Opportunities and Challenges of Social Security Transition in Montenegro

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Introduction – economic framework

After the disintegration of SFRY, Montenegro was a part of FRY by 2003, and after that of the State Union of Serbia and Montenegro.[110] In June 2006, Montenegro became an independent country. A year later, Montenegro signed an Agreement on Stabilization and Association with the EU, and in December 2008, became a candidate for EU membership.

The disintegration of ex-Yugoslavia, political problems and economic crises marked the first period (1990s) of transition changes, especially until 1994, when economic activity, expressed through GDP, was halved compared to 1989. Until 1997, economic recovery was recorded, but in the following two years, it was decreased again, due to "political crisis in the FRY and disagreements between the Montenegrin and Serbian Governments. This situation culminated after the war on Kosovo in 1999, when the Government of Montenegro made a complete distance from the policy of the federal state and started its own reforms" (EC, 2008, p. 4).

One of the first measures was an introduction of the German mark (instead of dinar), which had a positive impact on inflation rate reduction. At the same time, this period (the 2000s) has been characterized by constant growth in GDP, albeit relatively low, until 2006. After that, the growth was higher, primarily due to foreign investments and increased activities in the services, tourism and real estates sectors.

Average salaries have been increasing since 1999, and especially after 2006, but despite that, they are still relatively low.

The labour market has been characterized by a drop in employment, rising unemployment and work in the grey economy. During the period 1991-2003, the number of employed decreased, and in the following years, its rise was recorded (in 2005 – 144 340) (The National Employment Strategy for 2007-2010).

"At the end of 2006, 38,869 unemployed people were registered with the Employment Office of Montenegro. Compared to 2003, when 70,499 people were registered as unemployed, this is a reduction of 31,630 or 44,86%. Compared to the end of 2005, when 48,845 unemployed people were registered, unemployment decreased by 9,976 people or 20.42%. The unemployment rate, presented as a ratio of the number of unemployed and the number of active population, was 14.72% (13.9% and 15.8% in the male and female population respectively) in 2006. Compared to the previous years, a constant decrease of unemployment was registered, from 26.7% in 2003 to 14.72% in 2006. However, based on Labour Market Surveys conducted by MONSTAT in 2004 and 2005, unemployment rates were 27.7% and 30.3% respectively". (Ministry of Health, Labour and Social Welfare, 2008, p. 9)

In the years after independence, Montenegro recorded satisfying levels of macro-economic stability and economic growth per average rate of 8.7% (2006-2008). The world economic crisis decelerated economic development and resulted in the aggravation of overall economic indicators, as well as labour market situation.[111]

[110] The Serbian and Montenegrin social security systems have many important characteristics in common. However, they have never been identical, even in the period of co-existence within the same state(s).

[111] "Based on date of Labour Force Survey in 2009 213,600 persons were employed, i.e. 3.7% less compared to the previous year. At the same time, unemployment rose by 12.5%. The average number of employed in the three months of 2010 was 171,707, which is 1,846 persons or 1.1% more compared to the same period of 2009 (169 861). At the end of March 2010, 33,117 unemployed persons were recorded with the Employment Office (out of which 14,705 or 44.4% were women). Compared to March 2009, number of unemployed increased by 3,947 persons or 13.5% (Ministry of Finance, 2010).

Pensions

Pension system in transition

The Montenegrin pension system[112] has been developing pursuant to economic prerequisites and political objectives of having an independent country. Pension reforms started in 2001 with discussions about difficulties in the system functioning and the need to introduce a multi-pillar model.[113] Problems in the realization of legally prescribed rights and their insufficient financing were a consequence of high unemployment rates, a high volume of unregistered employment (grey economy), declining fertility rates, population aging and slow economic recovery. In 2003, a new *Law on Old-Age and Disability Insurance*[114] was enacted and its implementation started in 2004. The basic changes were made in terms of reforming the mandatory insurance (PAYG) and introducing voluntary insurance (II and III pillars).

In the first transition years, there were parametric changes of the 1st pillar, and later, the three-pillar system was introduced. In the consultations with the WB, the Government opted for the introduction of the 3rd pillar, before the introduction of the 2nd pillar.

The *Strategy of Old-age and Disability System Development* (2005) suggested the changes aimed at contribution "to the construction of financially sustainable, fair, stable and efficient pension system."[115]

The three-pillar pension system model was projected so as to enable financial stability of the system, increased levels of national savings, capital market development through increased levels of investments and decreased pressures on the budget. The transition period was also characterized by efforts directed towards the reorganization and increasing efficiency of the Old-age Fund, improving quality of the services, strengthening administrative capacities, the modernization of information technology system and harmonization of legislation with the EU standards.

Structure of the pension scheme

The pension system in Montenegro is organized in the form of a multi-pillar model, comprising of the following (article 1):[116]

1. mandatory old-age and disability insurance based on pay-as-you-go system;
2. mandatory old-age insurance based on individual capitalized savings;
3. voluntary old-age insurance based on individual capitalized savings.

Mandatory old-age and disability insurance based on employment (solidarity between generations) is based on current financing. Depending on the length of contribution years and amount of the basis for paying contributions, the insured people effectuate their rights in case of old age, disability and physical defects, and members of their families have certain rights in case of a death of an insured person. Funds for paying pensions from the 1st pillar are provided from contributions paid by employees and employers, and also the state in certain circumstances.

The 2nd pillar will be regulated by a special law.[117] Strategic documents envisage the foundation of this part of obligatory insur-

[112] *General Property Law* of 1888 contained certain provisions regarding social insurance. The first *Law on Pensions* was enacted in 1902 during the rule of the Duke Nikola I Petrovic. The right to pension belonged to civil servants, Montenegrin archbishop, teachers, widows and children of retired civil servants in case of their death.

[113] The system has been reformed with USAID (Bearing Point) consultations and later under the direct impact of the World Bank.

[114] The Law on Old-Age and Disability Insurance, "Official Gazette of the Republic of Montenegro", no. 54/03.

[115] Increasing economic efficiency and following the principle of fairness were supposed to contribute to the realization of social aims "including certain level of minimal protection in case of old age, disability and death, higher levels of information for beneficiaries, enabling an open and transparent system".

[116] The Law on Old-Age and Disability Insurance, "Official Gazette of the Republic of Montenegro", no. 54/03, 39/04, 61/04, 79/04, 81/04, 29/05, 14/07, 47/07 and "Official Gazette of Montenegro", no. 12/07 of December 14, 2007, 13/07 of December 18, 2007, 79/08 of December 23, 2008.

[117] The Ministry of Finance and the Ministry of Labour and Social Welfare are obliged to prepare a normative framework.

ance on capital coverage, i.e. individual capitalized savings of insured persons and paying contributions into private pension funds. Huge transition costs, lack of resources in the mandatory insurance Fund and an underdeveloped capital market[118] resulted in non-existence of the 2nd pillar in the practice.

The *Law on Voluntary Pension Funds* was implemented in 2007, regulating the conditions for establishing managing societies, organizing funds based on individual capitalized savings and their business dealings. Funds collected in the voluntary pension fund are contributions paid by the fund's members and their investing for the purpose of increasing value of the fund's property. The Commission for Securities is a supervising body and by the middle of 2010 three societies for managing voluntary pension funds had obtained permits, but the number of members is modest.[119]

Coverage

The mandatory insurance system covers three groups: employees, self-employed people and farmers (article 9). *Employees* (article 10) are classified into ten categories, presenting the majority of insured people in Montenegro. *Self-employed* (article 11) and *farmers* (article 12) are specific categories precisely mentioned in the law.

Table 1 - Beneficiaries of rights from old-age and disability insurance (2004-2008)

	2004	2005	2006	2007	2008
Old-age pensions	39 479	40 852	41 314	41 314	43 360
Disability pensions	25 685	25 185	25 455	24 607	24 560
Survivor pensions	25 269	25 771	26 549	26 247	27 557
Benefit for physical defect	7 771	7 713	7 399	7 072	6 806
Benefit for care and assistance of another person	2 064	2004	1 828	1 696	1 579

Source: Monstat, 2009.

The *rights* from old-age and disability insurance (article 16) are such as follows: 1. in case of old-age – the right to old-age pension; 2. in case of disability – the right to disability pension; 3. in case of death – the right to survivor pension and funeral costs; 4. in case of physical defect caused by work injury or professional disease – the right to cash benefit for physical defect.

The right to old-age pension (article 17) can be effectuated by men and women at the age of 65 and 60 respectively and with at least 15 years of service, with a gradual age increase from 2004 to 2012. The Law also allows years of service with increased duration of 14 to 18 months, in case of which the age limit for the effectuation the pension right can be decreased so as to be 55 years of life. Insured men and women have the right to old-age pension also with 40 and 35 years of service respectively and at least 55 years of life.

The right to full disability pension can be effectuated by an insured with a complete loss of working capacity, and in case of a partial loss of working capacity, one can effectuate the right to a partial disability pension. The Law also prescribes in more detail conditions for acquiring the right to a disability pension

[118] In its Economic and Financial Program for 2009-2012, the Ministry of Finance of Montenegro envisages the creation of adequate analysis and making comparisons between legal experiences of countries which have already introduced the 2ndpillar by the end of 2010, in order to make a law on this pillar after that.

[119] At the end of 2009, a voluntary pension fund named "Penzija plus" had 375 members and the other one named "Market Penzija" 46 members.

in case of a work injury or a professional disease, i.e. disability at work.

The right to survivor pension can be effectuated by members of the family of a deceased insured with at least 5 years of service or 10 years of pension contributions or who fulfilled conditions for old-age and disability pension.

Mandatory insurance covers all employees in Montenegro and there is no data about the number of people without the right to pension. The elderly are also exposed to a higher than average poverty risk. This points to the fact that benefits based on insurance are low and that a certain number of people did not fulfil conditions for effectuation of rights. The *Strategy of Elderly Protection Development* envisages the introduction of the 0 pillar, i.e. "social pensions."

Old age dependency ratio

Population aging and negative trends on the labour market (falling employment and rising unemployment) are determinants of a pension system functioning.

At the beginning of the 1990s, the dependency ratio presenting the ratio of employed and pensioners, was about 2.05. In 2002, it dropped to 1.3. According to data from the Fund of Old-age and Disability Insurance, in 1995 there were 125,089 employed contributors and 73,988 pensioners so that the dependency ratio was 1.69. Five years after, the number of employed dropped to 114,076, while the number of pensioners increased to 84,761 so that the dependency ratio was 1.35. A further drop in employment and rise in the number of pensioners, resulted in changing the ratio, so that in 2010 there were 97,000 pensioners and the number of employed amounted to around 169,000 resulting in the dependency rate of 1.8 (Dan, March 23, 2010). In March 2010 there were 97,867 pensioners: 45,462 (46.5%) of them were old-age pensioners, 24,251 (24.7%) disability pensioners and 28,155 (28.85) survivor pensioners.

The Montenegrin pension system is under strong pressure of demographic changes expressed in terms of more prominent population aging. According to data from the population census of 2003, out of a total 620,145 inhabitants, 103,393 or 16.67% were over 60 years, and 74,160 or 11.96% inhabitants were over 65 years. In 1953, person over 60 years presented 10.42% of total population and in 1991 – 12.78%. Based on current projections, the population will increase to 643,844 in 2021 but in 2031 it will decrease to 537,761, i.e. 596 693 by 2050 (Monstat, 2009).

Table 2 - Age structure of the population (2001-2031)

Year	*2001*	*2011*	*2021*	*2031*
0-14	126,911	120,817	116,976	106,288
15-64	412,856	429,983	426,148	414,113
65+	76,529	85,072	100,720	117,360
Total	616,296	635,872	643,844	637,761
Year	*2001*	*2011*	*2021*	*2031*
0-14	20.60%	19.00%	18.20%	16.70%
15-64	67.00%	76.60%	66.20%	64.90%
65+	12.40%	13.40%	15.60%	18.40%
Total	100%	100%	100%	100%

Source: Bacovic, 2006.

Demographic aging has resulted in a decrease in the working age population (15-64 years) in the overall structure, so that their share drops from 67.0% in 2001 to 66.2% in 2021 and 64.9% in 2031. Contrary to that, people over 65 years presented 12.4% of the overall population in 2001 and in 2011 their share will be 13.4%. This percentage will rise to 16.5% and 18.4% in 2021 and 2031 respectively. In 2001, the dependency ratio of persons over 65 years and working age population (15-64 years) was 5.4% but in the following decades it will decrease (Bacovic, 2006).

Financing

Contributions are the basic source of financing the rights belonging to mandatory old-age and disability insurance in Montenegro.[120] However, increasingly important are budgetary donations, due to deficit in the Fund.[121] Contribution rates have been changing during previous years with a view to decreasing the burden on salaries and in 2010 total contributions for old-age and disability insurance have amounted to 20.5% (employees 15% and employers 5.5%).[122] For years of service with increased duration, employers pay additional contributions varying from 6% to 18%.

Table 3 - Tax rates and contributions on salaries

	2009	2010
Income tax for physical entities	*12%*	*9%*
Untaxable part of salary (monthly)	70 €	0 €
Total contributions paid by employers	14,5%	9,80%
Total contributions paid by employees	17,5%	24,0%
Total contributions for mandatory pension insurance	20,5%	20,5%
Total contributions for mandatory health insurance	10,5%	12,3%
Total contributions for unemployment insurance	1,0%	1,0%
Total contributions for mandatory social insurance	*32,0%*	*33,8%*

Source: Ministry of Finance, 2010.

Contribution based revenues cover an increasingly important part of pension expenditures, albeit one third of necessary funds is still paid from the budget. In 2007, contribution based revenues were 73.2% of total revenues; EUR 61.15 million or 25.7% of total revenues was donated from the budget and also EUR 2.54 million or 1.0% of total revenues was donated from other sources. The deficit in the pensions system was about 2.5% of GDP, while total expenditures of the system were 9.61% of GDP. In 2008, contribution based revenues presented 75% of expenditures of the Fund of Old-age and Disability Insurance and in the first ten months of 2009, they were 4% smaller compared to the same period of 2008. In 2009, EUR 1 of total pension expenditures was covered with about EUR 0.60 of contributions, while EUR 0.35 was provided through budgetary transfer and the remaining EUR 0.05 from the privatization funds.

[120] The Law on Contributions for Mandatory Social Insurance, "Official Gazette of the Republic of Montenegro", no. 13/07 and 78/08 establishes contribution basis. In 2009, they were 20.5%, 10.5 and 1% for old-age and disability, health and unemployment insurance respectively.

[121] Planned transfers for social protection in the budget for 2010 participate with 34.56% in totally planned expenditures. The major expenditures belong to the rights from old-age and disability insurance (EUR 321 million); after that for social welfare (EUR 43,534 million), technologically redundant employees (EUR 20,534 million), health care (EUR 14,055 million) and health insurance (EUR 7,320 million) (Ministry of Finance, 2010).

[122] In 2008, contribution rates borne by employers and employees were 8% and 12%.

In 2001 and 2003, pension expenditures presented 11.44% of GDP and 10.69% of GDP respectively. In the following years, their drop was recorded so that they amounted to 9.49% GDP and 9.10% GDP in 2005 and 2006 respectively, with an increase in 2007 (9.61%) (EC, 2008: 96). According to data from the Ministry of Finance, in the current budget and in the budget of state funds in 2008, there were EUR 251 million (8.13% GDP) for the rights belonging to old-age and disability insurance. The budget rebalance in 2009 enabled EUR 332 million or 10.79% GDP for old-age and disability insurance.

The structure of revenues and expenditures in the Fund of Old-age and Disability Insurance points to a deficit increase. In 2006, 2008 and 2009, deficit of the Fund was 2.6% GDP, 2.2% GDP and 4.4% GDP respectively. The difference between revenues and expenditures is financed from the budget, through different subventions (ISSP, 2010).

Pension benefits

Pension amount is determined so that "personal points of an insured person are multiplied with the value of pension for one personal point on the day of the right effectuation" (article 20). The maximum pension is determined in such a way that the personal point of an insured person can be 4 at the most (article 28). The minimum pension (old-age, disability and survivor) is determined so that personal coefficient is 0.5. Pensions are adjusted twice a year (January 1st and July 1st of a current year) pursuant to an average salary and costs of living in Montenegro (article 58).

In the middle of 2010, the average pension in Montenegro[123] amounted to "55% of an average salary (EUR 465). The minimum pension[124] based on a new law amounts to EUR 92, and the pensions below EUR 100 have been received currently by less than 1,300 pensioners (January 2004 – 39,242,January 2007 – 31,494, January 2008 – 4,183). According to previous regulations, the minimum pension amount was dependent upon years of service and it has varied from EUR 143 (below 20 years of service) to EUR 235 (35-40 years of service) (Pobjeda, 2010). In 2008, the poverty rate in pensioners with minimal pensions was 15.7% and social exclusion index was 8.9. Only 4.3% pensioners with minimal pensions have received material support for families to the amount of EUR 73.3 per month (UNDP, 2009, p. 49).

In 2010,[125] the average pension amounted to EUR 255.34 which is 110% higher compared to December 2003 (EUR 121.59) (the new *Law on Old-age and Disability Insurance* came into force on January 1, 2004). Compared to December 2004, 2005 and 2007, pension benefits have been higher by 98%, 86% and 38% respectively.

In the year of the economic crisis in Montenegro, 2009, pensions were raised by 7.35% (pensions for January were increased by 4.9% and pensions by July 2.45%). A pension in July 2009, (EUR 256.67) was 18% higher compared to a pension in July 2008 (EUR 217.17). In January 2010, as a consequence of the impact of the economic-financial crisis on the growth of salaries in the second half of 2009 compared to the first one, pensions were decreased by 0.55% (Pobjeda, June 6, 2010).

[123] At the beginning of 2010 there were 2,997 military pensioners in Montenegro with an average monthly pension of EUR 360. Average military pensions are for about EUR 100 higher than the civil pensions. According to the President of Military Pensioners' Association, this is due to higher educational levels of military pensioners (the lowest achievement is secondary school) and more than 92% military pensioners went to pension with complete years of service (Dan, February 8, 2010).

[124] The Law on Old-age and Disability Insurance has set the minimal pension to 45 EUR. However, in the following years, that amount has been raising so that in 2008 it achieved 71 EUR.

[125] According to the quotation of the Manager of the Fund of Old-age and Disability Insurance as of June 6, 2010, pensions in Montenegro are highest in the region. Average pension of EUR 255 is higher than the Serbian average (EUR 210), Bulgarian (EUR 145), Romanian (177), B&H (EUR 171), Albanian (EUR 55). Montenegrin average is on the level of the EU member states – Estonia (EUR 285), Lietuva (EUR 258), Litvania (EUR 220).

Health care

Achievements and challenges of the past

Twenty years after the breakdown of socialism, the Montenegrin health care system is dominantly public. Private practice exists and it has been developing, but generally clear regulations are absent.

Health insurance is mandatory and it was founded on Bismarckian principles of paying contributions. It is universally available in practice. In terms of that, the only discontinuity with the socialist period is an introduction of a voluntary health insurance in 2004.

Some general social barriers (and among them: the financial ones), but also problems in the functioning of the health system itself, disabled and deferred reforms during the 1990s. On the one hand, health system reform was not prioritized because of the existence within a wider social system, the basic characteristics of which were literal collapse of economy and society as a whole and poverty and war in its immediate vicinity. On the other hand, in such circumstances of constant and multiple deprivation and a lack of basic material (and almost every other form of) security, proclaimed generous health care presented one of the few compensatory mechanisms to the population. It was this system to which politicians had frequently referred to (and relied upon) in the pre-election campaigns, but its shortages in practice were almost flagrant. Therefore, original rhetoric about the need to make a complete and immediate disconnect with socialist heritage was replaced by public discourse about the necessity of maintaining continuity with the good practice of socialism. These ambiguous views, among other things, disabled creation of a clear vision of health reforms. Finally, orientation to the EU membership gave much needed impulse for short-term and medium-term changes.

Legal reforms in health started in 2004 by enacting regulations presenting an innovated framework of the health system (the *Law on Health Care* and the *Law on Health Insurance*). Essential reforms were made only after that – "real operational reform processes started later, with the support of credit arrangements of the WB" (RFZO, 2008, p. 3) and it is not possible to completely evaluate their scope at the moment. The crisis of the health care system was manifested also through aggravated indicators of health status of the population and disturbances in health insurance stability. The most serious diseases of the health system were the following: "over-dimensional public and total consumption, lack of improvement in the quality of services, lack of information about health and bad managing. Primary health care does not play a significant role in the process of prevention, detection and treatment, employees in the health sector have low salaries, network of public hospitals and health centres is not efficient, prices of medicines are significantly above world standards" (EC, 2008, p. 9).

Structure of health care system – infrastructure and management

The structure of health institutions[126] comprises of health services, organized on three levels of care: primary, secondary and tertiary. Public ownership over health care institutions and unchanged organizational division during the twenty-year transition period have presented a part of the tradition and more forced, than favourable solutions. Privatization of dental practices and the introduction of the concept of a chosen medical doctor are innovations directed towards savings and increasing efficiency in the health system structure. Prob-

[126] The network of public health institutions comprises of 18 health centres, an Institute for urgent medical care, seven general hospitals, three special hospitals, a Clinical centre, an Institute for public health and a pharmaceutical institution (FZO, 2009).

lems of territorial unavailability and inaccessibility, as well as unequal quality of services, along with unregistered but supposedly high expenditures for private health sector, have not been solved yet.[127]

Primary health care is realized within health centres, which contrary to the period before the reforms, now have three parts: ambulances of chosen medical doctors, i.e. teams of chosen medical doctors, centres for chosen medical doctors' support (at the local and regional levels) and support units (for visiting-nurse service, physical therapy at the primary level and medical transportation). These changes were motivated by the need to establish the primary level as a basis of the health system. It is envisaged that 80-85% of health needs should be satisfied at the primary level (FZO, 2009).[128]

Secondary health care is provided by specialist out-patient departments and hospital beds, and *tertiary* health care is provided by sub-specialist out-patient departments, diagnostic centres and hospital departments. The basic intention of secondary and tertiary health care reforms is improving the quality of health care and services.

Encouraging private initiative, as well as the inclusion of the private sector in rendering health services at the cost of funds realized based on mandatory health insurance is currently on the level of unclear and abstract (sub)aims of the health policy.[129] It is motivated by widening the scope of individual responsibilities for their own health status, i.e. savings for the state but clear, strategic directions of connecting private and state health institutions are absent.

A mandatory system of health insurance is managed by the Fund of Health Insurance. It is the only bearer of mandatory health insurance but it also provides and conducts the voluntary health insurance. Contrary to mandatory insurance, which is based on the principles of obligation, mutuality and solidarity, voluntary insurance envisages rights which are absent from the system of mandatory insurance.[130]

Coverage

The right to health care has been extensively defined, so that the coverage of the population with mandatory health insurance is 100% - universal. All categories of the population, i.e. all legal residents of Montenegro realize the rights of the health care system. The Law establishes that "citizens of the Republic of Montenegro are completely equal regarding effectuation the right to health care" (RFZO, 2006, p. 34), as well as that "health care is conducted on the principles of availability, accessibility and complete approach to primary health care and specialist-conciliar and hospital health care" (RFZO, 2006, p. 34).

[127] At the same time, the unfavourable structure of employees in the health sector is a persistent problem: out of total number of employees (8,154), 73% are health professionals and associates and the remaining 27% are non-medical workers (FZO, 2009).

[128] "Good organization of the health system favours primary health care, which in turn impacts positively on efficiency of the total health system. Changes in the health centres will gradually remedy developmental disproportions which have been a problem in the health system development" (EC, 2008, p. 9).

[129] The exception is strict privatization of dental service.

[130] The first implementation phase of the Project of Voluntary Health Insurance Introduction is realized, but the realization of the second phase is dependent first of all on legal changes of current legislation regulating health insurance.

Table 4 - Insured persons

Basis of insurance		2008	%
Employed	Holders	182,397	28.38
	Members	121,546	18.91
	Total	303,943	47.29
Unemployed	Holders	97,006	15.09
	Members	63,053	9.81
	Total	160,059	24.90
Retired	Holders	97,762	15.21
	Members	29,461	4.58
	Total	127,223	19.79
Farmers	Holders	9,832	1.53
	Members	7,292	1.13
	Total	17,124	2.66
Refugees		18,584	2.89
Others	Holders	12,104	1.88
	Members	3,707	0.58
	Total	15,811	2.46
Total		642,744	100.00

Source: FZO(2009)

The declared principle of availability of health care to all citizens is realized.[131] However, qualitative aspects of researching social exclusion do not present a completely uniform picture. For example, data about the coverage of beneficiaries of social welfare benefits and child allowances are consistent with the data about universal health care coverage. However, they are also an evidence about the factual inability of the rights' effectuation because of huge (territorial) distances, long waiting or simple lack of financial sources for covering health care costs (UNDP, 2009). Additionally, vulnerable groups have problems in effectuation of certain rights that cannot be realized in the state sector and they are directed towards the private. Their financial position disables their approach to private health sector.

Health status of the population

In the period 1999/2000, the life expectancy rate was 73.56 years (76.27 and 71.05 for women and men respectively). According to data from 2004, this indicator showed a slight aggravation (73.1 years) (RFZO, 2006) and after that an improvement, but also a slight one. The life expectancy rate in 2007 was 73.77 years (76.06 and 71.22 for women and men respectively) (FZO, 2009).

The mortality rate indicator in Montenegro has been aggravated. A general mortality rate of 7.4 from 1994 increased to 9.2 in the ten-year period that followed. After that, there was a slight rise, replaced by slight drop of mortality rate, which became stable at 9.51 in 2007 (FZO, 2009).[132]

[131] Almost half of beneficiaries are employed and members of their families (47.9%). Unemployed are the second largest category (24.9%), and pensioners (19.79%) after them. Farmer represent only 2.66%, as well as refuges (2.89%) and the so called other categories (2.46%) (funds are provided from the budget) (FZO, 2009).

[132] However, in the same period (1994-2004), infant mortality rate decreased by double, so that it was 7.8 to 1000 live born infants in 2004 (RFZO, 2006). From the following year (2005), this indicator has shown extreme variations. It experienced a dramatic rise compared to 2004, since it amounted to 9.52 and in 2006 even 11.02. In 2007, it was decreased to 7.40. An explanation is small number of infants in Montenegro "where a small number of cases dramatically increases, i.e. decreases this rate" (FZO, 2009, p. 32).

Financing

By 2007, when important legal changes regarding contribution rates were introduced, mandatory health insurance was financed per rate of 13.5% (6% and 7.5% of earnings were paid by employers and employees respectively).[133] After that period, contribution rates were decreased, with the tendency for further decreases. Therefore, in 2008, contribution rates for health insurance amounted to 12%, in 2009 – 10.5% (5.5 and 5% by employers and employees respectively), and it was envisaged to be 9% in 2010 (5% and 4% by employers and employees respectively). At the moment, despite decreased contribution rates, revenues have not decreased. The main reason for that is improvement of the system of contributions' collection.

Apart from the contribution based revenues, health insurance is financed also from other sources.[134]

Expenditures for mandatory health insurance in the Montenegrin GDP were increasing in the period of 2000 and 2001, after which a trend of their decrease followed. With 5.68% GDP in 2000, they increased to 7.08 GDP in 2002, which was the highest percentage of expenditures for health in GDP during the decade. Since 2003, apart from the decreasing trend, it is worth noting that they have been below 7% GDP (RFZO, 2006, 2008). The percentage of expenditures for mandatory health insurance within public consumption was 13.68%, 14.58% and 14.35% in 2004, 2005 and 2006 respectively (RFZO, 2006).

Cost containment measures

There exists a co-payment of insured people in the costs of using health care in Montenegro (article 59 of the Law on Health Insurance). Its amount varies depending on the type of disease, diagnostic, treatment and rehabilitation costs as well as health care level (article 60). The Law also prescribes some exceptions, i.e. categories of the population to which this obligation does not refer to – children, pregnant women, women during delivery and one year after that, the elderly over 65 years, social welfare beneficiaries, as well as people with certain diseases (article 61).

Since the circle of beneficiaries without an obligation of paying participation has been extensively defined and its amount is more than symbolic, co-payment is not a significant source of revenues for health insurance. "Regarding private funds in the health system, there is only a co-payment measure – participation of insured people in bearing costs of using health care, covering less than 1% of total revenues for health care" (FZO, 2009, p. 46).

Many of the Government's financial plans envisage raising and widening of co-payment measure, as one of the alternatives for the creation of a sustainable health system. However, practical steps towards that aim have been absent.

A strategic orientation toward the introduction of new models of paying on all three levels of health care has been present. At the level of primary health care, there were projects dealing with methodology of determination capitation value and costs of health services, with a view to optimizing health consumption and improving quality of services. These new models of payment were not known during the socialist period and the 1990s, but there was a significant resistance to their introduction during the 2000s. Only since January 2009, calculations based on this principle have begun in the primary health care.

[133] The Fund of Old-age and Disability Insurance paid contributions for health insurance of pensioners per rate of 19% of pension benefit.

[134] One fifth of the revenues of the Fund of Health Insurance are budgetary resources (for health care of unemployed who do not receive cash benefits and refugees as well as for covering minuses).

On the other hand, there are no official and organized data about private payments for health in Montenegro, so that it is not possible to evaluate and compare them precisely. It seems that under-the-table payments still exist, but despite occasional affairs, these "transactions" are still out of the public scope.

Health benefits

The rights of citizens based on mandatory health insurance are the right to health care; the right to benefit during temporary inability to work and compensation of travel costs incurred in connection with health protection (article 15).

The right to health care has been extensively defined and includes preventive measures, medical check-ups and treatment (within the Republic and abroad), medicines and medical agents, as well as medical-technical devices. The Law additionally highlights and quotes categories of special importance – children, the elderly over 65 years, pregnant women, disabled.

The right to benefit during temporary inability to work is realized by insured persons in all cases of temporary inability to work, due to an illness, injury, medical examinations, etc. and in case of taking care of an ill member of their immediate family or accompanying an ill member of their immediate family during medical treatment or examination. During the first 60 days of the leave, the benefit is paid at the cost of the employer, and after that at the cost of the Fund. The benefit amount is dependent on the previous salary and it varies from 70-100% salary, while it is paid from the first day of the leave. If a person is unable to work for more than 10 months, then his/her working capacity is to be evaluated.

The right to compensation of travel costs incurred in connection with health protection is realized by an insured person, but also by their companions. It is effectuated in cases of directing them into another place, regarding the effectuation of the right to health care or evaluation temporary inability for work.

Unemployment protection

Employment and strategic orientations

The basic elements of the employment policy have been defined in strategic documents and action plans. As the basis for the period 2001-2010, the following was defined "comprehensive approach to solving labour market problems" through realization of priority measures and activities. In 2008, the Strategy[135] was updated with a view to "increasing the level and quality of employment" to the general rate of 60% at least and decreasing unemployment to 10%. The strategic priorities of 2011 are: 1. raising employment and reducing unemployment; 2. increasing productivity and quality of work; 3. strengthening social cohesion.[136]

The rights of the unemployed were defined by a special *Law on Employment* which had been changed several times in the previous period.[137] Insurance based rights could be effectuated by people eligible based on conditions regarding previous years of service and payment of contributions in a certain period. Eligibility conditions became stricter during the time and there were changes regarding the calculation method of cash benefit amount and duration of payment. The number of beneficiaries of the rights belonging to passive measures has been increasing, even though the preferred method for solving the unemployment problem is via prioritizing active measures. At the beginning of 2010, a *Law*

[135] The *National Strategy of Employment and Human Resources Development* for the period 2007-2011.
[136] The Action plan presents specific measures per periods.
[137] The Law on Employment, "Official Gazette of the Republic of Montenegro", no. 5/02, 79/04, 21/08.

on Employment and Realizing Rights Based on Unemployment Insurance was enacted.[138]

Coverage

"An unemployed person is a person between 15 and 65 years, who is a Montenegrin citizen or a foreigner with a personal working permit, registered with the Employment Office of Montenegro, capable or partially capable of work, without a job and actively seeking it" (article 3).[139]

Unemployment insurance requires from employees and employers to pay contributions in order to provide funds for the realization of rights (article 4).[140] The insurance does not cover people working in the grey economy.

Unemployment insurance rights can be effectuated by people meeting conditions in terms of employment duration, causes of losing a job[141] and registering with the competent service (within 30 days).[142] The right to cash benefit can be realized by an insured person who has 12 months of service in continuity or 12 months of service with interruptions during the last 18 months, prior to losing a job (article 47).

Financing

The realization of unemployment insurance based rights is within the competence of the Employment Office and they are financed from contributions, Employment Office resources, donations, interests, gifts.[143] The *Law on Contributions for Mandatory Social Insurance* determines the circle of contributors (article 7) and establishes the contribution rate of 1%.[144]

Table 5 - Projection of social contributions in the consolidated budget balance (2011-2013)

	Projection for 2011		Projection for 2012		Projection for 2013	
	mil. €	% GDP	mil. €	%GDP	mil. €	%GDP
Source revenues of the budget	1,182.55	35.59	1,278.4	35.75	1,380.90	35.76
Taxes	753.00	22.66	817.85	22.87	887.51	22.98
Contributions	342.16	10.30	365.24	10.22	391.00	10.13
Contributions for old-age and disability insurance	207.58	6.25	221.28	6.19	238.09	6.17
Contributions for health insurance	120.41	3.62	128.36	3.59	136.12	3.53
Contributions for unemployment insurance	10.51	0.32	11.21	0.31	12.06	0.31
Transfers for social protection	424.32	12.77	428.56	11.99	435.85	11.29

Source: Ministry of Finance (2010)

[138] The Law on Employment and Realizing Rights Based on Unemployment Insurance, "Official Gazette of Montenegro", no. 14/2010.

[139] Full-time pupils, students, pensioners and farmers registered with the Registry of Farmers also have the status of unemployed persons.

[140] Before the latest legal changes, it was provided that also people employed in a foreign country can effectuate these rights, provided that they are not insured on the basis of inter-state agreements (article 46 and 47 of the Law of 2002).

[141] With the consent of an insured person and without their fault.

[142] The Law prescribes the following rights: the right to cash benefit, old-age and disability insurance and health insurance (during the effectuation of the right to cash benefit).

[143] The state is a guarantor of the effectuation of the Office's obligations (article 18).

[144] It is equally divided between employee and employer.

Funds for the realization of legally prescribed rights are provided in the budget.[145]Based on data from the Ministry of Finance in 2009, contributions for old-age and disability insurance were 6.62% of GDP while the contributions for unemployment insurance were 0.30% of GDP. The 2010 budget has envisaged the collection of more than EUR 10 million or 0.32% of GDP on the basis of unemployment insurance. Expenditures for "the funds for technologically redundant employees" in the 2010 budget have been planned to the amount of EUR 20.95 million, out of which EUR 5,214,000 is to be used for severance payments, EUR 15,179,880for unemployment benefits and EUR 201,000 for other costs.

Unemployment benefits

The duration of paying cash benefits depends on the duration of previous employment and varies from 3 to 12 months. For an insured with 1-5, 5-10, 10-15, 15-20, 20-25 and over 25 years of service it is paid for3, 4, 6, 8, 10 and 12 months, respectively (article 51).

The number of beneficiaries of cash benefits based on temporary inability for work has been significantly increasing: in 2004, it was 4,310 (on average per month), in 2005 – 6,137, and in 2006 – 7,535 unemployed individuals realized this right. This has resulted in an increase in annual expenditures for the purpose of paying this benefit from EUR 1.3 million in 2003 to EUR 5.3 million in 2006. In 2007, 8,240 persons or 21.1% of those unemployed effectuated the right to cash benefit, which was an enormous rise compared to the situation in 2002 (2,325) (Ministry of Finance, 2010). In the following years, the number of beneficiaries of insurance based rights increased, primarily as a consequence of laying off employees in privatized companies.[146]

Women and men with more than 30 and 35 years of insurance, respectively, have the right to cash benefit as long as they are without a job, i.e. until they find a new employment. In case an unemployed has more than 25 years of insurance and is a parent to a child realizing the right to disability allowance, then he/she has the right to cash benefit until finding a new job or any of the reasons for the cessation of this right.[147]

Based on the Law of 2002, the *amount* of unemployment cash benefit was determined as 65% of minimal salary plus contributions for old-age and disability insurance. By a draft of the new Law (2009), it was envisaged to increase the amount from EUR 33 to EUR 55, having in mind that this amount has not been changed for seven years, while the salaries rose by 215%. By the middle of 2002, unemployment cash benefit amounted to 20% of the average salary, and by the middle of 2009, only 7%. The new Law of 2010 determines the cash benefit as 40% of the minimal salary established by the General Collective Agreement (article 57).

[145] Evaluation of necessary funds for unemployment insurance based cash benefits have been planned based on the number and structure of the beneficiaries on the occasion of preparing law on budget for the following year and expected labour market trends.

[146] "In September 2009, there were 12 278 beneficiaries of cash benefit: 6 981 of them effectuated the right to an increased cash benefit (which was equal to an amount of the lowest pension of EUR 92,52 net, i.e. EUR 116,11 gross) and 5 297 of them effectuated the right to a regular cash benefit (EUR 33 net, i.e. EUR 41.41 gross). EUR 1.121.365,57 was directed toward paying the mentioned cash benefits (EUR 872.542,87 for increased cash benefits and EUR 248.630,08 for regular cash benefits) amounting to about EUR 13.500.000 on the annual level. It is estimated that the number of beneficiaries to an increased cash benefit will decrease from current 7 000 to about 5 000 in 2012, while the number of beneficiaries to a regular cash benefit will increase from current 5 000 to about 6 500 in 2010, i.e. about 9 000 in 2012. Based on the abovementioned, it is estimated that in the period from 2010-2012, about EUR 15.000.000 will be necessary for paying cash benefits per year" (Explanation of the Law on Employment and Unemployment Insurance, 2010, p. 6).

[147] The Law prescribes conditions for the continuation, standing and ceasing the right to cash benefit (articles 52-54).

Active labour market measures

Active employment policy comprises of "plans, programs and measures directed towards increasing employment, i.e. decreasing unemployment" (article 28). The *National Strategy of Employment and Human Resources Development* establishes active employment policy, its priorities and aims. The action plan is the basic instrument of active employment policy in a one-year period.

Active policy measures are such as follows (article 31): 1. informing about possibilities and conditions for employment 2. mediation in employment 3. professional orientation 4. financing trainees 5. support to self-employment 6. subventions for employment 7. education and training of adults 8. professional rehabilitation of persons with difficulties to find employment 9. public works 10. grants and other measures directed to increasing employment, i.e. reducing unemployment.

Within the framework of measures directed towards increasing employment, the majority of the funds[148] have been directed towards paying insurance based rights and severances for redundant employees. Active measures programmes are not adequately present in the work of the Employment Office and only a small proportion is intended for them.[149]

Based on records of unemployed persons in the first trimester of 2010, until April of the current year, there were 10,092 interviews with unemployed individuals, while 16,488 employment plans were made and 23,118 employment plans were realized.

Measures against undeclared work

The crisis and transition in the last decade are characterized by a significant engagement of labour force in the grey economy. In Montenegro, as well as in other Republics of ex-Yugoslavia, earnings outside the regular market became the basic survival strategy for redundant employees, refugees and IDPs, retired and low-paid workers. Along with officially registered earnings, employers used to pay certain funds to employees in person. During the last few years, the majority of activities on the grey market have been performed through seasonal work of labour force from Montenegro and neighbouring countries.

Research[150] shows that in 2007, 22.6% of those employed worked in the grey economy.[151] Out of the total number of employed in the period, a partially registered salary was received by 17.5%, and employer or employee paid contributions for only one part of the salary, most frequently on the minimal guaranteed salary. The majority of those engaged within the grey sector are 20-29 years old, most frequently they work in hotels and restaurants (19.1%), agriculture (18.0%) and wholesale trade or trade (15.7%) (ISSP, ZP, 2007).

Losses due to evading an obligation of paying taxes and contributions are enormous.[152] The state has reduced fiscal obligations for employers and in 2010 they are about 40% lower compared to 2004, with a view to better participation of employees in the regular labour market. There are estimations that

[148] There is no precise data about expenditures for the active labour market measures, but the coverage of unemployed with certain measures can be seen from the Report on the Work of the Employment Office.

[149] The Law on Budget does not provide for special funds for active measures, so that it is difficult to estimate their share in GDP. "In 2009, the Institute organized 102 public works, in which 1,531 unemployed persons were engaged, which is 262 persons more compared to 2008. The plan for 2009 envisages realization of 70 public works that would employ 1,200 unemployed persons registered with the Office. Process of professional informing includes 466 clients" (ZP, 2010).

[150] The Institute for Strategic Studies and Forecasts and Employment Office of Montenegro (2007).

[151] The Grey economy in Montenegro has three main forms: employment in the grey economy sector, unregistered employment in the official sector and employment in the official sector with "partial" registration.

[152] The state has lost EUR 150 per employee every month or EUR 1,800 every year. Research shows that on each EUR 400 paid in the grey sector, EUR 207 is lost (EUR 2,484 on the annual level) and that for its 5,000 employees in the grey sector (estimation in 2009), the state loses between 9 and 13 million EUR.

about Ľ of those unemployed in Montenegro in 2010 have worked on the grey market.[153]

Labour inspections have controlled the activities of companies with modest results.

Social assistance

Poverty

The genesis of poverty in Montenegro dates to significantly prior to the 1990s. Even within the socialist state, Montenegro belonged to the club of underdeveloped and poorer regions. The transition period from the beginning of the 1990s additionally intensified poverty scale, depth and severity. In the shadow of transition to the multi-party system and market economy, the whole last decade of the 20th century was marked by (hyper)inflation, sanctions by the international community and war in the immediate vicinity. In such unfavourable conditions, a sharp decrease of the living standard was reported as early as 1992, remaining almost without any significant improvement for the next ten years.

Along with those categories that can be usually marked as vulnerable, in that period poverty specifically jeopardized those whose existence was dependent on incomes based on social insurance rights (pensioners) and officially employed in the so-called state/social companies.[154] The state activities directed towards the poor were neither of an adequate scope nor of a systemic character, but improvised, as a result and necessity of the scope of the problem in the situation of impoverishing of the state itself. Consequently, the results of poverty eradication were extremely modest.

The period after the bombing in 1999 was the beginning of Montenegrin reforms, among others, in social assistance. Regarding that, on the occasion of creation of the *Strategy of Development and Poverty Reduction* of 2003, poverty in Montenegro was profiled based on data obtained in the HCMS in 2002. It was established that 12.2% of the population was poor, and that even more then 1/3 of the population was economically jeopardized and an extremely large group of the population was concentrated around the poverty line.This meant that only minor changes of criteria or in economic trends would result in big differences in the number and percentage of the poor. Two years later, in 2004, the poverty rate decreased to 10.8%, and the rate of economically jeopardized population decreased to 28%, leading to the conclusion that "poverty remained stable, despite registered economic growth and increase in salaries" (UNDP, 2009, p. 23). Based on the latest data from 2007, the poverty rate in Montenegro amounted to 10.9%. Regional differences, however, have remained stable, as well as above the average exposure to poverty of certain vulnerable categories. However, concern is brought by data based on which poverty risk is 24.3% (UNDP, 2009), compared to 16% of EU27 (i.e. 16% in EU25 and 17% in EU15).

Structure of social assistance system – management and institutions

The state system of the help for the poor, with its prominent characteristics of centralization, is coordinated by the competent Ministry, in which jurisdiction, social and child assistance institutions are. Regarding social assistance institutions in its stricter meaning, they are as follows: social welfare centres (SWCs), institutions for accommodation of children and

[153] The *Strategy of Professional Vocation Development 2010-2014.*

[154] "The needs of the population were reduced to satisfying the needs for food, most frequently the cheapest kind, clothes and shoes. People were trying to find different solutions and the state did not have an adequate solution for the situation. Queues for bread and milk, empty shelves in super markets, union aid in terms of flour, sugar, and oil, were the main characteristics of the time. Many people tried to find salvation through returning to villages and producing basic articles in order to meet the basic needs" (Jankovic, 2010, pp. 57-58).

youths, as well as institutions for accommodation of disabled and elderly adults[155] (The Law on Social and Child Assistance, 2005).

SWCs are the basic segment and the first line of social and child assistance with authorizations at the local level. "However, the organization of SWCs is inadequate and insufficiently stimulating for development of services at the local level, and finally, not rational. Out of ten SWCs, only three are independent municipal centres, while the others are for several municipalities" (Ministry of Health, Labour and Social Welfare, 2007, p. 10). Decentralization trends have recently commenced, in such the dominant orientation of centres toward cash benefits has not been overcome yet.

The number of institutions for accommodation of children and youths complies with previous and current needs, but they are not adequately territorially distributed.[156] This problem, existent also during the 1990s, has not been adequately solved up to day, and institutions for accommodation of disabled and elderly adults[157] do not satisfy the needs of the Montenegrin population even quantitatively. Deinstitutionalization is seen as a favourable trend in the development of the system but there have been no important steps taken in that direction so far.This means that institutional accommodation is present also in those circumstances in which it would be a less favourable option if there were alternative forms of care.

Since the beginning of the 1990s, many national and international non-governmental organizations have been engaged in different, frequently isolated areas, belonging to social assistance, creating a certain addendum to the state system. Their dominant humanitarian character during the crisis of the 1990s (aid in food, fuel, clothes, shoes, etc. for the most vulnerable population) has been gradually transformed into providing some specific services – legal aid to refugees and internally displaced persons and psycho-social assistance to victims of domestic violence, etc. However, this segment has been underdeveloped, without access to budgetary funds and is lacking in cooperation between the state and informal sector. The exception is the Red Cross, more because of its traditional roots and existence.

Coverage

Generally, social assistance, as a system of organized activities of the state, directed towards offering benefits and services for providing basic existence, has not been based on the principle of paying contributions, as an eligibility precondition. In terms of that, all citizens of Montenegro can effectuate the rights to social assistance; with limitations regarding satisfying certain legal requirements (the rights to cash assistance are means-tested).

Along with the general formulation about the provision of the minimal social security to the citizens unable to work and without funds for living, the legal changes of 2005 acknowledged additionally special assistance of children,[158] disabled, elderly and families in so-called special circumstances requiring thus different forms of social assistance. These changes have pointed to a better recognition of specificities of certain needs, as well as the

[155] Based on regulations of 2005, also centres for counselling, researching and professional activities in the area of social and child assistance were supposed to be established. Their tasks are to vary from monitoring, studying, analysing, to proposing measures and activities in the area of social and child assistance (The Law on Social and Child Assistance, 2005). At the same time, institutions for holidays and recreation of children, envisaged by the Law, cannot be considered social assistance institutions, bearing in mind their orientation to the whole population of children, but child assistance institutions in its wider meaning.

[156] Only two institutions are not in the capital.

[157] There are only two institutions of this type: Home for pensioners and other elderly "Grabovac" in Risno and Institute for Schooling and Rehabilitation of Persons with Hearing and Speaking Disturbances in Kotor.

[158] Children without parental care, children with physical, mental and sensory disturbances, abused and mistreated children, children with behavioural disorders.

necessity for more adequate reactions when they occur. Along with the non-discrimination principle, they were put into the law, as a part of efforts and aspirations of the Montenegrin state to approach to the EU in the near future.

Financing

Benefits and services from the social assistance system are financed centrally from the budget, contrary to disproportionately smaller part of funds provided by local communities (mainly for lump sum benefits, in the last five years). Even though local communities have been (normatively) encouraged to provide funds for social assistance, those funds are not sufficient, and their motivation has been frequently exhausted due to bad financial positions. Generally, funds from the Republic budget, which have been stable during the last several years, contrary to constant deficits during the 1990s "are insufficient for cash benefits, maintaining the quality of existing services and the development of new ones" (Ministry of Health, Labour and Social Welfare, 2007, p. 13). In that context, a special problem regarding providing the minimal social security is lack of funds for the extension of programs, i.e. population scope and modernization of services in the institutions and out of them. Certainly, the main support of the Montenegrin social assistance system is traditional family with its prominent protective functions. However, a decade long crisis at the end of the previous century has impoverished and exhausted (material and other) resources of Montenegrin families. Despite previous prominent patriarchal patterns, Montenegrin families are in the processes of changing and nuclearization, but economic threats are an important barrier to that. In that context, recommendations about greater engagement of beneficiaries do not look very realistic.

Table 6 - Share of social expenditures in the Republic budget 2003-2008 (total amounts and shares)

	2003	2004	2005	2006	2007	2008
Child allowances	3,151	3,414	3,420	3,812	4,273	4,515
Protection of war veterans and disabled	3,685	8,209	7,518	7,507	8,314	9,050
Material support to families	8,971	8,277	8,857	10,302	12.911	13,346
Maternity leave	5,400	5,997	6,135	6,562	6,332	7,850
Care and help of another person	2,600	2,280	2,557	3,160	4,664	5,492
Expenditures for accommodation institutions	2,485	2,515	2,517	2,442	2,416	2,700
Other social services	843	863	1,152	291	-	200
Sub-total	27,135	31,555	32,156	34,076	38,910	43,153
Distribution of funds for severance payments of employees declared as redundant during the privatization and restructuring of companies	12,844	10,123	7,623	4,350	1,579	21,400
Total	39,979	41,678	39,779	38,426	40,489	64,553
% of current Republic budget	*9.0%*	*9.5%*	*7.9%*	*6.5%*	*6.9%*	*8.6%*
% of national GDP	*2.9%*	*2.7%*	*2.3%*	*2.0%*	*1.9%*	*2.7%*

Source: National Human Development Report(2009)

"Data about consumption for social assistance pursuant to ESSPROS methodology is not available and the only source of data about consumption for social assistance is data from the central budget (budget laws)" (EC, 2008, p. 5). However, it is not classified consistently and it would have to be broken down further, in order to be able to have an insight into its wholeness, but also into its structure (separate items). Therefore, much necessary (but missing) data hinders acquiring holistic and realistic insights, among other things, when talking about social assistance consumption.

Based on data for this decade, expenditures for social assistance as a percentage of GDP have been decreasing steadily, and as a percentage of current republic budgets, they have been decreasing with certain variations from 2003 to 2007. A registered increase in 2008, however, was the result of paying severance payments to employees declared as redundant during the privatization and restructuring. This does not reflect a realistic and essential increase of expenditures for existing items (for material assistance and social service). An additional reduction of expenditures for social assistance, based on current rates, has certainly especially bad consequences in the situation of the economic crisis that did not avoid Montenegro in 2009 and 2010.

Social assistance benefits

The field of social assistance that at the beginning of the transition was regulated by previous socialist law was originally regulated by the *Law on Social and Child Assistance* of 1993.[159] Three years after the transition beginning, when all shortfalls in the law were seen, "certain changes in social and child assistance based rights occurred, in order to enable better direction of help to those who really needed help" (Arandarenko, Djurovic, 2004, p. 13). This The Law of 1993 provided for the following rights:

- rights to cash assistance (right to provision for families, benefit for care and assistance of another person, compensation of funeral costs and child allowance)
- rights to institutional and non-institutional accommodation (accommodation in institutions of social assistance and other families)
- combined services (right to training, right to health care and right to social work services) (The Law on Social and Child Assistance, 1993).

A new Law of 2005, of the same name, enacted two years after the beginning of the implementation of the Strategy of Development and Poverty Reduction in Montenegro of 2003, maintained all previously existing rights, while the rights to material assistance were amended so as to include also the right to a lump-sum benefit and personal disability allowance (The Law on Social and Child Assistance, 2005).

[159] The Law on Social and Child Assistance "Official Gazette of the Republic of Montenegro" no. 45/93, 16/95 and 44/01.

Table 7 - Survey of current social assistance rights

Right (benefit)	Purpose	Eligibility	Number of beneficiaries (individuals, families), 2008	Expenditures, EUR 000, 2008
Material support for families	To provide a minimum of income	- amount of current monthly income is below EUR 50, 60, 72, 85, 95 for one-member, two-member, three-member, four-member, five-member or more member families, respectively; - an applicant is not an owner of business premises or he/she does not use them; - an applicant is not an owner or he/she does not use an apartment or a building in urban or sub-urban construction area bigger than one-room, two-room, three-room apartment for one-member, two or three-member, four or more-member families respectively; - an applicant is not an owner or he/she does not use an agricultural land, i.e. forests in the area bigger than 2000m^2, 3000m^2, 4000m^2, 5000m^2, 6000m^2 for one-member, two-member, three-member, four-member, five-member or more member families respectively or he/she is not an owner or he/she does not use another land in the area bigger than 20000m^2; - members of the family were not offeredemployment or training; members of the family are not owners of movable property.	12,756	12,729.21

Disability allowance	To provide an income to persons unable to earn a living	- persons who were unable to work prior to their 18 years and persons unable to lead an, independent life and work.	1,347	853
Allowance for providing assistance and care of another person	To provide an income to persons who undertake the care of another person	- persons with severe disturbances needing constant care and assistance by another person, in case they are not married or they do not have children or a child is unable to work or is below 15 years; - an insured person who was blind prior to his/her employment or become blind during employment; - an insured person with dystrophy (or a similar muscle disease) or a disease occurred during employment.	1,624	3,806.62
Accommodation in social assistance institution	For accommodation of children without parental care, children with special needs, juvenile delinquents and elderly	- children without parental care and children whose development is disturbed or aggravated by family conditions. Children realize the right to make decisions after completion of full-time secondary schooling; children and youths with physical, mental and sensory disturbances; children with behavioural disturbances; persons with physical, mental and sensory disturbances who cannot (due to housing, health or social circumstances) get another assistance; adult disabled persons and elderly who cannot (due to housing, health or social circumstances) get appropriate assistance;	668	1,407.50

Accommodation in another family	For accommodation of children without parental care, children with special needs, juvenile delinquents and elderly, pregnant women and single parents	- children without parental care and children whose development is disturbed by family conditions; - children and youth with physical, mental and sensory disturbances; - children with behavioural disturbances; - persons with physical, mental and sensory disturbances who cannot (due to housing, health or social circumstances) get another assistance; - adult disabled persons who cannot (due to housing, health or social circumstances) get appropriate assistance; - pregnant women or single parents with a child up to 3 years who due to social circumstances need accommodation.	275	765.49
Assistance to children and youths with special needs	Assistance for children and youths unable to take care of themselves and earn a living	- children and youths unable to take care of themselves and earn a living	250	n.a.
Lump sum benefit	Lump sum cash assistance for families and persons aimed at improvement of their living conditions	In case of a special occurrences aggravating housing, material or health status of families or individuals resulting in their need for social assistance.	n.a.	1,080

Source: UNDP (2009).

The right to material support to families and child allowance are the two most important cash transfers.

The amount of material assistance is dependent on income and earnings of families, as well as the number of family members. Until 2005, minimum amounts of material assistance were obtained by individuals (40% of average salary in the Republic in the month preceding the month of payment), and maximum amounts – five-member and bigger families (80%). Accepting EUR currency enabled the introduction of monetary amounts into the law, so that it was provided for individuals to obtain assistance to the amount of EUR 50 (which was at the same the minimum amount)

and five-member and bigger families – EUR 95 (the maximum amount). Even though these amounts have been increased in the meanwhile,[160] they are still extremely modest and they do not exceed the poverty line defined on the occasion of the Strategy creation. It also seems that these amounts significantly discourage all efforts directed toward social inclusion of the poor. There are no limits regarding the length of time of the right effectuation.

The amount of child allowance is established as a percentage of minimal salary in the Republic in the month preceding the payment and it varies depending on "categorization."[161] Duration of the right was limited by the legal age (18 years) although with certain exceptions connected to full-time schooling. Legal changes introduced fixed amounts for child allowances, which are the lowest for children of material assistance beneficiaries (EUR 15), and the highest for children with disorders who will not qualify for any form of work, as well as for children without parental care (EUR 25).[162] There are limits in connection with years of life. The amount is extremely low, almost symbolic. At the same time, allowances are paid through parents (mothers are not favoured, even though theory offers arguments that allowances have a better chance in reaching children when targeted via mothers).

Measures against poverty and social exclusion

The strategic framework for poverty reduction in Montenegro was designed in 2003 when an analysis of characteristics and specifics of poverty was done for the needs of strategy creation. Based on poverty profile, aims and objectives of policies were defined for the following three-year period: "(i) creation of preconditions for sustainable and equal economic development, which would decrease rate of economically jeopardized population; (ii) providing social stability and reducing poverty rate and (iii) defining key poverty indicators pursuant to the MDGs and their following through an integrated system of monitoring and evaluation, during the period of the implementation of the Strategy" (Ministry of Health, Labour and Social Welfare, 2003, p. 9).

The second phase of poverty reduction was started by enacting the *Strategy of Poverty and Social Exclusion Reduction* in 2007. It was followed by adopting three important documents for the social assistance field: *Strategy of Social and Child Assistance Development in Montenegro, Strategy of Disabled Inclusion* and *Strategy of Elderly Protection in Montenegro*. New research on poverty in 2007 pointed to the problems of social exclusion as well. Therefore, the areas of health, education, social assistance and the labour market have been defined as especially sensitive, from the point of view of implementing certain additional inclusive measures.

Conclusion

The social security system of Montenegro has still many transition characteristics – its Bismarckian basis and (self-claimed) egalitarian-socialist tradition have been rapidly transforming into a system with significant residual elements. It can be seen first of all in certain changes and reforms of pension and the

[160] In 2009, material support to families without income was such as follows: EUR 60.50, 72.60, 87.12, 102.85 and 114.95 for one-member, two-member, three-member, four-member and five-member or more member families, respectively (Ministry of Labour and Social Welfare, 2010).

[161] 1) for children from families receiving material assistance - 30%; 2) for children lightly disturbed in development, attending special schools or special classes in regular schools - 40%; 3) for children with physical and mental disorders who will not be able to live and work independently - 50% (The Law on Social and Child Assistance, 1993).

[162] Amounts of child allowances are: 1) for child of material assistance beneficiary EUR 15; 2) for child with physical, mental and sensory disorders who will be qualified for work and living EUR 20; 3) for child with physical, mental and sensory disorders who will not be able to qualify for work and living EUR 25; 4) for child without parental care EUR 25.

health system, where direct financial stimuli of the World Bank (but also of other international institutions) had the final word in creating laws and practice.

An analysis of pension insurance reforms has shown that the major steps were taken in the area of the system of inter-generational solidarity (1st pillar), first of all in terms of making stricter conditions for acquiring pension rights. As other countries in the region, Montenegro raised the age of retirement, introduced a new calculation formula, changed indexation, re-organized its funds and improved registries of insured people and beneficiaries of rights. Another part of the reform package, which meant the introduction of capitalized funds, has been implemented far more slowly. The *Law on Voluntary Pension Funds* was enacted in 2006, but their work in practice is yet to be developed. The introduction of the 2nd pillar has been delayed, because of the absence of its normative framework.

One of the problems to be faced by the society of Montenegro and for which the pension system does not have a solution, is a huge number of people who were employed, but left without a job due to various reasons during the beginning of the period of transition. Their years of service are not long enough (less than 15 years) to be able to realize pension rights. At the same time, the pension insurance system does not contain sufficient stimuli for longer work. Adequacy of pension benefits is an additional problem. Its solving does not raise necessary attention, but it will not be solved by the simple introduction of three-pillar model.

Health care and health insurance in Montenegro are universal, but not of uniform quality and equal availability. Health reform was primarily directed toward primary health care, but it did not create a system the basis of which would be preventative activities and rational savings, both for population and for the state budget. On the one hand, expenditures for health are beyond the possibilities of the Montenegrin state, and on the other hand, concerns that the poor will be most adversely affected and deprived by the measures of selective saving seem justified.

The existence of the private sector in the shadow does not contribute to the solution of this problem, especially when vulnerable groups are in question; having in mind they are not able to pay for health services that have market prices. There are no signs of regulating the relation between the state and private health sectors, and contracting between the state fund and private practice has not been viable. The introduction of voluntary health insurance has started, albeit not completed, and it is dependent on further legal changes. Low purchasing power of the population will be a threat for the affirmation of additional insurance forms.

The foundation of the system of unemployment insurance in Montenegro on the principle of contribution paying (i.e. previous employment) makes this part of the system a chance and possibility for a proportionally extremely small number of unemployed in limited time periods. The real scope of unemployment in Montenegro, as well as employment in the grey economy, points to an extremely large population of potential beneficiaries. Decreasing employment rates will have an unfavourable impact on the number of contributors.

All these, at the same time, highlight the importance of active measures on the labour market. Even though their importance is recognized in strategic documents, they are not adequately represented. It will have severe consequences for the realization of aims provided by the National Employment Strategy of 2008. Additionally, the absence of active labour market measures will essentially have the worst impact on vulnerable groups and

those who have more problems in finding employment (disabled, minority groups, elderly workers, and youth).

Rights in the social assistance system are diversified; they have been even extended by the latest legal changes, but amounts are not sufficient. Contrary to that, previously universal child allowances have become residual and transferred into a social policy measure of an extremely modest amount too. Low development of counselling services additionally decreases the effect of cash assistance and discourages poverty and social exclusion reduction. Inadequacy of measures of active inclusion and of cash assistance to beneficiaries capable of work only contributes to that.

Additional efforts should be put into the creation of a better network of social and child assistance institutions and the improvement of their professional, administrative and technical capacities. The social assistance system is centralized, but the widening of jurisdiction of local communities needs the creation of realistic preconditions – current legal regulations about their role have not been widely used in practice.

Pensions

Structure	*Pillars*	The first pillar	The II pillar	The third pillar
		In 1991, only the first pillar existed. In 2003 it underwent parametric changes.	In 2004, it was supposed to introduce the second pillar, but the Law was not passed.	The Law on Voluntary Pension Funds was passed in 2007.
	Financing of pillars	Mandatory public (pay-as-you-go principle, contributions by employees and employers, with state interventions in case of deficits).		Funds paid by members with a view to increasing value.
	Management	The Old-age and Disability Insurance Fund.		Private pension funds. Commission for Securities is the supervising body.
Population covered	*Coverage of population*	Insured employed, self-employed and farmers.		Insured members.
	Covered risks	Old-age, disability, death, physical defect.		Old-age, disability, death, physical defect.
	The first pillar *Eligibility criteria*	*Old age pension* In 2001: - 20 years of insurance, when aged 60 (men)and 55 (women) - at least 15 years of insurance, when aged 65 (men)and 60 (women) - 40 (men) and 35 (women) years of insurance, when at least aged 50 Since 2004: - 15 years of insurance, when aged 65 (men)and 60 (women) - 40 (men) and 35 (women) years of insurance, when at least aged 55 *Disability pension* - Complete or partial loss of working capacity - In the case of disability due to work injury or professional disease, the right can be effectuated despite the years of insurance - In the case ofdisability due to out-of-work injury or working capacity loss occurred prior to the effectuation of the right to old-age pension, an insured has to have pension insurance for at least 1/3 of working life *Survivor pension* - members of family of a dead insured person with at least 5 years of service or 10 years of pension insurance or who fulfilled conditions for old-age and disability pension or he/she was a beneficiary of old-age or disability pension		

Old-age dependency ratio	*Number of pensioners and number of insured*	In the last two decades, the number of those employed has been decreasing and the number of pensioners has been increasing. - 1995 -125,089 employed and 73,988 pensioners - 2000 - 113,818 contributors and 84,761 pensioners - 2003 - 111,852 insured and 89,235 beneficiaries of pension rights - 2007 - 156,408 insured and 93,477 pensioners - March 2010 - 97,867 pensioners, out of which: 45,462 (46,5%) old-age, 24.251 (24,7%) disability and 28.155 (28,8%) survivor.
	% of people over 65 compared to people 15-64	2001 - 15-54: 412'856 (67,0%) - 65+: 76,529 (12,4%) Dependency ratio 1990 – about 2.05; 1995 – 1.69; 2000 – 1.35; 2002 – 1.3; 2010 – 1.8
Financing	*Contribution rate*	- 2008: contribution rate of 20,5%: employers 8%, employed 12,0% - 2009: contribution rate of 20,5%: employers 8,5%, employed 12,0% - 2010: contribution rate of 20,5%: employers 5,5%, employed 15,0%
	% of of state budget	- The deficit in the Old-age and Disability Insurance Fund compensated by the state 2006 - 2,6%GDP; 2008 - 2,2%GDP; 2009 - 4,4%GDP
	Ratio between insurance and state budget financing	The ratio has changed, but in the last few years contributions have provided about 70% of revenues and 30% has originated from the budget.
	- pension expenditures (% of GDP)	2000 - 11,44%; 2001 - 10,27%; 2002 - 11,20%; 2003 - 10,69%; 2004 – 10,09; 2005 -9,49%; 2006 – 9,10%; 2007 – 9,61%; 2008 - 8,13%; 2009 - 8,13%; 2009 – 10,79%
Benefits	*Average wage, replacement rate*	- 2007 - 56.7%; 2010 - 55%; - 2010 - 39.30%; 2030 -32.20% (estimates)
	Minimum/ Maximum pension	The 2004 Law: - The Maximum pension is established so that the personal point can be maximally 4. - The Minimum pension is established so that the personal point is 0.5. - Adjusting of pensions is done twice a year per «Swiss formula» (50% based on earning and 50% costs of living).
	Number of people receiving minimum pension	- 2004 -39,242; - 2007 -31,494; - 2008 - 4,183; - 2010 -1,300 (estimates)
	Privileged pension rights	- 2008 - 54 beneficiaries of pensions from EUR 688 to EUR 850 - More than EUR 850 - 2 pensioners

Health-care

Structure	*Structure*	*There exists two types of health insurance:* *1. Mandatory public and* *2. Voluntary (as of 2004).* *The first implementation phase of the Project of Voluntary Health Insurance Introduction is complete, but the completion of the second phase is dependent first of all on legal changes of current legislation regulating health insurance.* Public health institutions have been organized on three levels of care: primary, secondary and tertiary. *Primary* health care is provided within health centres divided into three parts. *Secondary* health care is provided by specialist out-patient departments and hospital beds. *Tertiary* health care is provided by sub-specialist out-patient departments, diagnostic centres and hospital departments.
	Infrastructure	The structure of public health institutions comprises of: - 18 health centres, - an Institute for urgent medical care, - seven general hospitals, - three special hospitals, - a Clinical centre, - an Institute for public health and - a pharmaceutical institution.
	Management	The mandatory system of health insurance is managed by the Fund of Health Insurance. It is the only bearer of mandatory health insurance but it also provides and conducts the voluntary health insurance.
	Private health care	There is no data about its size compared to the state sector. There is no clear strategy of integration of the state and the private sector.
Population covered	*Coverage of population*	The mandatory system is contribution based, but the coverage is universal. All categories of the population, i.e. all legal residents of Montenegro have equal rights in the health system.
	Eligibility criteria	The mandatory health insurance and health protection system comprise of the rights of employed, members of their families and other persons defined by the Law.
	Not covered	Coverage is universal.
Health status	*Life expectancy rates*	1999/2000 – the life expectancy rate was 73.56 years (76.27 and 71.05 for women and men respectively). 2004 - 73.1 years 2007 - 73.77 years (76.06 and 71.22 for women and men respectively) 2008 - 71.06 years for men and 76.23 years for women.
	Mortality rates	1994 - 7.4 2004 - 9.2 2007 - 9.51

Financing	*Contribution rates*	In 2007 - 13.5% (6% and 7.5% of earnings was paid by employers and employees) respectively. 2008 - 12% 2009 – 10.5% (5.5 and 5% by employers and employees respectively) 2010 - 9% (5% and 4% by employers and employees respectively).
	% of state budget	Expenditures for mandatory health insurance in the Montenegrin GDP increased in the period of 2000 and 2001, after which a trend of their decrease followed. With 5.68% GDP in 2000, they increased to 7.08 GDP in 2002, which was the highest percentage of expenditure for health in GDP during the decade. Since 2003 they have been below 7% GDP.
	Ratio between insurance and state budget financing	During the 1990s – constant deficits in the Fund. One fifth of the revenues of the Health Insurance Fund are budgetary resources (for health care of the unemployed who do not receive cash benefits and refugees as well as for covering deficits)
	Health-care expenditures	Percentage of expenditure for mandatory health insurance within public consumption was 13.68%, 14.58% and 14.35% in 2004, 2005 and 2006 respectively.
	Health-care revenues	Currently, contribution based revenues are 78.95% of total revenues of the Fund.
Cost-containment measures	*Measures*	Co-payments only.
	Exemptions	Children, pregnant women, women during delivery and one year after that, elderly over 65 years, persons effectuating the right to social welfare benefits, as well as people with certain diseases.
	Ratio between the coverage and the patient's payment	Co-payments present less than 1% of health care expenditures.
	% of patient's payment compared to family income	There is no data.
Benefits	*Guaranteed rights*	The rights of citizens based on mandatory health insurance are the right to health care; the right to benefit during temporary inability for work and compensation of travel costs incurred in connection with health protection

Unemployment protection

Coverage	*Eligibility criteria*	- 2002 - the minimum insurance period was 9 months of insurance without interruption, i.e. 12 months with interruptions in the previous 18-month period - 2010 - insurance period of at least 12 months without interruption or with interruptions in the previous 18 months
	Not covered	- unemployed, engaged in grey economy who do not pay contributions and those who are without a job but do not have a long enough period of insurance - a small share of the total number of unemployed achieve insurance based rights
Financing	*Contribution rates*	Employed and employer: - 2002 and 2010: per 0.55%
	Expenditure on unemployment benefit	- Contributions for unemployment insurance - 2009 - 0.30% GDP; 2010 - 0.32% GDP - 2011 - 0.32% GDP, 2012 - 0.31 and 2013 - 0.31% GDP (estimates)
Benefits	*Types of benefits*	The Laws of: - 2002: 1. cash benefit; 2. cash aid; 3. pension and health insurance during the effectuation of the right to cash benefit; - 2010: 1. cash benefit; 2. pension and health insurance during the effectuation of the right to cash benefit;
	Number of people receiving unemployment benefits	- 2002 – 2,325 - 2004 – 4,310 - 2005 – 6,137 - 2006 – 7,535 - 2007 – 8,240 - 2009 – 12,278
	Maximum duration of benefit	The duration of benefit is dependent on duration of insurance. The 2002 Law: - 12 months for years of insurance from 20 to 25 years without interruptions - With more than 25 years of insurance – until finding a new job, i.e. occurring any of the conditions for the cessation of the right to cash benefit The 2010 Law: - 12 months for unemployed with more than 25 years of insurance - With more than 30 (women) and 35 (men) years of insurance - until finding a new job, i.e. occurring any of the conditions for the cessation of the right to cash benefit - With 25 years of insurance and in case he/she is a parent to a person receiving disability allowance - until finding a new job, i.e. occurring any of the conditions for the cessation of the right to cash benefit

Active labour market policies	*Policies*	The 2010 Law: 1. informing about employment opportunities and conditions; 2. mediating in getting a job; 3. professional orientation; 4. financing of trainees; 5. support for self-employment; 6. subsidies for employing; 7. education and training of adults; 8. professional rehabilitation of persons having more difficulties in finding a job; 9. public works; 10. grants and other measures directed to increase employment , i.e. unemployment decrease.
	Financing	Active labour market programs are financed by the state budget, local communities, donations, credits, interests, etc.
Other measures against undeclared work	*Measures*	- Reduction of the financial burden of employers - Stimulating inclusion into legal economy - Sanctions
	Financing	Indirect, sanctions.

Social assistance

Structure	*Infrastructure*	*The 1993Law on Social and Child Assistance*	*The 2005Law on Social and Child Assistance*
		Public institutions in the area of social and child assistance: 1) social welfare centres (SWC); 2) facilities for accommodation of children and youths; 3) facilities for accommodation of adults and the elderly, 4) facilities for holidays and recreation of children (article 90).	Public institutions in the area of social and child institutions: 1) facilities for accommodation of children and youth; 2) facilities for accommodation of disabled adults and the elderly; 3) social welfare centres (SWC); 4) centres for counselling, research and expert tasks in the area of social and child assistance (article 69).

		There are: - 10 CSWs – all municipalities (21) are covered; 3 of them are organized for separate municipalities, while within the remaining 7 – each covers two or more municipalities. Professionals do not have adequate expertise.	CSWs for the municipalities (number of employees): - Podgorica, Cetinje, Danilovgrad and Kolasin (100) - Niksic, Savnik and Pluzine (44) - Pljevlje and Zabljak (20) - Bijelo Polje and Mojkovac (34) - Berane and Andrijevica (24) - Rozaje (10) - Plav (12) - Bar and Ulcinj (26) - Kotor, Tivat and Budva (23) - Herceg Novi (13) (May, 2010).
		- 7 institutions for the accommodation of children and youths – they are not suited to specific needs of all children and sometimes children need to be accommodated out of Montenegro. - 2 institutions for the accommodation of disabled adults and the elderly - insufficient capacities, not territorially available.	- Home for pensioners and other elderly persons "Grabovac" in Risan (102) - Children's home "Mladost" in Bijela (103) - Special Institutions for Children and Youth"Komanski most " in Podgorica (43) - Centre for Children and Youth " Ljubovic" Podgorica (39)
	Management	Ministry competent for social affairs (social and child assistance)	
Coverage	*Covered population*	Universal system.	
	Eligibility criteria	Generally, all citizens of Montenegro (and also foreigners and persons without citizenship under special circumstances). Actual conditions depend on a right in question. The rights to cash assistance are realized based on means-testing, and other rights can be effectuated by those in need of them.	
	Specific vulnerable groups	Without specific reference to vulnerable groups	1) persons incapable of work 2) children without parental care 3) children with physical, mental and sensory defects 4) misused and mistreated children 5) children with behavioural problems 6) disabled 7) elderly 8) persons and families in need of adequate forms of social and child assistance due to some specific circumstances (article 4).

Financing	*Contribution rates*	Not applicable.	
	% of state budget	2003 – 9.0%; 2004 – 9.5%; 2005 – 7.9%; 2006 – 6.5%; 2007 - 6.9%; 2008 – 8.6%	
	Ratio between insurance and state budget financing	Not applicable.	
	Expenditures on social welfare benefits (% of GDP)	2003 – 2.9%; 2004 – 2.7%; 2005 – 2.3%; 2006 – 2.0%; 2007 – 1.9%; 2008 – 2.7%	
	Revenues (% of GDP)	Not applicable.	
Benefits	*Types of benefits*	1) material support to families 2) aid in gaining professional qualifications 3)accommodation in social assistance institution or other family 4)allowance for providing assistance and care of another person 5) health care 6) funeral costs 7) social work services (article 7). The right to child allowance also belongs to this group (article 41).	1) material support to families 2) disability allowance 3) allowance for providing assistance and care of another person (EUR 60) 4) accommodation in social assistance institution 5) accommodation in other family 6) aid in professional rehabilitation and gaining professional qualifications 7) health care 8) funeral costs (EUR 300) 9) lump sum benefit (article 12). The right to child allowance also belongs to this group (article 43).

	Minimum/ maximum assistance	Material support to families	Child allowance	Material support to families	Child allowance
		Minimum: 40% of average salary in the month preceding the payment for one-member families; Maximum: 80% of average salary in the month preceding the right effectuation for five-member and bigger families.	Minimum: 30% of the minimal salary in the month preceding the payment for children from the families effectuating the right to material assistance to families; Maximum: 50% of the minimal salary in the month preceding the payment for children with physical and mental defects that cannot be trained for work.	Minimum: EUR 50 for one-member families (EUR 60.50 as of 2009); Maximum: EUR 95 (EUR 114.95 as of 2009) for five-member and bigger families.	Minimum: EUR 15 (EUR 18.15 as of 2009) for children from the families effectuating the right to material assistance to families; Maximum: EUR 25 for children with physical and mental defects that cannot be trained for work and for children without parental care.
	Duration of benefits	No limits in terms of duration. The only exception is child allowance that can be effectuated until 18 years (or until the completion of regular schooling).			
Measures against poverty and social exclusion	*Measures*	*Strategy of Development and Poverty Reduction of 2003*		*Strategy of Poverty and Social Exclusion Reduction of 2007*	
		Objectives: 1) creation of new jobs 2) development of more efficient social welfare 3) health care, education, environment and infrastructure should be in the function of poverty reduction.		Objectives: providing social stability and reducing economic deprivation. Special attention is paid to vulnerable groups. The connection with the areas of education, health care, employment and social assistance is made.	
	Financing	System of financing measures and programs directed toward poverty and social exclusion reduction is centralized: except for lump-sum benefits, all funds arefrom the Republic budget			

Statistical Annex

	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
GDP in million euro										1 066	1 295	1 360	1 510	1 670	1 815	2 149	2 808		
GDP (per capita) in euro										1 750	2 113	2 208	2 435	2 684	2 912	3 443	4 484		
GDP growth rate											1,1	1,9	2,5	4,4	4,2	8,6	10,3		
General government debt (% of GDP)												57,1			39,6	38,3	32,4		
Consumer price index																		7,4	
Employment rate									39,2	38,5	37,1	37,7	36,2	37,4	41	41	43	43,2	
Unemployment rate									19,3	19,3	21,2	20,7	22,7/27,7	30,3	29,6	19,3	16,8	16,8	13,1
Average wage	6805	111	42	142	309	660	878	1 228	164,4	181	211	149,1	173,9	195,3	213,1	246	338	416	
Labour productivity																			
(At risk of) Poverty rate												9,4	12,2	10,9	11,3	11,3	8	10,8	10,8
Inequality of income distribution (Gini)															25,9	24,4	26,4	25,3	26,7
Social expenditure (% of GDP)										17	16,99	18,04	18,21	16,97	15,55	15,67	15,8		
Old age & survivorship													8,7	8,7	8,1	9,3	9		9,85
Health & disability										5,68	6,11	6,77	6,39	5,72	6	5,49	4,93	5,17	4,31
Unemployment benefit										0,07	0,04	0,07		0,09	0,19	0,25	0,23		
Social assistance (benefit)										1,9	1,28	1,19	1,36	1,38	1,3	1,15	1,23		2,25
Structure of the economy (Gross value added by main sectors (%))																			
Industry										19,2	20,7	20	19,2	18,7	17,1	16	13,6		
Agriculture										12,4	11,9	12,2	11 6	10,9	10,4	10,1	8,5		
Services										64,1	63,4	63,8	65,8	66,9	68,9	69,5	73,7		
Average wage:																			
1) 1991: dinars																			
2) 1992 - 1996: new dinars																			
3) 1997 - 1998: new dinars (modified definition of an average salary)																			
4) 1999 – current: EUR (average nominal monthly wages and salaries)																			
Poverty rate:																			
Nationally defined based on Household Consumption Survey - it is an aboslute poverty line																			

GDP (million)in Euro
2000 – 2007
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GDP (per capita) in Euro
2000 – 2007
European Commission (2009). *Montenegro 2009 Progress Report*.
GDP growth rate
2001 – 2007
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List of abbreviations

EU	European Union
FRY	Federal Republic of Yugoslavia
GDP	Gross domestic product
HCMS	Household Consumption Measurement Survey
IDP	internally displace person
MDG	millennium development goal
MONSTAT	Statistical Office of Montenegro
PAYG	pay-as-you-go
SFRY	Socialist Federal Republic of Yugoslavia
SWC	Social Welfare Centre

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