficiently developed, although there is a clear requirement for timely collection, aggregation and data processing relating to the health system. The reason for developing a health information system lies in the requirement to collect and process data that is necessary as support for the management, planning and decision-making process.

5) In many countries in transition, over the previous period there has been significant degradation to the health system, medical profession, as well as etiquette in health. It is necessary to commence a number of measures with the objective to strengthen etiquette in health care, and guarantee human rights to citizens. It is necessary to strengthen the awareness of health as one of the basic human rights, as well as the awareness of a patient’s rights to timely and exact information with regard to his/her state of health and active participation in his/her treatment.

6) Countries in transition are generally facing increased expenditure due to inadequate control of prescription medicines by doctors and consumption of medicines, both prescription medicines and medicines consumed in stationary health institutions. In order to carry out national medicine policy the following processes need to be regulated:
   - Establishing institutional framework (laws and other regulations);
   - Registration of medicines and medicinal products;
   - Quality control and researching medicines and medicinal products;
   - Control of production and internal and external trade;
   - Control of maximum price of medicines.
3. Kosovo

Provisional institutions of government in Kosovo function under the constitutional framework developed by UNMIK (United Nations Mission in Kosovo). Responsibilities for foreign affairs, security, return of minorities and internal affairs remain with the UN Special Representative of the Secretary General (SRSG). An agreement for the gradual transfer of competencies by the end of 2003 was reached between SRSG and the Kosovo Provisional Government. Democratic elections were held in Kosovo in 2000 and 2001 and the transfer of competencies from UNMIK to the government has begun. A Ministry of Health has been established within the Provisional Government to lead the modernisation of the health sector.

Three years after the conflict, and in spite of considerable investment from international agencies, the health information system within Kosovo is not yet fully developed. So far, the quality of data in Kosovo is still of poor reliability and should be treated with caution.

The National Institute of Public Health (IPH), together with regional IPHs, is in charge of data collection. Private health services in Kosovo are not regulated and therefore much health data, particularly on health financing and private sector health activity is incomplete.  

3.1 Health service structure and provision

The Ministry of Health (MoH) was established in Kosovo in February 2002 with responsibility for policy development, strategic planning, licensing, quality assurance, and budgeting. Its primary role is to monitor, supervise and support both the hospitals and primary health care. The MoH includes: Kosovo Drug Regulatory Agency (KDRA), Kosovo Food Safety Agency, Pristina University Hospital, Institute of Public Health, Kosovo Health Care Commissioning Agency and District health authorities that aim to improve coordination at the district level between secondary and primary health care.

Health services in Kosovo have been significantly affected by three factors:

1. The inheritance of a typical socialist health system and infrastructure, which was neglected in the 1990s and then disrupted and destroyed by the conflict in 1999
2. The reconstruction and redevelopment in recent years
3. A lack of capacity in key institutions, most notably the newly formed MoH

The challenges presented by the inherited system can be summarised as follows:

- Specialty oriented health system

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19 David Simpson, Bajram Maxhuni Kosovo Health Profile June 2003 www.dfidhealthrc.org
• Little or no strategic planning
• Poor distribution of human resources with too many staff at hospital level and in urban areas and an under provision in rural areas
• Lack of adequately trained human resources compared with European standards
• Lack of health management skills
• Unregulated private health sector
• Over prescribing and uncontrolled private pharmacies
• Poor facilities, equipment, and infrastructure at the three levels of care provision
• No referral system and gate keeping, resulting in excessive demand on hospital services
• Lack of access for minority groups to the full range of available health services

Primary Health Care (PHC) services are provided by more than 30 Health Houses (now referred to as Family Medicine Centres) and health punctas, which are smaller health houses in rural areas offering very basic primary care services. PHC services are provided by non-specialist GP’s and inadequately trained nurses although measures to train specialist PHC staff have commenced. There are no standardised protocols, little evidence of team working and a lack of continuity of care. Medical records are not used systematically. There are few health promotion and disease prevention activities and little or no continuing professional education.

Secondary Health Care services are provided by five regional hospitals and the university hospital in Pristina. Hospital provision is compromised by poor facilities, lack of equipment and a lack of adequately trained staff. In general, hospitals are overwhelmed with large numbers of inappropriate outpatients due to the lack of a referral system from PHC and self referral by patients themselves. Hospital capacity in Kosovo, measured by total bed numbers, is low by regional or European averages. However, the average length of stay is 12 days, and there is a low average low bed occupation rate of 69.5%, suggesting inefficient use of existing resources. This situation is similar to that found in other hospital systems in the region of South East Europe.

Human resources management is weak and many staff are employed by the health sector to provide them with an income in lieu of social welfare payments. Workforce planning is poor and there is an excess of health professionals in many disciplines and in urban areas but an insufficient number of generalists in rural areas. In addition, there are high numbers of unemployed doctors, dentists and nurses with medical schools continuing to take on high numbers of new students each year. According to WHO, in principle all Kosovars have access to health care although in practice this is not the case. The most common barrier to health
care access is the cost of the service. The most expensive items of expenditure for patients are drugs, including those required during hospital treatment, as well as more general expenses and informal payments made to staff in order to ensure access to health care. The high incidence of informal payments is often attributed, at least in part, to the low salaries received by health care staff. Minority communities often have particular difficulty in accessing health services, as well as those people living in poverty, the elderly, invalids, veterans and those living in rural areas. In particular, further focus is needed to ensure the inclusion of the minority enclaves in the public health sector to discourage the establishment of parallel health systems.

3.2 Health sector financing

The health sector is mainly financed from the consolidated budget of Kosovo and donations from the international community, governmental and non-governmental organisations, with a small amount of income from co-payment. Kosovo’s gross domestic product (GDP) according to revised IMF estimation was 1,946 billion Euro in 2001. The public expenditure on health in 2001 was 48.52 million Euro. 6.37% of the estimated GDP was spent on health care in 2001, 3.22% was spent privately, 2.41% was from the public sources and 0.74% from international assistance. The following estimate of expenditures on health in based on Living Standard Measurement Survey (LSMS) data:

- 3% of the population visit private doctors once a month, corresponding to a total 756,000 visits a year. Average expenditure per visit is approximately 16.6 Euro.
- 15% of the population visit public health facilities per month. The total number of visits a year is 3,780,000. Average expenditure per visit is approximately 12.1 Euro.

5% of the population are admitted to hospitals per year. This represents a total of 105,000 admissions per year. The average private expenditure on drugs per admission is approximately 39.9 Euro.

3.3 Key Health Policies

In February 2001, the predecessor of the MoH launched the Health Policy for Kosovo as a follow-up to the Interim Health Policy Guidelines published in September 1999. The key features of the policy are:

- Primary Health Care will be the cornerstone of the health care system
- Dental care will be provided as a component of primary health care.
- Hospital based services will be accessed through a referral system.

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20 Ibidem
• Facilities will be based on demographic and patient needs.
• Maternal health care and mental health care will be given specific attention and improved.
• Specific health services such as oral health, prevention and rehabilitation, learning difficulties, emergency transport, occupational health and drugs and medical supplies will be improved.
• The improvement of management, financing and development of human resources will be a priority.

Some elements of the policy have already been pursued, but because of the instability within the MoH much remains to be done to implement the strategy.

Health reform activities to date include:
• Development of the health financing system including health insurance
• Investment by international agencies in facility rehabilitation and equipment
• A training programme for clinical specialists and Continuing Medical Education has begun
• A Family Medicine training programme has begun
• The MoH has issued an administrative instruction 9/2002, establishing a Centre for Development of Family Medicine
• Six community mental health centres have been established

So far, these activities are at the initial stages of implementation and there is a need for continuous support in the future in order to achieve the objectives of the health policy.

Conclusions

Increasing the efficiency of the health system, guaranteeing equal access to health care, ensuring transparency and selective decentralization in the field of resources management, creating diversification of sources and methods of financing, developing an organized national medicine policy and improving human resources for health care are the main points of the health care reform in both Serbia and Montenegro. The main problem in Serbia, Montenegro and Kosovo is the particular challenge of meeting the health needs of the higher number of refugees and IDPs, including many Romany. Some initial progress has been made but the period between the definition of goals of the reform and their realization will last at least several years.