SOCIAL PROTECTION AND SOCIAL INCLUSION IN MONTENEGRO

Executive summary

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Executive Summary

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The Study

The system of social protection in Montenegro, with a special emphasis on the problems of social exclusion is presented in this study. The study gives an up-to-date analysis of the current system, based on an analysis of economic, demographic, and labour market trends that influence social protection, as well as analyses of the social welfare system and the pension and health systems. The study describes the main institutions and the legislation of the current social protection system, as well as current reforms and challenges.

Montenegro became independent in June 2006. During the period from 1991 to independence, Montenegro was part of the Federal Republic of Yugoslavia (up to 2003) and later the State Union of Serbia and Montenegro. However, the social protection system in Montenegro was developed/ reformed independently from the social protection system in Serbia, although both systems had close cooperation in various areas. As far as the system in the period prior to 1991 is concerned, Montenegro shared the same political, economic and social welfare system structures with other Yugoslav Republics, such as Croatia and Macedonia (EU candidate countries).

The purpose of this study is to inform, within the context of launching similar studies in Albania, BiH, Serbia and Kosovo, the Montenegrin perspective on the process of accession in the area of social protection and social inclusion in the Western Balkans. The study followed the general outline of the study on "The Social Protection System in 13 Candidate Countries" carried out in 2003 [1], as well as the study on "Social Protection and Social Inclusion in Croatia"[2], and the study on "Social Protection and Social Inclusion in the former Yugoslav Republic of Macedonia'. This study is presented in line with EU objectives on social protection and social inclusion[3].

The summary provides a brief overview of the study in both English and Montenegrin languages.

Economic, Demographic and Social Trends Influencing the Social Protection System

Montenegro has entered the transition process as a part of the Federal Republic of Yugoslavia (the state created after the dissolution of the SFRY by Serbia and Montenegro) in the early nineties. At that time, the level of economic development in

[1] http://ec.europa.eu/employment_social/social_inclusion/docs/2006/study_croatia_en.pdf
[2] http://ec.europa.eu/employment_social/social_protection/index_en.htm
[3] http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2006/objectives_en.pdf

Montenegro was low and lagged behind the other Republics. The transition process was followed by the war in the surrounding countries, hyperinflation and international economic sanctions. This combination of events influenced the economic slowdown and the activity measured by the GDP was reduced by half in 1994 in comparison with 1989, which was considered to have been the most successful year in the Montenegrin economy as well as in whole of the SFRY. During the period after 1994, GDP growth accelerated, however, during the period from 1997 to 1999, GDP growth slowed down due to the political crisis in the FRY and because of disagreement between the Montenegrin and Serbian authorities, which culminated after the war in Kosovo in 1999, when the Government of Montenegro distanced itself completely from the federal state and started to implement reforms independently.

In 1999, the DM was introduced as a legal tender, and the period after 1999 was characterized by lower inflation levels (which turned into a one digit level in 2002) and by steady, but relatively low growth.

In 2006, Montenegro became independent and the post-independence period was marked by a high GDP growth rate, driven mostly by a high increase of the FDI, an increase in service sector activities such as tourism and tourism related activities and the real-estate sector. GDP growth in 2007 was estimated at 7% in real terms. It is expected that the GDP will record high rates in the period from 2008-2010, however growth will be lower (2009-6.0% and 5.5% in 2010).[4]

During the period after 1999, and especially over the last two years, average wages recorded high real growth rates. The average real annual net wage growth in 2006 and 2007 reached 15%. In the first quarter of 2008 the average net wage in Montenegro was €393, €576[5] in gross terms (which includes the net wage and the employee share of contributions), and increased by approximately 8% in real terms when compared with the same period in 2007. However, despite high growth rates, the average wage in Montenegro is still relatively low.

Despite the progress achieved over the last several years, in terms of the falling unemployment rate, the Montenegrin labour market still has several serious deficiencies. Firstly, a relatively low population activity, especially regarding females, a high incidence of long-term unemployment and a misbalance between labour supply and labour demand. All of these could be attributed to several factors – job losses due to restructuring, entry barriers to the labour market (a high level of employment protection and the high fiscal burden imposed on labour). In addition to this, an issue of high concern in the Montenegrin labour market is the high level of undeclared work, according to the 2007 Labour Force Survey data,[6] close to 50,000 or 22.6% of the total number of people in employment. In addition, 31,000 or 17.5% of registered employed persons only paid social security contributions on 50% of their actual wages.

[4] Source: Economic and Fiscal Program, Ministry of Finance, 2007
[5] MONSTAT, Monthly Statistical Review, No.4, 2008
[6] ISSP/EAM Labour Force Survey 2007, http://www.zzz.cg.yu/shared/Radna%20snaga%20i%20zaposlenost%20Final%20ISSP.pdf

The 2007 Labour Force Survey data[7] showed that the unemployment rate in Montenegro in June 2007 was 12.6% amongst the working age population (15-64), which is the lowest level recorded in the last 20 years. However, more than 55.0% of unemployed individuals were unemployed for over a year. The gender unemployment rate indicated that unemployment among females of working age was lower and amounted to 11.7% in 2007, whilst unemployment of males of working age was 13.5%. Lower unemployment among females could be explained by a lower activity level in this population group, as well as the fact that job growth over the last couple of years was recorded in activities that traditionally employ females (trade, tourism).

According to the 2003 Census, Montenegro has population of 620,740 inhabitants. According to the census, the greatest number of Montenegrin citizens declared themselves to be ethnic Montenegrins (43.2%). 31.3% indicated that they were Serbs, 7.8% indicated that they were Bosnian, and 5% described themselves as Albanian. Compared with the 1991 census, the ethnic structure of the population has changed significantly. Namely, Montenegrins made up 61.9% of total population in 1991, whilst 9.3% were Serbs, 6.6% were Albanian, and 14.6% were Muslim. This change in identity is the result of events in the 1990s in the surrounding former Yugoslav Republic, as well as from the referendum process in 2006, when the majority of opponents to the independence of Montenegro declared themselves to be ethnic Serbs. According to UN ESA Population Division projections[8], there will be an increase in population growth until 2021, after which the size of the population will begin to decline. The estimated population in the middle of 2006 was 624,241. It will increase to 643,844 in 2021, but will fall to 596,693 by 2050, a decrease of approximately 5%.

The Social Protection and Social Welfare Systems

The social protection system in Montenegro has two main parts - non-contributory, financed by central budget tax revenues (social services as defined by law – prevention, counselling, therapy and advice, institutional and non-institutional care, and social welfare benefits) and contributory, based on the social insurance system (pensions and disability[9], health and unemployment insurance). The tradition of egalitarian social welfare and Bismarckian social insurance still dominates in Montenegro, although reforms are planned especially in the pension and health sectors, resulting from the influence of international financial institutions (i.e. World Bank), and are oriented more towards residual and individualized social protection.

[7] ISSP/EAM Labour Force Survey 2007 http://www.zzz.cg.yu/shared/Radna%20snaga%20i%20zaposlenost%20Final%20ISSP.pdf

[8] UN ESA – World Population Prospects: The 2005 Revision, 2005

[9] The pension system provides a range of benefits – age, disability and survivors' pensions, as well as body injury compensation and health insurance for beneficiaries and family members.

Data on expenditure on social protection according to the ESSPROS methodology is not available, and the only source of social protection data is from the central budget (Budget Laws). Social protection spending in Montenegro, according to the 2007 Budget Execution Report, amounted to €426.9 million or 17.44% of the estimated GDP. Social protection benefits and allowances made up 15.8%[10] of the GDP, whilst social care, social services and measures made up 0.52% of the GDP in 2007. Other costs, primarily related to institutional costs for social protection, made up 1.13% of GDP. Social assistance benefits made up 1.23% of the GDP, whilst contributory benefits made up 14.57% of the GDP.

In terms of the administration of the overall social protection system, the Ministry of Health, Labour and Social Welfare is the main institution in charge. Institutions responsible for the delivery of social protection are Centres for Social Work (for the welfare part), residential institutions (for institutional care), the Pension and Disability Insurance Fund (for pension and disability insurance), the Health Insurance Fund (for health insurance) and the Employment Agency of Montenegro (for unemployment insurance).

The social protection system provides contributory and non-contributory benefits. Contributory social benefits include: unemployment benefit, maternity benefits, and pension benefits (age, survivor and disability pensions and body injury compensation). The most important non-contributory benefits include: family material support (a means tested benefit), child allowance, personal disability benefit, carers' allowance, faster family benefit as well as other benefits. Since the start of the transition period, eligibility and criteria for obtaining benefits have changed, some benefits' eligibility has broadened and for some it has tightened. For the most important benefit - family material support, eligibility has broadened, whilst, for example, child allowance benefit eligibility has tightened from a universal to a limited coverage. Also, some new benefits have been introduced, amongst the most important of which is the personal disability benefit.

In 2007, the average amount of paid social welfare benefits were: family material support - €76.74, child allowance benefit – €17.24, carers' allowance €55, personal disability benefit - €55, and foster family accommodation € 214.7. The number of family material support beneficiaries in 2007 was 12,741 families and 39,281 individuals, whilst child benefit was received by 9,475 families and 18,524 children.

Social insurance benefits are financed from contributions for pension and disability, health and unemployment insurance. The total share of contributions from the gross salary[11] (a base for the calculation of contributions) is 34%, from which employees pay 19% of their gross salary and employers 15% of the gross salary. The tax wedge[12] imposed on labour consequently exceeded 40%. As contributions are not sufficient to

[10] Includes public health expenditures.
[11] Gross salary includes net salary and the employees' share of social security contributions as well as personal income tax.
[12] The share of social security contributions and taxes in wage labour cost.

cover all the expenditures of a contribution based social protection, the state budget also contributes to the overall costs of social insurance.

The unemployment benefit level is set at 65% of the national basic minimum wage, and is currently 37.5€ (net), plus paid social security contributions. Relative to the average wage, the unemployment benefit is quite low (less than 10% of the current average wage), and cannot thus be treated as an important supportive measure for those who lose their jobs. The duration of unemployment benefit ranges from 3 to 12 months. In addition to this, if the insured person has over 30 years of working experience, he/she is entitled to unemployment benefit until he/she becomes employed or is eligible for retirement. The average duration of benefit claimed in Montenegro is about 12 months. In addition to this benefit, every unemployed person, as well as their family members, is entitled to health insurance (if the insurance is not provided otherwise). In 2007, an average of 8,240 persons or 21.1% of unemployed people received unemployment benefits, which was an enormous increase from 2002 when the number of beneficiaries was 2,325.

Maternity benefit (only for insured individuals) in Montenegro is full salary compensation for a period of one year. Prior to delivery, 45 days before the determined delivery term, the pregnant women can take her pregnancy leave, whilst 28 days prior to delivery she is obliged to take leave. Usually the employer pays the salary to the mother and than applies to the Ministry to be refunded. Every employee is entitled to sickness benefit in the case of illness or injury. During the period of leave, the employee is entitled to full salary compensation. In the case that the period of leave is shorter than 60 days, the employer has to pay the cost. If the period of leave is longer than 60 days, the Health Insurance Fund compensates the full salary of the employee/insured person.

Besides financial benefits, the social protection system in Montenegro provides social services to citizens. According to the legal framework, social work services are: preventative activities; diagnostic treatments; and counselling-therapeutic work, institutional and non-institutional care. However in reality, the social services provided by the MHLSW are limited to: institutional care provided by nine residential institutions, foster care for children placed within their extended family, counselling for the court in divorce and custody cases, and counselling for the courts in cases involving young offenders.

Poverty and Social Exclusion

Poverty measurement in Montenegro is not based on harmonized data sources, nor are EU comparative indicators applied when estimating the poverty line. Also, there is no nationally adopted definition of social exclusion, which could serve as a base for the analysis of the situation in Montenegro. However, the Ministry of Health, Labour and Social Welfare has identified Roma, refugees and displaced persons as the groups most

vulnerable to poverty and social exclusion. In addition to these groups, people with disabilities, the elderly and children are also considered to be vulnerable groups.

Laeken indicators have still not been calculated in Montenegro. Nonetheless, the calculation of these indicators is planned according to the newly adopted poverty reduction strategy. According to the plans, at the beginning, the main indicators of poverty will be based on expenditure, not income, due to the continued, significant presence of undeclared work in Montenegro (around 15% of the GDP according to most recent estimates). Indicators will be developed and monitored continuously by MONSTAT, the official statistical institution.

According to the newest available data, the absolute poverty line for 2006 is 144.68€ per equivalent adult person per month. As this data is calculated and published by MONSTAT, the official statistical institution, it should be considered as the new benchmark for regularly monitoring poverty in Montenegro.[13] According to this data, 11.3% of the Montenegrin population, or 71,000 citizens were poor during the years 2005 and 2006. Also, the wider poverty line is defined from the level of the absolute poverty line plus 25%, in order to identify the vulnerable population. It includes, in addition to the poor population, citizens who are at high risk of poverty. This poverty line is set at the level of 180.85€ per month, and according to figures in 2005, the poverty rate was 25.3%, whilst in 2006 it was 23.6%. The poverty rate remained the same in 2005 and 2006, whilst other indicators showed slight signs of improvement regarding the situation concerning the poor population.

The poverty gap was 2.1% in 2005 and 1.9% in 2006, which means that the difference between the consumption of the poor and the absolute poverty line decreased during the observed period. The share of the lowest decile (the poorest 10%) in total consumption levels increased slightly from 4.2% to 4.3%, whilst the share of the highest decile (the richest 10%) decreased from 21.6% to 20.2%. The Gini coefficient for the distribution of equivalent consumption decreased from 0.26 in 2005 to 0.24 in 2006.

A significant share of the population is vulnerable to even the smallest shocks, both positive and negative. Economic vulnerability between 2003 and 2004 was marginally reduced (from just over 20% non-poor, but vulnerable to just under 20% the population), which reflected some effects of more regular state support and a real wage increase. Still, vulnerability to poverty, especially among farmers and families outside regular employment remains high.

The Pension System

[13]Strategy for Alleviation of Poverty and Social Exclusion 2007, uses as official poverty line the one which is determined based on the ISSP Household Survey 2004 data, as these were the available data at the moment of creation of the APSE, according to which, poverty line is set at the level of 116.2€ per person per month.

Since the beginning of the transition period, the PAYG pension system in Montenegro has continuously faced funding challenges due to the huge rate of unemployment, the high level of undeclared work, falling fertility rates, an ageing population, as well as the slow overall growth of the economy. Negative demographic trends and decreased employment are just some of many reasons that have spurred on the implementation of pension reform. Pension reform in Montenegro was initiated in 2001. Reform of the current pension system started with a reform of the mandatory pillar (PAYG) in 2004, and with this reform the introduction of voluntary pension insurance was taken further.

According to the Law on Pension and Disability Insurance, pension coverage in Montenegro is broad and applies to all employees, self-employed persons, and farmers. At the end of 2007, there were 156,408 insured persons in the country. During the same period, the number of pension beneficiaries (old-age, disability and survivor pensions) was 93,477. Also, in February 2008 there were 2,976 military pension beneficiaries. There are more than 30,000 retired persons in Montenegro who receive less than €100. According to the MONSTAT data, the number of pensioners who are over the age of 65, except for the beneficiaries of survivors pensions, amounted to 41,630 in October 2007, which was 51.8% of the total population over the age of 65. This also implied that close to 50% or 39,861 of persons aged over 65 were not covered by pension benefits.

he average paid pensions in 2007 were as follows: for old-age pension – €191.70, for disability pension – €144.72, and for survivors' pension – €123.70, whilst the minimum pension was €71,6. The replacement rate in 2007 amounted to 56.7%, which was less than in previous years. There has been a noticeable decline in the replacement rate in Montenegro in the last several years. If the wage increase trend is continued, replacement rates will continue to decline and will amount 50.2% in 2010, 39.3% in 2020 and 32.2% in 2030.

The principal source of funding for the pension system is revenues from gross salary contributions. Assistance from the state budget covers the difference, as well as the payment of pensions for special categories of pensioners. The gap between expenditure and revenue became the inherent responsibility of the state budget. According to the 2007 budget, revenue from contributions amounted to € 173.84 million or 73.2% of total revenue (the plan anticipated a 67.5% share), revenue from the state budget amounted to €61.15 million or 25.7% of total revenue and other revenue and receipts amounted to €2.54 million or 1.0% of all total revenue. The pension system deficit amounted to roughly 2.5% of the GDP, whilst total overall pension expenditure amounted to 9.61% of the GDP.

The Health Care System and Long-Term Care

Montenegro has begun a comprehensive reform process of its health system, which inherited its tradition from the Socialistic Federal Republic of Yugoslavia. Some of the most important problems inherent in Montenegro's health care system are: excess

public and total expenditure, the lack of improvement in the health quality system, the absence of an information system regarding health and poor management. Primary Health Care does not play an important role in the process of prevention, detection and treatment; employees in the health sector have low salaries; the public hospital and health centre network are inefficient; the price of medicine is significantly above international standards. Finally, the existence of an irregular private sector should be brought to light.

The proper organization of health care activities gives priority to primary health care, in turn contributing to the overall efficiency of the health care system. Changes in health centres will gradually correct development disproportions, which have thus far been a problem in health care development. Private sector payments are quite high, which subsequently affects access to health care for a large number of citizens.

According to health indicators, Montenegro is at the same level as other countries in the region, but it is noticeably behind the developed European states. Indicators of the capacity of the health system are often at the same level as European countries, but Montenegro falls short when it comes to service quality.

The share of public expenditure on health care in total costs decreased from 100% in 1990 to 87% in 2005. Overall, sustainable health financing must be secured, including adequate funding for public health services, effective preventive programs and increased capital investments. Another challenge is the decentralization process which is still in a very early stage. Thus far, the information system has not sufficiently supported the process. Even though ongoing reforms are promoting universal access as well as equality for all citizens, long waiting times, as well as the availability of some services and drugs only in the private sector, have restricted access to health care for vulnerable groups.

Key Challenges Ahead

Key challenges have been structured according to EU objectives for social protection and the social inclusion process, adopted by the European Council in March 2006.

Challenges for the Social Protection and Social Welfare System:

- Targeting social protection benefits to fit demands for social welfare. Social welfare benefits should be focused either on eligibility or on the duration and size of benefits. Rigidities in both aspects threaten the adequacy, accessibility and social cohesion of beneficiaries.

- Transparency and monitoring of the system. A transparent and accessible system of social protection could increase the confidence of social welfare beneficiaries. More rigid sanctions for the violation of the social protection system, both by beneficiaries and administrative bodies, could improve the public opinion of professionals involved in the social protection system.

- Decentralization of Centres for Social Work in terms of financing and the delivery of welfare. This would involve local municipalities, with the main aim of securing improved access to and the efficiency of the social welfare system.

- Improved administrative capacities of institutions included in the social welfare provision, primarily the MHSLW, and institutions in charge of delivering of social services.

Challenges to the Eradication of Poverty and Social Exclusion:

- The identification and design of appropriate measures for excluded groups, including those not yet recognized by the government as being excluded, and to include the working poor, redundant workers, females from ethnic communities living in rural areas, large families, unemployed parents and single parents, and those living in state institutions.

- The diversification of policy measures for various groups living in poverty, including adjusting measures to meet the actual needs of beneficiaries, combining training and counselling services for individuals that fall into the poverty zone and by increasing financial assistance for the traditionally (Roma) or chronically poor.

- The increase in access to various social resources, to rights and services, especially access to education and health care for those living in remote rural areas.

- The inclusion into the education system and the training of young unemployed persons.

- The prevention of social exclusion by increasing enrolment into the education system, by reducing the number of early drop-outs and by increasing access to primary education for vulnerable groups, i.e. Roma children, children with disabilities.

- The efficient implementation of planned activities for poverty eradication, as well as carrying out active monitoring of the implementation process. Existing strategies for combating poverty in Montenegro have been established in accordance with EU objectives and show the willingness of the government to intensify its work on the alleviation of social exclusion in Montenegro.

- The coordination of multi-sectoral and multi-institutional actions as well as the intensification of communication between stakeholders, especially those at national and local levels, and with NGOs involved in the alleviation of social exclusion and poverty.

- The provision of financial sources dedicated to targeted policies and the planning of actions necessary for the implementation of different projects on the ground. It is imperative that the state budget clearly defines the funds that are

dedicated to the implementation of activities working to eliminate social exclusion.

- The improvement of knowledge and data available about social exclusion. A clear program of research and surveys should be drafted for the long term. Some of these surveys should be the responsibility of National Statistics, but independent research institutions, including collaboration between domestic and international research institutions, as well as international organizations, should all take part. This process should be a part of a much wider process of improving statistical capabilities, with the added aim of harmonizing statistics with EU requirements.

Pension Challenges:

- The assessment of who, among the elderly, both male and female, is not covered by pension insurance, and those lacking support either form formal or informal social networks, should be included in social inclusion programs.

- The assessment of which groups are not, but should be, covered by the pension system – redundant workers, those employed in the informal sector, those employed in the subsistence economy, vulnerable ethnic groups like Roma, those without working records, those who are unable to work, etc.

- The creation of an institutional framework that will encourage people to work longer and more productively. The main challenges are to include those who are not formally employed, or are not sufficiently employed to receive the minimum wage, into the system. The minimum pension should be such that it will not disrupt work incentives. One of the priorities of reform is also to reduce the costs of administering the system.

- The adequacy of retirement income. Measures should not only be aimed at ensuring a certain standard of living for the elderly, but more generally at providing a means for people to maintain, to a reasonable degree, the standard of living they reached in their working lives, and to enable pensioners to participate actively in public, social and cultural life.

- The modernization of the system. The main objective should be to adopt measures aimed at promoting more flexible employment and career patterns, to bridge the opportunity gap between women and men, and to demonstrate that the pension system is able to meet its requirements.

- The achievement of financial sustainability in the system. The collection of contributions should be significantly improved, by minimizing evasion and non-compliance, as this has a decisive impact on the viability of the pension system.

- The improvement of transparency within the pension system through public debates on the future of the pension system.

Challenges for Accessible, High Quality and Sustainable Health and Long-Term Care:

- A well organized and effective healthcare system that will be effective, efficient and equitable and that will promote solidarity between groups (rich and poor, healthy and sick, young and old).

- Extending primary health care reform. Primary health care is the health service most available to the population. It monitors health, studies factors that impact on health and provides preventive measures and treatments that do not require sophisticated technology or a specialized knowledge. Primary health care is also at the base of the health care pyramid from which specialized secondary and tertiary services are directed for more extensive health care needs.

- A universal health care approach – Greater attention should be given to private sector payments. Current costs are high enough to affect access to health care for a large number of citizens. Cost control measures taken in most countries have shown an increased financial risk for services providers and for patients. If that risk is not neutralized with increased productivity it is possible that vulnerable groups will be most affected. Therefore, monitoring the impact of reform measures against household consumption should be introduced. Monitoring should help to identify problems and offer solutions. This is in line with the EU objective of access to adequate health and long-term care for all.

- Improvement in quality and efficiency through intervention on the supply side – As the owner of the major part of the health service network, the government should start at least two initiatives addressing the inefficiencies in the current health care system. The first is to make hospitals more efficient in order to increase quality of health services and to adjust to the varied epidemical profile of Montenegro's population. This reform would include the merging of specialized centres in order to achieve economies of scale. The second initiative is the decentralization of primary and secondary health care, i.e. to transfer of responsibility to local governments.

- Access to health care of vulnerable groups. Poor housing conditions appear to be a key factor in the poor health of RAE, even after developing a natural immunity to various diseases in their environment. A priority in terms of improving the health conditions of RAE, would be to provide legal housing with improved sewerage and water supply systems.

- An education program should be implemented for citizens in order to inform them of the consequences of their own health decisions. Health education should be included in primary schools and high schools as a special subject, and/or within other subjects. Children and teenagers (and their parents indirectly) would adopt a basic knowledge of healthy living, personal hygiene, nutrition, physical exercise, illness and injury prevention, sexual education, addictions (alcoholism, drugs, smoking) and their impact, etc.

- Sustainable health financing will need to be secured, including adequate funding for public health services; population based preventive programs and capital investments.