



Crna Gora

Ministarstvo zdravlja



Integrity Assessment of the Health Care System in Montenegro

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1. INTRODUCTION AND METHODOLOGY OF THE RESEARCH

The “Integrity assessment of the health care system in Montenegro” is based on research which was commissioned by the Ministry of Health, World Health Organization and UNDP in Montenegro and carried out by the selected company CEED Consulting.

The aim of the research was the overall analysis of the integrity of the health care system and all its parts, and the scope of its activities. According to this defined objective, the research included the following segments of health care system performance:

- Health care system functioning;
- Health care system reform;
- Private health care;
- Determining the level of informal payments and their quantifiers.

In order to gain insight into the views and attitudes on the given topics according to the socioeconomic and regional characteristics of respondents, quantitative research was conducted by a direct interviewing method (face-to-face). This method included three target groups: two groups of health care system users – hospital patients and patients of primary health care during 2010, and medical staff in the public health care system. Quantitative research was conducted on a sample of 3,000 hospital patients, 1,159 patients of primary health care and 301 health care workers. The Health Insurance Fund provided data on patients of primary health care, while general hospitals, specialist hospitals and the Clinical Centre of Montenegro provided data on the number of patients in the first six months of 2010.

The respondents included in this research were guaranteed anonymity, which contributed to obtaining more honest and accurate data processed in this report. Data entry was carried out in Microsoft Excel and data processing with the necessary logical controls was carried out in the program SPSS (Statistical Package for Social Science and data analysis). In accordance with the project objectives, a team of analysts from the CEED Consulting carried out the data analysis and drew conclusions.

Considering the manner in which the sample was created, particularly its representativeness¹ and applied methodology, we consider that the presented findings can be treated as valid indicators of integrity in the Montenegrin health care system.

¹ Representation of the sample implies selected units of observed groups, i.e. population have all characteristics of entire population.

2. DESK REVIEW OF THE MONTENEGRO HEALTH CARE SYSTEM

2.1. Legal regulation

A necessary prerequisite for the implementation of reform activities, which has begun to be implemented within the Montenegro health care system, was the establishment of a suitable institutional framework, as a critical condition for the improvement of health care and the stable functioning of the health care system as a whole. To that end, the existing acts were improved and new reform acts defining the general principles of health care were passed. The health care system and its organization are directed towards an increase in efficiency and quality, in accordance with the principles of a democratic society (Patient's Rights Act, (Official Gazette of Montenegro, No. 40/2010), the Genetic Data Protection Act (Official Gazette of Montenegro, No. 25/10), the Nursing Law (Official Gazette of Montenegro, No. 25/10), the Law on Taking and Using Biological Samples (Official Gazette of Montenegro, No. 14/10), the Law on Production and Trade Control of Substances that can be used in the Production of Narcotics and Psychotropic Substances (Official Gazette of Montenegro, No. 83/09), the Law on Infertility Treatment Assisted by Reproductive Technologies (Official Gazette of Montenegro, No. 74/09), the Sanitary Inspection Act (Official Gazette of Montenegro, No. 14/10), the Law on the Taking and Transplantation of Human Body Parts for the Purpose of Treatment (Official Gazette of Montenegro, No. 76/09) and the Law on Noise Protection in the Environment (Official Gazette of Montenegro, No. 45/06)). In addition, a significant body of secondary legislation was passed, creating conditions for the full implementation of legislation, for the purpose of providing equal rights in using health care (the Rulebook on specific conditions in terms of standard, normative and ways of exercising the right to primary health care either through a chosen team of doctors or one doctor according to Article 19, paragraph 5, in relation to Article 39, paragraph 2 of the Law on Health Care (Official Gazette of Montenegro, No. 39/04) and the provision on the scope of rights and standards of health care from obligatory health insurance pursuant to Article 17 of the Law on Health Insurance (Official Gazette of Montenegro, No. 39/04)).

The area of health care in Montenegro is primarily regulated by the Law on Health Care (Official Gazette of Montenegro, No. 39/04 and 14/10) and the Health Insurance Law (Official Gazette of Montenegro, No. 39/2004). In order to fight corruption in the health care system the Law on Health Inspection (Official Gazette of Montenegro, 79/08) is particularly significant, as well as the Action Plan for the fight against corruption in the area of health care for the period 2009-2013. Application of these legal regulations significantly limits the space for corrupt action.

In order to improve the **quality of health care**, the Law on Health Care stipulates that health institutions are obliged to establish monitoring and evaluation procedures as an integral part of their regular and professional activities in providing health care services to the population. To that end, in state-owned health care institutions, it is anticipated that a Health Care Control Committee will be formed.

Professional work quality assessment is, according to Article 112 of this Law, performed as an internal assessment (within the competence of health care institutions) and an external assessment (organized and conducted by the Ministry of Health), and includes the evaluation and measurement of the following factors: the fulfillment of prescribed working conditions in health care institutions; the implementation of the adopted health care system standards; reducing unwanted, unnecessary and inappropriate procedures and measures undertaken for the professional advancement and continuing education of health care workers.

The rights and obligations of citizens in accessing health care, pursuant to the Health Care Act and Patients' Rights Act, among other things, imply the right of a patient to freely choose a doctor of medicine in accordance with the new model of primary health care, and to be informed and notified on their health condition and the ways of providing health care services. Patients have self determination on everything regarding their life and health, except in cases when it directly endangers their life and the lives of other people; access to medical records and documents; the right to seek other professional opinions; the right to privacy and confidentiality; the right to timely health care; the right to objection; the right to compensation for damages, etc. Amendments to the law are related to the obligatory forming of the Ombudsman Service for patients, which is defined by the director of the health care institution, and the punishment (amount of fine) if the patient's rights are found to have been violated. Consistent implementation of the provisions of this law will significantly affect the improvement of the status and autonomy of a patient within the health care system, which will minimize the possibilities for actions that are not in the interest of a patient.

The above-mentioned laws prescribe that **monitoring over the implementation of laws and regulations** be performed by the Ministry of Health, through its health care inspectors. The rights and duties of health care inspectors, health care institutions and the parties in inspection supervision proceedings are defined by the Health Care Inspection Act. This regulation has no direct basis in any EU document, but its solutions are based on the recommendations and guidelines of the World Health Organization. Pursuant to Article 3 of this law, the health care inspector must keep strictly confidential the identity of the initiator of an application which points to a violation of the law or other regulations related to health care issues. This regulation encourages citizens to report cases of malpractice to a greater extent and without the fear that it could lead to worse treatment.

2.2. Infrastructure and staff

The health care system of Montenegro is organized as a single health region and is predominantly based on the public sector. Public Health Institutions are organized through a network of primary, secondary and tertiary health care that consists of 18 Health Care Centres, seven General Hospitals, three Specialised Hospitals, the Clinical Centre of Montenegro, the Emergency Institute, the Public Health Institute and the Montenegro Pharmacy Institution 'Montefarm', which consists of 41 pharmacies in all municipalities of Montenegro. The private health care sector is not integrated into the health care system yet, and it consists of a number of medical practices, dental practices, wholesale stores and pharmacies.

The Health Care Centre is the referential primary health care centre providing support to the chosen team of doctors. In terms of organisation, a health care centre has three basic parts: a *chosen doctor outpatient facility (surgery)*, or chosen doctor teams (chosen doctor paediatrician, chosen doctor for adults and chosen doctor gynaecologist); *chosen doctor support centres* organized at the local and regional level for: pulmonary disease and tuberculosis, diagnostics, mental health, children with special needs, prevention, etc. and *support units for*: patronage, primary physical therapy and medical transport.

In relation to the number of examinations/check ups planned by the Health Care programme in Montenegro for 2008, doctors of medicine performed 3.5 examinations/check ups on average per insurant/beneficiary (planned 3.9), i.e. the chosen doctors of medicine achieved 90.05% of their plan in 2008. When compared to the number of visits to the doctor in private practice, the number of consultations with a specialist at the level of health care centres (0.59 examinations per insurant/beneficiary) is satisfactory. At the hospital level, there were 1.05 examinations per insurant/beneficiary.

Table 1. Health care indicators (per 100,000 inhabitants)
according to data from Monstat² and Eurostat³:

	Number of doctors		Number of hospital beds	
	1998	2008	1998	2008
Montenegro	121.10	215.85	680.64	615.66
Regional countries				
Croatia	227.5	266.1	601.5	547.3
FYR Macedonia	-	-	516.0	463.1 (2006)
EU countries				
Bulgaria	346.0	361.3	843.5	650.8
Romania	188.2 (1999)	221.5	731.6	657.4
Slovenia	219.1	229.7	559.1	476.9
Germany	317.5	356.2	929.3	820.3
France	-	-	832.5	684.8
Italy	-	-	555.1	371.4
Belgium	373.1	293.2	787.5	660.1
Spain	287.3	352.2	378.4	324.5

Based on the data presented, it can be seen that, in 2008, Montenegro had a lower than average number of doctors not only in comparison to EU countries, but also to the countries in the region, which also were going through a process of transition. Next to that, the number of doctors shows a rising trend, while the number of hospitals is progressively decreasing in accordance with developments in other countries. Namely, the number of visits to physicians increased in 2008 by 39.7%, while visits to other health care providers decreased by 15.5% in relation to 1999. These data are testimony to the success of the Montenegrin health care system reform, given that one of the main goals of initiating the reform was for primary health care to solve the majority of health issues, with the secondary and tertiary level only being used by patients who really need it. However, the question is whether the decreased number of patients at specialist surgeries was only a consequence of health care reorganisation, or whether

² Statistical Yearbook of Montenegro 2009

³ http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/data_public_health/main_tables

this percentage decreased somewhat due to the long wait, which forces patients to seek an alternative in private institutions. The fact that partly confirms this assumption is that in 2008, 3.5% of adults waited more than one month for a specialist examination in primary health care, which is considerably higher compared to 2000, when this was the case with 2.5% of adults.⁴

2.3. Institutions

The Ministry of Health, the Health Insurance Fund and public and private health care institutions are included in the organisation and health care service delivery in Montenegro.

The health care information system was developed within the reform activities of the **Ministry of Health**, and it serves as a support to all business-medical activities and business-financial processes in health care centres. The implementation of this system was completed in all 18 health care centres with about 2,500 employees. Since 2009, electronic receipt, electronic referral, electronic notes of remittance for sick-leave and an entire electronic billing system has been set in place in the Montenegrin health care system, at the primary level. This means that all operating processes in health care centres are IT supported.⁵ The introduction of the information system ensures transparency in every segment of the health care service, which can serve as an efficient instrument in fighting corruption. Some of the future goals are public announcements and an insight into waiting lists for medical procedures, which is one more element towards solving this issue.

In 2008, the rising rate of deficit in the **Health Insurance Fund (HIF)** has significantly decreased from 2005 and 2007 in absolute value in EUR. These trends indicate that it will take an additional 3 to 4 years before HIF achieves a surplus.⁶ In 2008, the revenues achieved by the HIF were 32.5% higher in comparison to those in 2007, as a result of the overall economic growth in Montenegro, a more consistent collection of revenues and an increase in the scope of contribution payers.⁷ Despite the indication of positive trends in HIF revenue growth, the year 2009 recorded a decrease of 11.6% in comparison to revenues achieved in the previous year, as a result of a cut in the health insurance contribution rate from 12% to 10.5%, according to the Law on Contribution to Social Insurance (Official Gazette of Montenegro, No. 3/07) and a lower collection of contributions from tax payers. In parallel with the decrease in revenues compared to 2008, came an increase of expenditure on health care of 11.4%, as a result of a tariff increase for health

4 Montenegro Health System Improvement Project: Technical support in conducting Living Standards Measurement Survey, LSMS), National health survey, SMMRI Group, November 2008

5 <http://fzocg.me/print.php?id=367>, 29. 10.2010 (Agency MINA) Interview with the directors of the Health Insurance Fund of Montenegro Mr. Ramom Bralićem, M.S. 18.04.2009

6 Health Sector Improvement Project (MHSIP) Impact Report, consultant of M&E Dr Ravi Venkataraman, 2008

7 http://fzocg.me/documents/Publikacija/Publikacija_Forum.pdf, 28/10/2010, edition of the Health Insurance Fund: Health Insurance For You and Beside You, August 2009

care services in public health care institutions since July 2008, as well as the increased health care consumption in some segments of the population (medications, orthopaedic aids and devices, etc.) and a tariff increase for health care services in Serbia, etc.

Indicators of health care expenditure in Montenegro in relation to GDP or expenditures per capita are considerably lower than in the European framework. According to 2009 reports, Montenegro took penultimate place according to average allocations on health - €256.40 or 4.6% of GDP, ahead of Albania. The current tendency that the growth rate of health insurance contribution is decreasing cannot be relied upon, and could bring the financial sustainability of the health care system in Montenegro into question, since it is operating with difficulty even with the current rate. If the reduction of the contribution rate did take place, the consequence would be a reduction in the right to health care.

Given that there is a gap between the defined rights from health insurance and the financial capacity to meet them, combined with unrealistic expectations from citizens and employees in the health care sector, the belief of citizens and health system employees that they have the right to any health care services regardless of its necessity should be changed. Public awareness must be raised that every health service has its price and that health care is not free of charge, in order to accept and adjust to changes more easily.

In addition to this change in citizens' views and habits, it would be useful to provide an opportunity for the private health care sector to equally apply for resources from the HIF in order to ensure a positive impact on competition. In this way, both public and private institutions would be motivated to provide as qualitative health care service as possible, within the available resources. According to announcements, the Ministry of Health plans to include 15% to 20% of private practices (outpatient facilities/surgeries) in the health institution network in Montenegro, which will sign contracts with the Health Insurance Fund. Citizens would be able to get treatment as in public health institutions, provided that they have a certified referral and a health card. Including private practices in the institutional network will raise the level of health care and the patients will not wait longer than 30 days to have a specialist examination/check up. The Health Fund will provide funding for private surgeries/outpatient facilities included in the network, while public health institutions which are not able to provide health services due to organisation or some other issues will be deprived of the same amount of these funds. The most important factors that determine the successful implementation of this idea are not only defining the price that will cover the costs of private clinics, outpatient facilities and laboratories, but also the price the state budget can bear as well as harmonisation of the legal framework by the adoption of certain secondary legislation.⁸

In case this plan is implemented, it will mitigate the problem of double payment, i.e.

8 <http://www.rtcg.me/vijesti/drustvo/hronika/25049-u-mrezi-i-privatne-ambulante.html>, 29/10/2010.

the fact that some citizens, in addition to the obligatory health insurance contribution, are forced to pay extra when doctors from the public health care institutions direct them to a private health care institution in order to get efficient and timely service. In support of this statement, the data shows that in 2008 one out of four citizens (26.9%) had to pay for health care in the last 12 months. The main reasons for using private health care services were: no waiting, higher quality service and a better relationship with the patient. Also, the share of adults who supplied the necessary medical material by themselves in the period 12 months before the survey was 35.1%.⁹

The Public Health Institute's primary task is the monitoring and assessment of the situation in the health care system of Montenegro. The competence of the Institute is to identify risk factors to health from contagious and chronic mass uncontagious diseases, including biological, environmental, socioeconomic factors and lifestyles, and to undertake measures for either reducing their influence or their elimination. Apart from that, it prepares national programmes, development strategies, analyses of the condition of the population's health and a public health programme for tackling the most serious health problems. The institute is involved in health care planning and providing professional and methodological support for the implementation of plans of health care facilities in Montenegro. In terms of the prevention of contagious diseases, the Institute prepares national immunisation programmes and supervises their implementation in all health care centres. The Institute has also performed monitoring and control of environmental parameters important for public health.

2.4. Policy and Action Plans

Adopting a plan to implement the Health Policy by 2020, Montenegro got involved in the unique international process of implementation of the World Health Organisation documents 'Health for all in the XXI century'. The Health Policy Development Strategy opened the process of necessary health care system reforms that should provide higher quality health services and the improvement of public health and health conditions. In accordance with this, the Ministry of Health has published four strategic documents: 'Strategy for Health Care Development' (2003), 'Health Care Development Master Plan 2005-2010', 'Montenegro Health System Development Master Plan 2010-2013' and 'Strategic Health Insurance Development Plan until 2011.'

The development of the new document started in the beginning of 2009: a master plan with an action plan of implementation for the following mid-term period, which incorporated the guidelines of the European Union 'Together for Health': the EU strategic approach for the period 2008-2013. The goals stated in this document should have an important and positive effect on further strengthening the stability of the health care

9 Montenegro Health System Improvement Project: Technical support in conducting Living Standards Measurement Survey, LSMS), National health survey, SMMRI Group, November 2008

system and, by that means, building the capacity of the health care system to fight corruption. The important goals stated in the document are the following:

- Development of a legal framework for private-public partnership in the health sector, based on the analysis of the EU positive practices in areas of: including private institutions in the health care system; awarding concessions; commitment status; direct joint ventures; the leasing of equipment and premises in public institutions; and finding optimal models for Montenegro.
- Introducing voluntary financing of health care services as a way to increase the share of private money in the health care system in a public and transparent way. The Health Insurance Fund will provide financing of the basic health services package, while all other services, as a difference in price paid by insurant/beneficiary through the system of participation, would be the subject of voluntary health insurance. In this way, health care beneficiaries will be able to provide services not covered by compulsory health insurance (dental services), higher service standards than those usually applied, treatment abroad (not covered by the Health Insurance Fund), the services of a private doctor not included in health network and who has no signed contract with the HIF, etc. Voluntary insurance will be introduced as a financial and organisationally separated activity of the Health Insurance Fund and will rest on the principles of the Health Insurance Act.
- Further harmonisation of the legal framework in the health sector with EU regulations. The reformed legal framework will transfer financial accountability from the Health Insurance Fund to executors at the secondary and tertiary levels, which would result in the good-host behaviour of hospitals, the enhancement of positive competition as well as an increase in the quality of health services.
- Preparation for the introduction of the new payment system at the secondary health care level (Diagnosis-related group - DRG model). The DRG system, as a world recognised standard for the comparison of effectiveness and costs in the health care sector, will enable proper economic analysis that should define further steps and provide the comparability of data both among hospitals in the country and hospitals in the EU and beyond.
- At the secondary level of health, it is planned to give priority to outpatient treatment, which offers all medical procedures before hospital treatment. Hospital admittance will be allowed only after all medical examinations are completed or if the constant monitoring of vital functions is necessary. Specialist outpatient services and hospital services will not be organised separately, but each doctor will use a part of their working hours for the treatment of patients in outpatient facilities. These measures will bring a significant rationalisation of the available health sector resources.
- The Clinical Centre of Montenegro is a part of the health care system which currently provides secondary and tertiary health care services, which are not separated. The key problem does not lie in the fact that there is no organisational

separation of these services, but in the fact that it is not precisely defined what tertiary health care is and that it cannot be provided through general hospitals. This problem is another of the proposed tasks for the future stages of reforms.

The steps related to secondary and tertiary health care, in addition to the increase in service quality, are significant from the standpoint of rationalisation of consumption in these segments of the health care system. Namely, the expenses for these levels of health care were very high in 2009 and amounted to €91.2 million or 48.2% of the total fund expenditure. In comparison to the previous year, expenses increased by 17% and were €13.1 million, or 16.78%, higher than in the plan for 2009.¹⁰

It is worth mentioning that during 2009 special attention was devoted to the development of national action plans, which precisely define the roles and responsibilities of all actors in their implementation. Among other things, the Action plan for the fight against corruption in the area of health care for the period 2009-2013 was adopted.

2.5. Action Plan for the Fight Against Corruption in the Health Care Sector

The Criminal Code of Montenegro defines criminal acts with the elements of corruption as follows:

- Taking a bribe occurs when a person acting in an official capacity requests or receives a gift or any other benefit for agreeing to perform within the scope of his/her official powers an act he should not perform, or not perform an official act which he/she should perform. Giving a bribe occurs when a person offers a certain benefit to an official person to perform the abovementioned acts.
- Abuse of office exists when a person acting in an official capacity uses his/her position or authority to acquire a benefit for himself/herself or causes damage to another person.
- Illegal influence exists when a person acting in an official capacity requests or receives certain benefits to mediate a certain official act to be performed or not performed by using his/her official influence. Leading to illegal influence exists when a person gives, offers, or promises a certain benefit to an official person for the abovementioned actions.
- Unlawful receiving of gifts exists when a person accountable acquires an unlawful benefit to conclude a contract or provide a service on the damage of his/her company or some other entity. Unlawful giving of gifts occurs when a person provides an unlawful benefit to a person accountable to perform the abovementioned acts.
- Other criminal acts with corruption-related elements are: a violation of equality in performing business activity; abuse of a monopolistic position; abuse of assessment; disclosure of a business secret; malpractice.

¹⁰ http://fzocg.me/docs/30/izvjestaj_o_radu_i_poslovanju_fonda2009.pdf

It is believed that corruption in the health care sector has a negative effect on the quality and availability of health services, reduces the scope of services provided and increases the costs of services, thereby posing a direct threat of rendering the goals of the health care system reform meaningless and reducing the achieved results.

Upon consideration of the experiences of neighbouring countries, and the analysis of roles and relations among numerous actors in the delivery of health services, and the very course of provision of health care in the Montenegrin health system, it's possible to single out measures to strengthen weak spots within the system and reduce the space for corruption, until the reform process is completed.

In order to strengthen the legal and institutional framework for tackling the issue of the simultaneous work of doctors in the public and private sector, amendments to the Health Care Act were adopted (Official Gazette, No. 39/04 and 14/10) relating to the limitation of work to health workers in the public and private sector, as well as increased accountability of health institution management. Article 74, paragraph 1 of this Act prescribes that a health care worker employed full time in a health care institution is allowed, with the director's consent, to perform additional work in another medical facility included in the health care institution's network. Article 136, paragraph 2 says that specific terms for performing additional work are defined by the Ministry of Health. The terms referred to in this article are the fulfilment of normatives, i.e. the achievement of qualitative results in health service delivery, while the way of performing additional work is to be defined by secondary legislation, for which preparation is in progress.

The passing of the Law on the Protection of Patients' Rights (Official Gazette of Montenegro, No. 40/2010) enabled more complete protection of these rights and specified responsibilities of all actors in the health services delivery process. According to Article 31 of this law, a patient who is not satisfied with the provided health service or with an action or behaviour of a health-care or any other worker may file a complaint. The complaint is filed with the director of a health care institution or to the patients' ombudsman. The patient who is not satisfied with the outcome of the complaint may address the health inspectorate, according to the law. As a part of exercising patients' rights, development of a brochure is planned and should be available in health institutions as well as the introduction of a system of complaints in the form of complaint boxes in health care institutions.

In the area of professional education for health care workers and the raising of awareness of the importance of quality improvement for health care, the Action plan measures anticipate development of plans for specialization, development of the regulation of professional norms and standards, the development of protocols, guidebooks and guidelines for clinical paths and the development of a quality management model.

In terms of providing safety and cost-effectiveness for health care technologies, it is necessary to define priorities in the procurement of and investment in medical equipment in health care institutions, and make public procurement notices available at the Ministry of Health website. All institutions within Montenegro's health care system are required to submit public procurement plans for each year to the Public Procurement Directorate starting from 2007 when the Directorate was established. The development of an annual public procurement plan is the basis for achieving the main goal - effective and efficient public resource spending. Decisions and conclusions on filed complaints on public procurement procedures are available at the Public Procurement Control Commission's web site. There are decisions on complaints addressed to the Health Insurance Fund, the Public Health Institute, the Clinical Centre of Montenegro, Specialized and General Hospitals, Health Centres and the Pharmacy Institute of Montenegro. The complaints are mostly related to medical devices and appliances, diagnostic equipment and office material. The complaints contained no visible reasons for re-launching the public procurement procedure or evidence that some illegal (corruptive) actions or some kind of malpractice was in question: non-transparency, incomplete bid, or criteria not specific enough.

Regarding the provision of financial incentives for the improvement of health care quality, health institutions should form teams (doctor and pharmacist) for the implementation of a rational pharmacotherapy and to set a reward system in place in order to provide a financial stimulus for health workers. A very effective measure in this part should be the one relating to introducing indicators of quality as criteria for the conclusion of health insurance contracts between the Health Insurance Fund and health institutions.

The Ministry of Health and the Directorate for Anti-Corruption Initiative (DACI) opened free telephone lines for reporting corruption. DACI in 2009 received about 98 reports, out of which 7 were related to the health care sector. In 2010, there were 140 reports, four of which were for the health care sector. The data points to a decrease in the number of complaints about corruption in the health care system in 2010, in comparison to the previous year. The largest number of complaints related to doctors' performance, more precisely to the practice of directing patients to private clinics where the doctors also work.

The Montenegrin Ombudsman is an institution that also receives complaints regarding the performance of health care institutions. In 2009 the Ombudsman received four complaints, of which, in two cases there was determined to have been a violation of patients' rights by the health care institution. In 2010, the Institution of the Ombudsman received one complaint on a health care institution's performance due to a violation of the right to health care. The procedure regarding this complaint is in progress.

The Non-Governmental Organization 'Montenegro Patient Rights Protection Association' ('Crnogorsko udruženje za zaštitu prava pacijenata') is active in ten cities in Montenegro. Their activities include psychological counselling and mediation in negotiations during the complaints process. According to statistics for 2010, there were 1,200 informative calls in total: in 754 cases psychological counselling was required, while 146 cases were solved by means of mediation. The largest number of calls, psychological counselling and negotiations were received in Podgorica, Tivat and Berane. Scheduling of counselling is done in order to assess whether help could be provided and it is utilised to give patients confidence in order to overcome a sense of vulnerability.

2.6. Montenegro Health Care System Reform

The Montenegro Health System Improvement Project (MHSIP), in the previous five-year period realised a number of activities in primary health care system reform, which is confirmed by reports on continuant monitoring and project activity evaluations.

The World Bank's Managing Board approved on November 3rd 2009 additional financing to MHSIP to the tune of €5.1 million designated for the completion of started activities within the primary health care reform in the period 01/01/2010 to 31/12/2012 and for starting the secondary and tertiary health care reform, which will result in an increase of positive competition and improved health service quality.

New Model of Primary Health Care - Chosen Doctor

By strengthening preventive and primary health care, not only are the majority of health issues solved in primary contact, but at the same time the proportion of the population contracting illnesses from the most common diseases can be significantly reduced, which has a positive impact on public health.

The primary health care reform process began in the Health Centre in Podgorica according to the adopted legal and secondary legislation regulations in 2005, while during 2008 other health centres have changed their organisational scheme, carried out registration of insurants/beneficiaries and health care is provided through chosen doctors, and support centres and units for chosen doctors.

The manner of payment for health care is capitation with a contractual arrangement between the Health Insurance Fund and the health institution for each chosen doctor in primary health care, selected by a minimum number of citizens. The contractual arrangement between the Fund and private doctors who meet the legally defined working conditions, and who are selected by a minimum number of citizens, stipulates the gradual levelling of the private and public sector in terms of possibilities to participate in health care implementation.

The chosen doctors achieve half of their revenues (50%) through capitation, while the other half (50%) by billing pre-defined services. In this way, downsizing of these types of payment are brought to a minimum, while the advantages are emphasized. If capitation is used as the only payment mechanism, then chosen doctors would have the incentive to provide as few services as possible, given that their revenues do not depend on the number of services provided, but on the number and age structure of the citizens who selected them. This could lead to a situation where they do not properly treat the citizens who selected them. On the other hand, if the other payment mechanism is applied (payment of a fee/charge for services provided), then chosen doctors would be motivated to provide as many services as possible regardless of whether they were really necessary or not, since the costs for health care services would constantly grow.¹¹

The success of the primary health care system reform is monitored by the Ministry of Health through surveys assessing the views and attitudes of patients and health care workers, which are conducted in two-year intervals starting from the planning and announcement of the reform in 2004. Even though clear indicators of the reform process showing success at the level of primary health care have been defined in terms of an increased number of patients visiting the same doctor, the positive trend achieved in the duration of consultations with a chosen doctor and in an increased number of patients using the advanced appointment system, key problems of the health care sector still remain, such as dissatisfaction with health care worker salaries, the lack of motivation among doctors, and waiting and queuing. Three years after initiation of the reform activities, health care workers and patients have not indicated increased satisfaction with the reform results. The majority of health care workers in 2008 were not yet aware of the capitation method, while those who had heard of this method had a neutral attitude because they find this method unclear.

In parallel with the primary health care reform, the rationalisation of hospital services has been carried out as well. This is particularly significant for Montenegro, since in 2003 41% of total health care system costs were from secondary health care, which is dominated by hospital treatment. This sudden increase in hospital capacities and expenses in general and specialized hospitals was very evident from 2000 to 2003, when the percentage of beds increased by 6.7%, but the percentage of patients in the same period dropped from 81.41% to 75.72%.

At the beginning of the reform implementation, there was a problem with constant employment of new staff, most of whose capacities were not fully used, especially in the category of administrative and technical affairs. Therefore it was planned to cut the number of employees by 2% each year in these departments, so in the next 5 years the number of non-medical staff would amount to 18% of the total number of employees in the health care system. It is realistic to expect an increase in the salaries of health institutions by 20% and an improvement in working conditions (equipment and professional advancement) if the total number of employees is reduced by 5% each year.¹²

11 <http://fzocg.me/docs/175/metodologija.pdf>, Republic Health Insurance Fund: Methodology of defining the value of capitation and the health service price in primary health care, Podgorica, October 2007

12 <http://www.questionnaire.gov.me/Annexes/Annex223.p>, 05/11/2010. Master plan development of the health care system in

Besides the reduction in the number of redundant employees in the health care sector, one of the methods for performance rationalisation in the health care system is cutting down the costs for medications. The Health Insurance Fund keeps the records on a database according to the type of medicine, price per unit, supplied quantity and total costs for each year. The information is quite detailed and the system for obtaining data is quite efficient, even though there are some delays. The PDO indicator (Project Development Objective), to “reduce the quantity of expensive medications paid for by the Fund (from the list of expensive-transport indicated medications)”, is calculated based on this database.

Namely, it was determined that the price of an expensive medication package decreased from €2.30 per unit in 2004 to €1.90 per unit in 2007 (a 13% drop). Except for the rationalisation of expenses for pharmaceutical products, the Law on Amendments to the Law on Medical Resources and a range of secondary legislation has been adopted. Implementation of these has been started through the Agency for Medications established in 2008 (Official Gazette of Montenegro, No. 62/08), whose goal is to set health care standards matching the European ones, as well as to enable better conditions for development, progress and competitiveness for the pharmaceutical industry and other actors in health care, as well as medication and the medical resources trade.

National Health Account¹³

At the moment of starting the MHISP in Montenegro, there were no official statistics available on national health expenses. To that end, the Ministry of Health, Labour and Social Welfare decided to create the National Health Bills – known as the main headquarters/head office – which is “specially designed to provide information regarding health care policy, including creating policies and their implementation, political dialogue and the supervision and evaluation of interventions in health care,” and all for the purpose of financial sustainability of the health care system.

Situation in the Financing of the Health Care System

The financing of health care in Montenegro is based on the dominant role of the public sector that provides resources for health care and services. The health care system is financed through compulsory health contributions, being a major source of financing, and general governmental revenues. The current contribution rate is 12.3 % and it is levied as a percentage of the gross salary. The unified collection of contributions and taxes has been introduced and endowed to the National Tax Administration. Unlike previous practice, the Health Insurance Fund is included in the treasury operation system.

Montenegro for the period 2005-2010

13 Eva Zver (November, 2008): Montenegro Health System Improvement Project, Technical assistance in the creation and development of health bills in Montenegro: Final report on the National health account (NHA) in Montenegro 2004-2006

Montenegro Health Care System Costs

The public share of total health expenses amounted to 74.8% in 2006. The private share of total health expenses increased in the period 2004-2006 from 23.6% to 25.2%. The costs for medical resources (non-hospital) are high (24% of total health expenses) and one extremely large portion of it (62%) is financed by household cash payments. An international comparison shows that the share of private costs that make up one quarter of total health sector expenses is almost equal to the European Union average, but it is slightly lower than in some countries in the region.

With 2.9% (2005) and 2.4% (2006) of household consumption going on cash payments for health care services, Montenegro is also close to the average of the OECD – Organisation for Economic Cooperation and Development (3%). According to the available data, it is estimated that about 60% (59.4% in 2006) of private expenses for the health care sector were for retail trade and other medical supply providers, 30.5% on outpatient service providers, with less than 10% going to hospitals (contributions to the social insurance fund are included).

Different methods of health care financing (formal and informal payments) may affect the level and distribution of costs for the health care sector and public access to health care services.

3. SUMMARY OF RESULTS – PATIENTS OF PRIMARY HEALTH CARE

3.1. Demographic characteristics

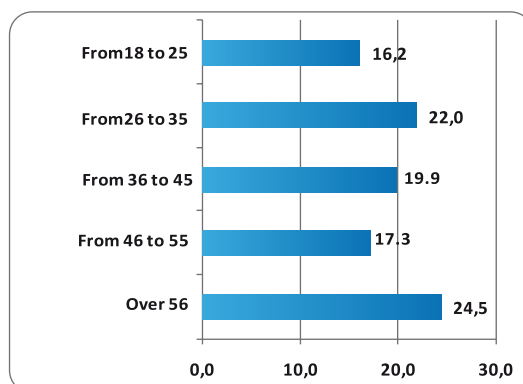
The survey was conducted in 17 municipalities where Health Centres were located, on a sample of 1,159 patients who used primary health care during 2010. Out of the total sample, 44.6% of respondents live in the central region, 35.9% in the southern and 19.5% in the northern region.

Table 2. Municipalities where the survey took place

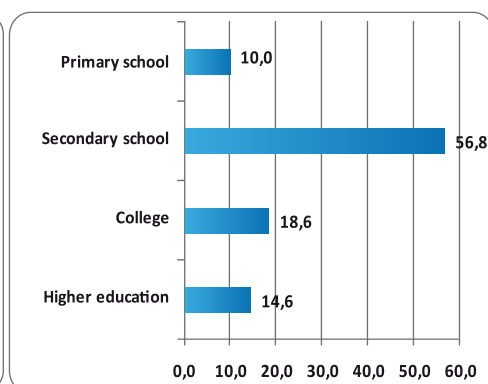
Municipality	Number of respondents	%
Podgorica	333	28.7
Herceg Novi	138	11.9
Nikšić	80	6.9
Bar	77	6.6
Budva	73	6.3
Ulcinj	66	5.7
Danilovgrad	62	5.3
Berane	47	4.1
Cetinje	42	3.6
Pljevlja	41	3.5
Kotor	40	3.5
Plav	38	3.3
Rožaje	30	2.6
Mojkovac	26	2.2
Bijelo Polje	24	2.1
Tivat	22	1.9
Kolašin	20	1.7
Total	1,159	100.0

The gender breakdown was almost equal: 52.7% of women and 47.3% of men. The average age was 43, while most people interviewed were 56 years of age (24.5%) and between 26 and 35 years of age (22.0%). Regarding their educational status, a half of respondents (56.8%) had secondary level of education.

Graphic 1. Age of respondents

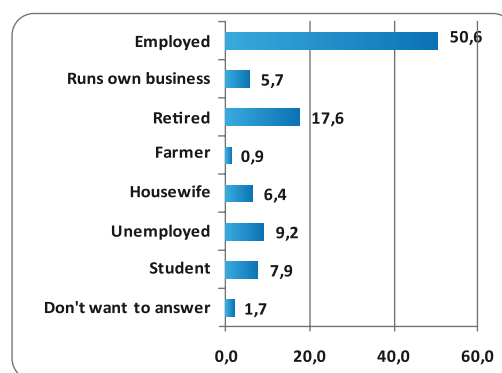


Graphic 2. Level of education

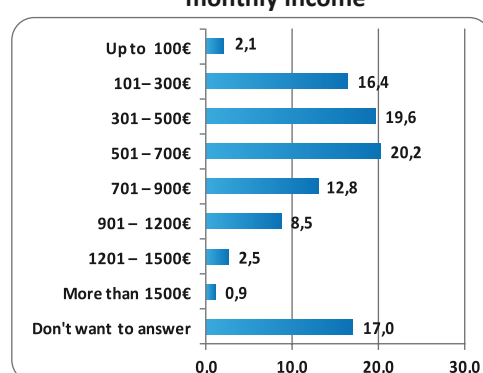


In the majority of cases, the households interviewed consisted of four (28.3%), three (22.4%) or five (21.8%) members. For two-thirds of households, the salary was the main source of income. One out of every two respondents had a job (50.6%), of which 57.3% were in the private sector. The total monthly income for a fifth of all households in the specified interval amounted to between €301 and €500 (19.6%) and the same proportion between €501 and €700 (20.2%).

Graphic 3. Occupation



Graphic 4. Level of household monthly income



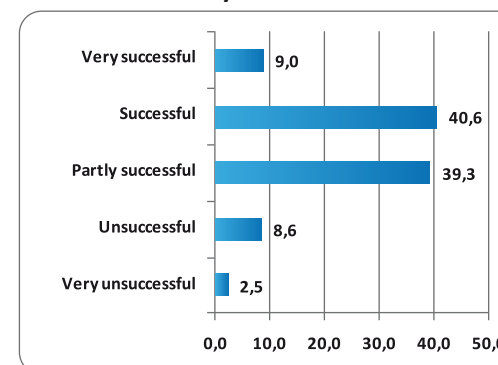
3.2. Health Care System Reform

3.2.1. General level of satisfaction with the reform so far

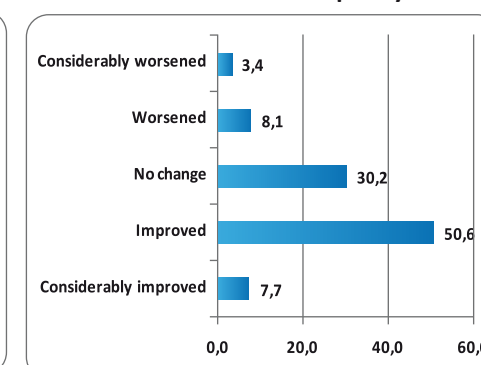
Regarding the effectiveness of the health system reform so far, patients at the primary health care level had a positive opinion. Namely, two-fifths of respondents (40.6%) assessed the health care system reform as successful, while nearly 39.3% thought the reform was partially successful. Respondents from the northern municipalities were the most satisfied with the health care system reform, assessing it as either very successful (18.1%) or successful (42.9%).

A half of the respondents (50.6%) thought that during the implementation of the health care system reform the quality of health services improved. On the other hand, 30.2% of respondents thought the quality of service remained the same. In accordance with the overall assessment of the implemented reform, for respondents from the north, the quality improvement was more pronounced in comparison to respondents from the southern region. The higher the level of education, the larger the number of respondents who assessed that the quality of health services “improved”, and the smaller the number of those assessing the quality as “significantly improved”. There is a strong correlation between answers on the reform so far and the changes in the quality of health service. This means that respondents who positively assessed the results of the reform have positively commented about the changes in the quality of health services in comparison to the period before the reform implementation.

Graphic 5. Assessment of the health care system reform so far



Graphic 6. Change in the health service quality

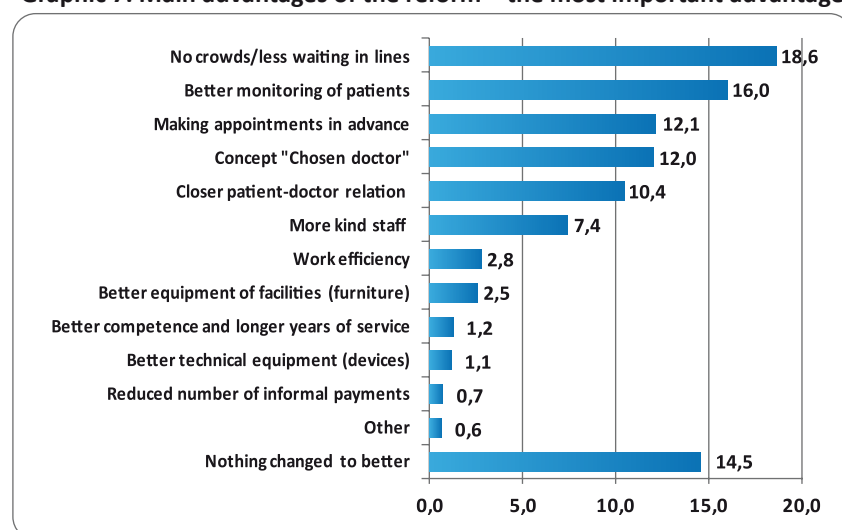


The characteristics which have improved in relation to the period before the reform, according to the respondents, were the following: a more qualitative relationship with the doctor, which results in better awareness of the patient's health condition and medical history (61.6%) and waiting times for patients to be seen by the doctor (53.5%), which is reduced by introducing compulsory appointments in advance. Based on the data obtained, it can be concluded that the health care reform implemented since 2003 at the primary level has resulted in positive changes because some of the defined objectives were achieved. However, the reform did not bring changes in doctors' motivation and competence (60.1% and 64.8% respectively) and the facilities' equipment (55.3%) according to patients of primary health care.

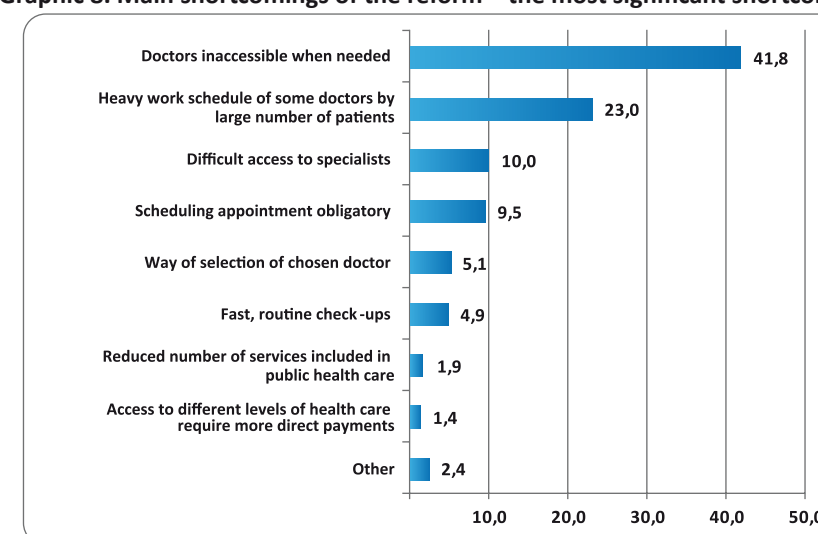
Table 3. Change of the health care characteristics (%)

	Improved	Worsened	No change
More qualitative relationship with the doctor	61.6	3.8	34.6
Waiting times for patients to be seen by the doctor	53.5	13.3	33.2
Time available for conversation with the doctor	49.0	8.7	42.3
Time available for examination	46.5	9.2	44.3
Crowds in the waiting room	42.9	14.7	42.4
Equipment of facilities	40.5	4.2	55.3
Doctor's competence	31.5	3.7	64.8
Availability of medications in pharmacies	28.6	17.9	53.5
Motivation of doctors	28.3	11.7	60.1

When it comes to the main advantages of the reform, the patients highlighted less time spent waiting (18.6%), better patient monitoring/better insight into the patient's health condition (16.0%), making appointments in advance (12.1%) and the concept of a 'chosen doctor' (12.0%), as having contributed to *"the increase in discipline in health centres"*. Observing the structure of answers by region, respondents in the central and southern regions (19.5% and 21.5% respectively) thought that the greatest advantage of the health reform was in less time spent waiting, while in the north (24.9%) they thought the best thing was a better insight into patients' health condition. Out of the total number of persons interviewed, 14.5% thought that there were no changes for the better as a result of the reform, because *"it has been poorly implemented in practice"*. This opinion was mostly stated by respondents with a lower level of education, with lower incomes, unemployed or people receiving social allowances. The research results have no option of determining whether this attitude was a result of their poor material situation, a lack of awareness of the health system reform or for some other reason.

Graphic 7. Main advantages of the reform – the most important advantage

According to citizens, the most significant shortcoming of the reform was that it made doctors "inaccessible" when they were needed the most (41.8%) due to compulsory scheduling in advance. This shortcoming was mostly stated by respondents in the southern region (49.0%), housewives (50.0%), respondents whose main source of income was from social allowances (55.6%) and those with the highest monthly incomes, i.e. more than €1,500 (63.6%). Also, this was the main shortcoming for respondents who were not satisfied with the reform results so far. Furthermore, patients also mentioned as the main shortcomings of the reform the heavy work schedule of some doctors with a large number of patients (23.0%) and limited access to specialists (20.6%) in comparison to the period before implementation of the reform.

Graphic 8. Main shortcomings of the reform – the most significant shortcoming

3.2.2. Problems in the health care sector

According to patients interviewed at the primary level, the most urgent problem the health care system faces in Montenegro is the lack of motivation among doctors (17.8%). In relation to how the previous health care system functioned, no improvements in this segment were made by the implementation of health care reform. More detailed analysis by region shows that the problems differ depending on the region. Thus, the most critical problem of the health system in the central region was the lack of motivation for doctors; in the northern region, the shortage of medicines in pharmacies; while in the southern, poor working conditions. From the results of respondents' satisfaction with the achieved reforms, it is evident that with decline in the level of satisfaction raises the number of respondents identifying lack of motivation among doctors as a problem for which a solution should be found immediately. In addition to the most important problems, citizens stated that the health care system in Montenegro also faces a lack of equipment in facilities (6.0%), low income among medical staff (6.5%) and outdated equipment (6.0%).

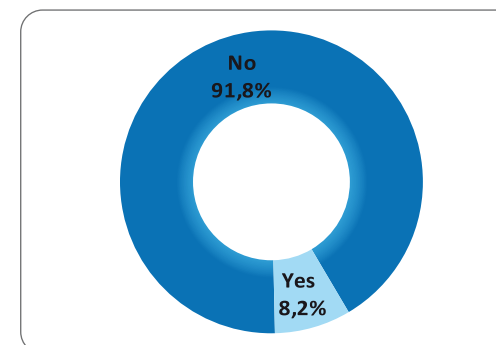
Table 4. The most urgent problem of the health care system (%)

	Montenegro	Centre	North	South
Unmotivated doctors	17.8	22.4	12.8	14.7
Qualification and competence of doctors	14.8	17.8	9.7	13.7
Shortage of medications in pharmacies	12.3	10.8	13.3	13.5
Poor working conditions	12.0	5.8	11.9	19.7
Lack of equipment in institutions	6.6	4.4	8.8	7.9
Low income of medical staff	6.5	7.0	8.4	4.8
Outdated equipment	6.0	3.1	6.2	9.6

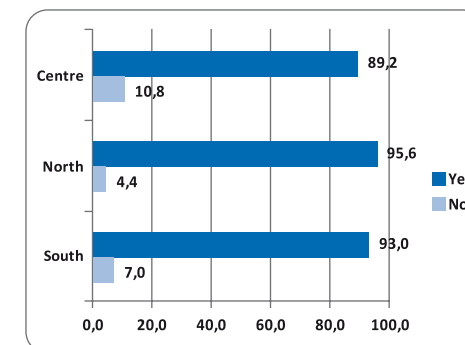
In order to comprehend opinions on the ways of overcoming the abovementioned problems, citizens had the opportunity to state what needed to be done in order to improve the existing health care system in Montenegro. Respondents mostly stated that the lack of motivation among health care workers could be solved by increasing their salaries (14.5%), introducing a system of rewards and advancement as well as nonmaterial forms of motivation (6.6%) - working conditions, the possibility of professional advancement, etc. Almost a fifth of all respondents (19.0%) said it was necessary to improve the technical equipment in facilities and by this they imply the purchase of modern appliances and devices that *"would contribute to less crowding"* and *"more precise and accurate analysis results"*. By investment in the qualifications of medical staff, respondents implied the specialization and additional training of medical staff as well as the employment of competent and qualified doctors (9.3%). Also, a significant number of respondents thought it would be necessary to dedicate more attention to patients by treating them better and developing a more amicable relationship between patients and doctors (8.2%), because *"doctors work in private practices and are not in the best mood when they work at public health centres and hospitals"*.

When asked whether they had suffered any negative health outcomes due to a failure in medical staff performance in the last year, nine out of ten respondents (91.8%) had not found themselves in such a situation. On the other hand, 8.2% said they had had negative health outcomes during their medical treatment. The results show that respondents from the central region more often had this negative experience than other respondents. Based on the results obtained it can be concluded that respondents had negative health outcomes mostly due to perfunctory routine check-ups and difficult access to specialists. The presence of negative health outcomes has a critical impact on the respondents' opinion regarding the success of reform implementation. In the largest number of cases, respondents who had a negative experience during their treatment in health care facilities, stated that their health conditions either worsened (45.5%) or were prolonged (18.2%) due to misdiagnosis or the doctor's incompetence.

Graphic 9. Negative health outcomes due to performance failure of health care workers



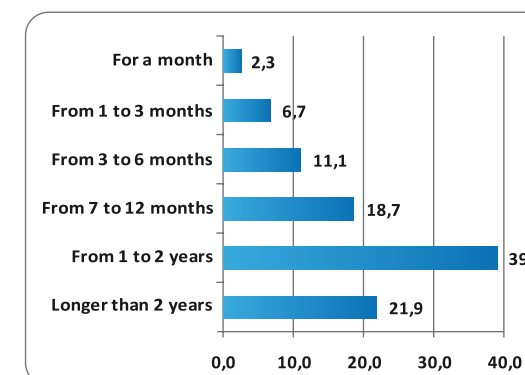
Graphic 10. Negative health outcomes by region



3.3. Chosen doctor

One of distinctive features of the health system reform which started in January 2008, is the "chosen doctor" concept. The results indicate that two-fifths of respondents have been visiting their chosen doctor for up to 2 years (39.9%). One-fifth of respondents (21.9%) stated that they had been visiting their chosen doctor for more than 2 years. This concept was firstly accepted by respondents with primary and secondary levels of education, retired people and farmers. The time period of visiting a chosen doctor impacts the attitude of a respondent on the reform processes in the health care system. In other words, the longer respondents have had a chosen doctor, the more their readiness grows to assess the reform positively.

Graphic 11. For how long have you been seeing your chosen doctor?



Respondents assessed different segments of the chosen doctor concept with respect to the extent the abovementioned characteristics apply to their chosen doctor. During the evaluation the following scale was used: 1 – never, 2 – sometimes, 3 – often and 4 – always. According to the results, respondents were most satisfied with the

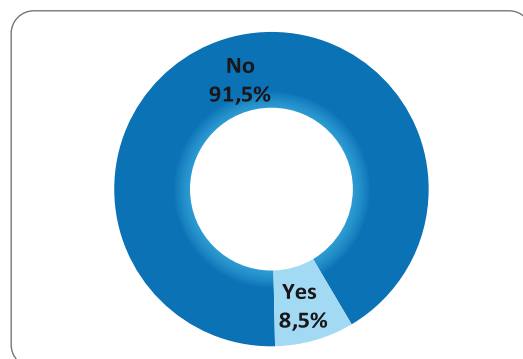
kindness of the chosen doctor (average rate 3.36), their commitment to work (average rate 3.30) and expertise (average rate 3.26). From the analysis of the results, it can be concluded that although the respondents stated that the biggest problem in the health care system was the lack of motivation of doctors, they found their chosen doctor sufficiently qualified and dedicated (average rate 3.15). On the other hand, the respondents thought they were not sufficiently involved in decision making about their future treatment (2.83), that all patients are not equally treated (2.87) and that they do not have enough time to ask additional questions during the examination (2.92).

Tabela 1. What is your opinion about your chosen doctor? (average values)

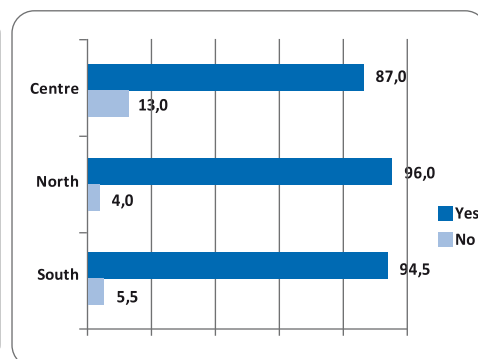
	Montenegro	Centre	North	South
Kindness	3.36	3.38	3.54	3.24
Devotion to work	3.30	3.28	3.42	3.25
Doctor's competence	3.26	3.21	3.46	3.20
Successful in setting diagnosis	3.20	3.19	3.40	3.10
Providing necessary information about the treatment	3.15	3.14	3.28	3.09
Enough time for additional questions	2.92	2.94	2.93	2.90
Equal treatment to all patients	2.87	2.99	3.08	2.62
Involvement in decision making about the treatment	2.83	2.85	2.92	2.75

In favour of the fact that the patients of primary health care were satisfied with the chosen doctor, the data shows that nine out of ten respondents (91.5%) said their chosen doctor remained the same. A more detailed analysis by region shows that respondents from the central region more often changed their chosen doctor compared to respondents from other regions, mainly due to the change of residence. Respondents from the north and south stated a poor patient-doctor relationship as the most common reason for changing their selected doctors.

Graphic 12. Have you changed your chosen doctor so far?



Graphic 13. Have you changed your chosen doctor so far (region)?



When speaking of the advantages of the chosen doctor model, patients most often highlighted better awareness by the doctor of the patient's medical history (23.6%), more dedication to the patients (19.0%) and kindness from medical staff, i.e. doctors and medical staff (13.6%). A more detailed analysis by region shows that the respondents from the north and south agree with the previous statements, while respondents from the central region mentioned among the first three advantages the reduced time of waiting to be examined, which is a result of making an appointment in advance.

Table 6. The highest level of satisfaction with the chosen doctor model (%)

	Montenegro	Centre	North	South
Better awareness of the course of illness	23.6	22.2	26.8	23.5
Higher devotion to patients	19.0	19.5	18.2	18.8
Kindness of doctors/medical staff	13.6	11.3	13.2	16.7
Reduced time of waiting to be examined	12.3	15.3	10.8	9.4

On the other hand, patients of primary health care were the least satisfied with the doctors' inaccessibility when needed (21.8%), disregard of scheduled appointment (13.8%) and compulsory scheduling in advance (10.1%). In order to overcome these problems, it happens that patients will schedule the examination when they actually don't have the need for it, *"I make an appointment with my chosen doctor every Monday, because I do not know when I am going to be sick"*. An additional problem occurs when the appointment needs to be made by phone, because *"it is impossible, since they do not answer the phone for days"*. Their dissatisfaction is aggravated by the fact that *"if a chosen doctor is absent, no one else will receive patients for examination"*. Also, patients objected to the choice of a doctor, because *"in the case a doctor that the patient wants to choose already has a large number of patients, he/she is not able to choose that particular doctor"*. In order to eliminate the abovementioned shortcomings, the patients proposed *"to clearly define the obligations of a chosen doctor, because he/she is available only when they want to receive a patient, and then the patients are forced to go to the emergency room or to private practice"*. Since one of the main goals of introducing the model of the chosen doctor is to make health care more affordable and available to a larger population, it is necessary to work on further education for both medical staff and patients on the basic role, goals and understanding of this model.

Table 7. The lowest level of satisfaction with the chosen doctor model (%)

	Montenegro	Centre	North	South
Inaccessibility of doctor when needed	21.8	20.1	21.1	24.3
Disregard of scheduled appointment	13.8	14.6	12.9	13.3
Compulsory scheduling in advance	10.1	8.7	5.7	14.0

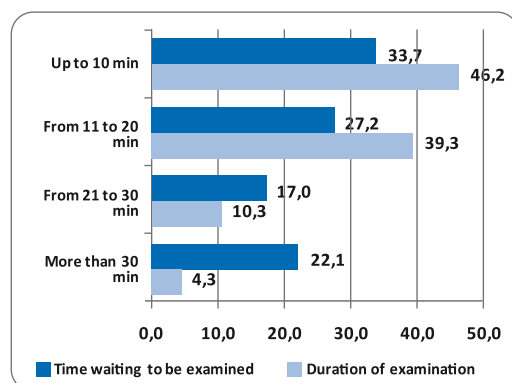
When speaking about the time they wait to be examined by their chosen doctor, six out of ten respondents (60.9%) waited longer than 20 minutes during their last visit. The longest time a third of respondents (33.7%) waited was up to 10 minutes. For almost a half of respondents (46.2%), the last examination lasted for 10 minutes. The average time

of waiting is 23 minutes, while the duration of the examination is 13 minutes. According to the available data, examination at the primary health care level lasts on average 15 to 20 minutes. The reasons for this underestimation of the duration of the examination were not the subject of this survey, but there is a possibility that respondents counted only the effective time of examination, without taking into account the time required to enter the current health condition of a patient into his/her medical record and based on that to prescribe appropriate therapy, which patients most often comment on as “more time is spend on typing on a computer than on the actual examination”.

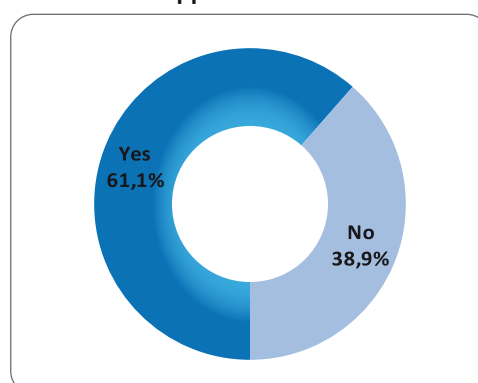
According to the number of patients by region, patients in the north on average wait less time to be examined than patients in the central and southern regions. Less time waiting to be examined results in the most often mentioned advantage of the reform: “less time spent waiting to be examined”, which was often the case even before implementing the reform. The time waiting to be examined and the level of satisfaction with the reform are positively correlated, thus those who wait less time for their examination assess the results of the reform more positively. Patients who make appointments in advance wait less, which is in accordance with the functioning of this model, where priority is given to patients who scheduled their examination in advance. Identified shortcomings could be removed by implementing a campaign for raising public awareness, i.e. acquiring the culture and habit to schedule appointments in advance. Also, besides making appointments in person or via telephone, it is desirable to include other forms of making appointments (on-line, voicemail etc).

Two-thirds of respondents (61.1%) previously made an appointment with their chosen doctor and most often one (42.1%) or two days (23.9%) before the examination.

Graphic 14. Time waiting to be examined and duration of examination



Graphic 15. Have you previously made an appointment?

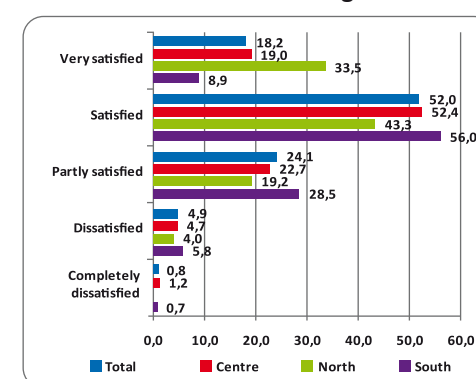


Half of the respondents (52.0%) were satisfied with the examination and consultation with their chosen doctor, while 24.1% of them were partially satisfied. Respondents from the northern region expressed the highest level of satisfaction with the examination with their chosen doctor in comparison to the other two regions. The level of satisfaction is closely linked to the education profile and material situation

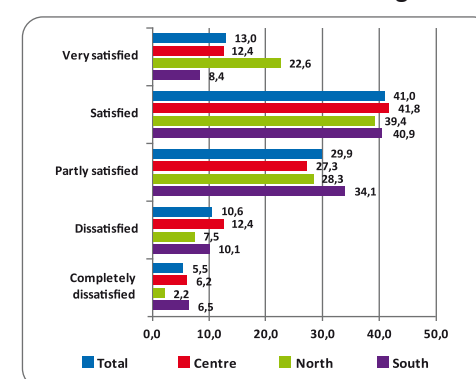
of the patients interviewed. Thus, respondents who are more educated and with a higher monthly income expressed a higher level of satisfaction with consultations with their chosen doctor. If the patients had a positive opinion of the chosen doctor (devotion to work and competence), they responded positively about their satisfaction with the performed examination. Also, the respondents' opinion on reform results and satisfaction with the examination are positively correlated, too. The level of satisfaction with the examination is influenced by the time waiting to be examined, thus the respondents who waited longer are more likely to give negative rates.

According to the results, four out of ten respondents (41.0%) were satisfied with the level of communication with the medical staff. As in the previous case, respondents from the northern region were the most satisfied with communication with the medical staff.

Graphic 16. Satisfaction with examination/consultation and region

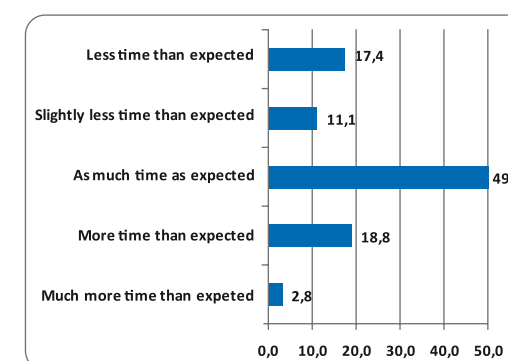


Graphic 17. Satisfaction with communication with medical staff and region



Regarding the duration of the examination, half of the respondents (49.9%) thought that their examination lasted for as long as they would have expected. Respondents with a lower monthly income assess that during their last visit to the health care centres they spent more time than expected. As in the previous cases, a trend is evident whereby respondents who spent less time than expected had a more positive attitude towards the reform. Also, a larger discrepancy between the expected and spent time influences the level of satisfaction with the examination/consultation with the chosen doctor.

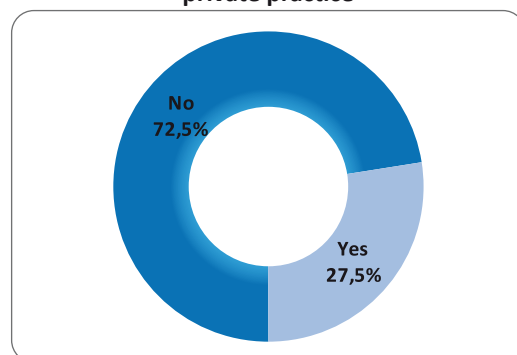
Graphic 18. Relation between expected and actually spent time during the last visit



3.4. Private Health Care

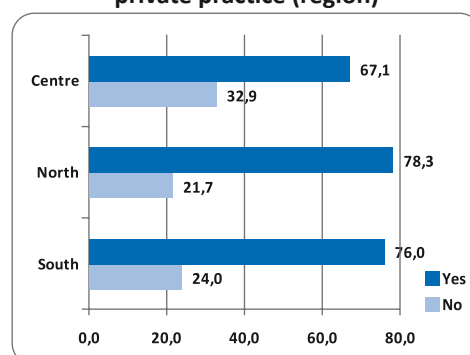
During the last year, most respondents (72.5%) did not use health care services in private practice. On the other hand, more than a quarter of respondents (27.5%) have used the services of private health care facilities, most often once (34.0%), twice (29.1%) or three times (10.2%). A more detailed analysis by region shows that the use of health care services in private practice is more prevalent in the central region compared to other regions. In addition, six out of ten respondents who had visited private health care facilities were women. There is a high level of alignment between the level of income, education and the use of private health care, thus respondents with a higher income and level of education use private health care to a greater extent in comparison with other respondent categories. With the level of satisfaction with implemented reform and the chosen doctor, the number of respondents who were treated in private health care institutions during 2010 declined, even though they had the right to treatment in public health care institutions. In addition to the abovementioned characteristics of patients, it was noticed that for patients who most often opt for treatment in private practice, the main shortcomings of the reform are seen in: access to different levels of health care requiring more direct expenses/payments; perfunctory and routine check ups; difficult access to specialists and more difficulties in selecting a doctor.

Graphic 19. Use of health care service in private practice



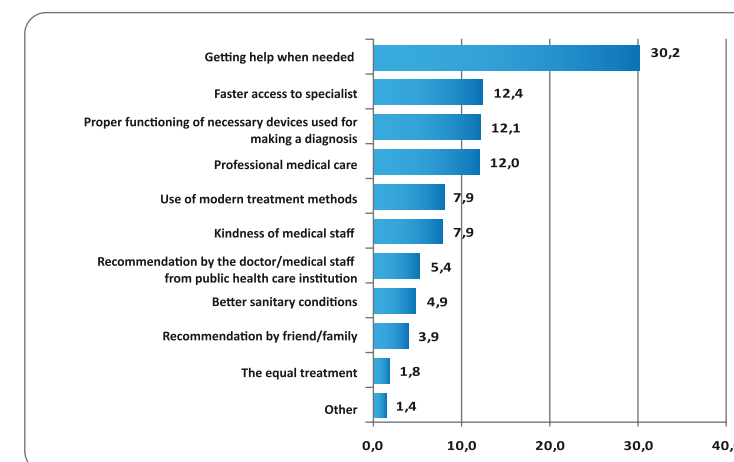
A half of respondents (56.1%) visited a doctor in a private practice for the purpose of examination, one-fifth (20.9%) for a laboratory analysis, and a tenth (12.6%) for radiological diagnostics. It can be concluded that patients in private practices used the health care services covered by health insurance and included in the public health care package. Patients interviewed most often justify making additional payments for the abovementioned services, which causes a decrease in their monthly income by the fact that they are receiving the service when needed (30.0%). This reason is dominant for respondents with a higher level of education and better material situation, as well as those who were less satisfied with the health care system reform process and chosen doctor. Given the fact that one of the most important tasks of the reform is to make

Graphic 20. Use of health care service in private practice (region)



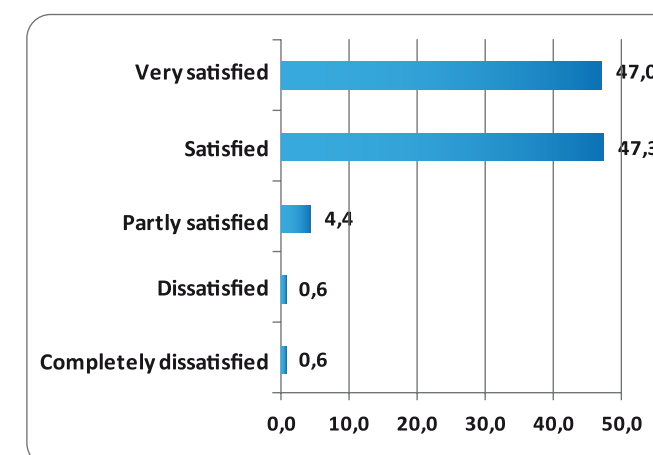
health care available to as many patients as possible, attention should be dedicated to removing identified shortcomings in further implementation of the reform activities.

Graphic 21. Reasons for use of health care service in private practice



A high percentage of respondents who used health care in private practice during 2010 had a positive opinion of these services. Namely, 47.0% of respondents were very satisfied, while 47.3% were satisfied with the treatment/service in private practice. Comparing the results of satisfaction between public and private practice, respondents who used private practice expressed a higher level of satisfaction with the services received in comparison to public health care.

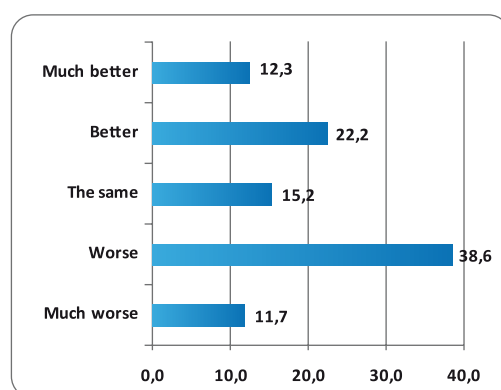
Graphic 22. Satisfaction with the treatment/service in private practice



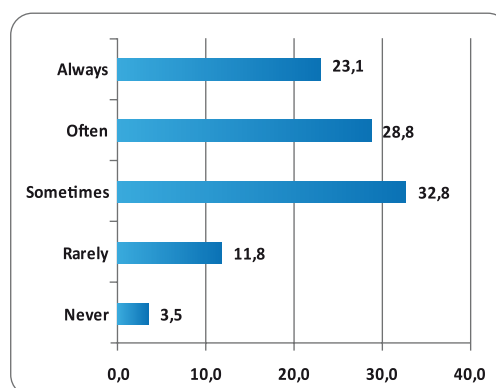
When speaking about the relationship between medical staff and their patients in public as opposed to private health care, half of the respondents assessed the relationship with the doctor/medical staff in public practice as worse (38.6%) and much worse (11.7%) than in private practice. On the other hand, one-fifth of respondents (22.2%) thought they gave

preference to the public health care system. In accordance with the abovementioned is the fact that in cases when there is a possibility of health insurance covering the costs of treatment in private practice, more than a half of respondents (51.9%) would always (23.1%) or often (28.8%) use this opportunity. The most common reason that 45.4% respondents gave for using this possibility is reflected in the fact that they would receive health care services at the moment when needed. This data should be observed in the context of a plan to include private capacities into the public health care network, through a possibility of concluding a contract on health care services to insured people between the private health care institutions and the Health Insurance Fund.

Graphic 23. Relation of doctor/medical staff in public in comparison to private practice



Graphic 24. If the health insurance would cover treatment costs in private practice, to what extent would you use its services?



4. SUMMARY OF THE RESULTS – PATIENTS WHO WERE HOSPITALISED

A hospital patients' survey was conducted with the purpose of gathering insights into their views on the functioning of the health care system, as well as assessing their experiences in terms of payments for medical services. Basic information about the patients interviewed and findings of the research for this target group of respondents are presented in this chapter.

4.1. Demographic characteristics

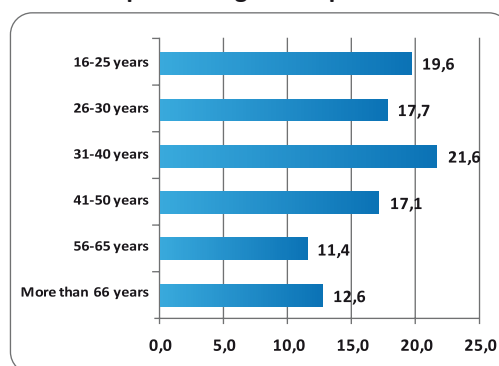
The survey included 3,000 patients from eight municipalities in Montenegro. The survey was conducted at the Clinical Centre in Podgorica, seven general and three specialized hospitals. A fifth of the patients (19.7%) at the time of interview had just been discharged from hospital, while the others (80.3%) had been hospitalized earlier in 2010. Regarding the hospital where these patients were hospitalized, almost a half of respondents mentioned Podgorica Clinical Centre (CC Podgorica), a tenth stated Bar and Berane General Hospitals (8.6% respectively), while the number of patients who were placed in other general and specialized hospitals was quite small. The distribution of interviewed people by hospitals has been stratified in accordance with the number of patients during the first half of 2010.

Table 8. Health institutions where respondents were hospitalised in

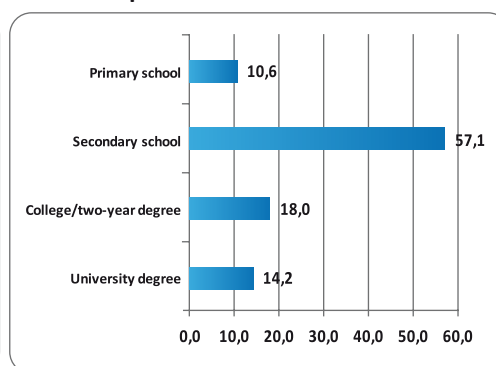
Health institution	Number of respondents	%
Podgorica Clinical Centre	1,410	47.0
Bar General Hospital	257	8.6
Berane General Hospital	258	8.6
Bijelo Polje General Hospital	160	5.3
Cetinje General Hospital	89	3.0
Kotor General Hospital	216	7.2
Nikšić General Hospital	277	9.2
Pljevlja General Hospital	112	3.7
Brezovik Specialist Hospital	92	3.1
Kotor Specialist Hospital	18	0.6
Risan Specialist Hospital	111	3.7
Total	3,000	100.0

Having examined the demographic characteristics of the surveyed patients, it was discovered that two thirds (65.4%) were female. Age structure of the respondents varied, and the educational structure is dominated by patients with secondary education (57.1%), which is presented in the following graphs.

Graphic 25. Age of respondents

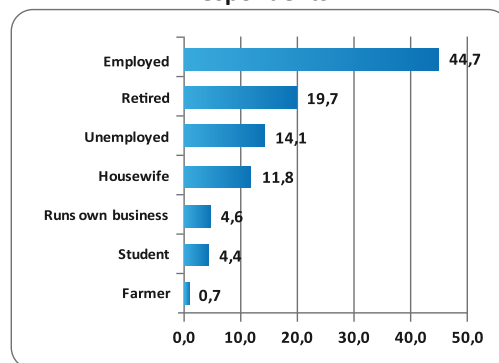


Graphic 26. Level of education

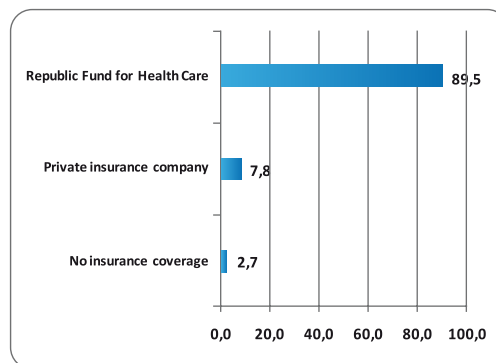


With regard to the current employment status of patients, four out of nine patients (44.7%) were employed, while the number of those employed in a private company is slightly higher than the number of those employed in a public institution/company.

Graphic 27. Current employment of respondents

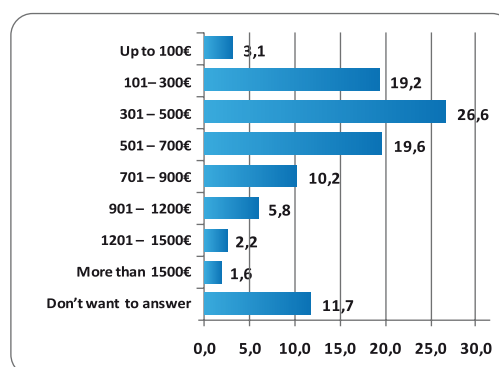


Graphic 28. Insurant's status

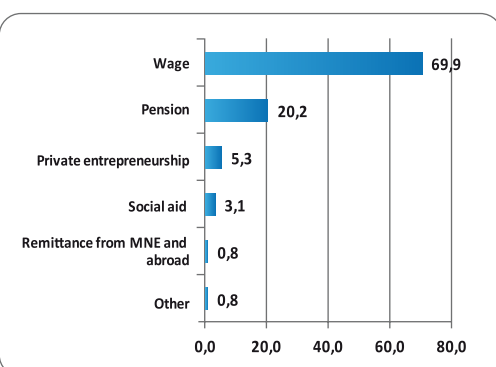


A half of the patients come from a four- or five-member household and they state salary (69.9%) and pensions (20%) as the main source of income in their households. When it comes to the total monthly amount of household income, the majority are from households that receive either €301-€500 (26.6%) or €501-€700 (19.6%).

Graphic 29. Total monthly income of the household



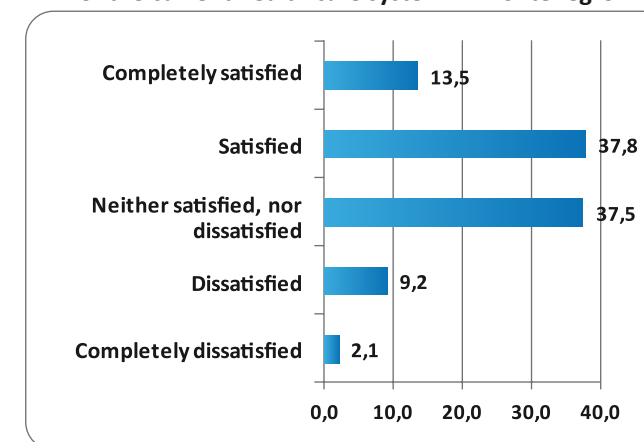
Graphic 30. Main source of income of the household



4.2. Attitude of hospital patients towards the current health care system

If we observe the level of satisfaction with the functioning of the existing health care system in Montenegro, respondents were generally satisfied. More than a half of the hospital patients interviewed (51.3%) were satisfied¹⁴ with the functioning of the current health care system. 37.5% of respondents had a neutral attitude regarding this issue. Only one out of nine respondents (9.2%) expressed dissatisfaction. Respondents in the north and south had a higher level of satisfaction than respondents from the central region regarding this matter.

Graphic 31. Level of satisfaction with the functioning of the current health care system in Montenegro



Patients had the opportunity to state what was really, in their opinion, the *most urgent problem* the health care system faces and they were able to choose from 20 options, or to specify something else. Analyzing their responses, it was discovered that the lack of motivation (18.6%) and level of qualification of doctors (16.0%), and too long waiting for medical care (13.8%) were perceived as the most urgent problems. The problem of too many employees was mentioned by the lowest number of interviewees (0.2%). Patients from the central region see the lack of motivation of doctors as the worst problem. In southern municipalities, doctor's qualifications and competence stand out as the next largest problems. Patients from the northern municipalities singled out waiting in line as the biggest problem. As the level of education and monthly household income rises, so does the importance of the problem of unmotivated and underqualified doctors, while waiting in line is cited as a lesser problem.

¹⁴ Completely satisfied + satisfied

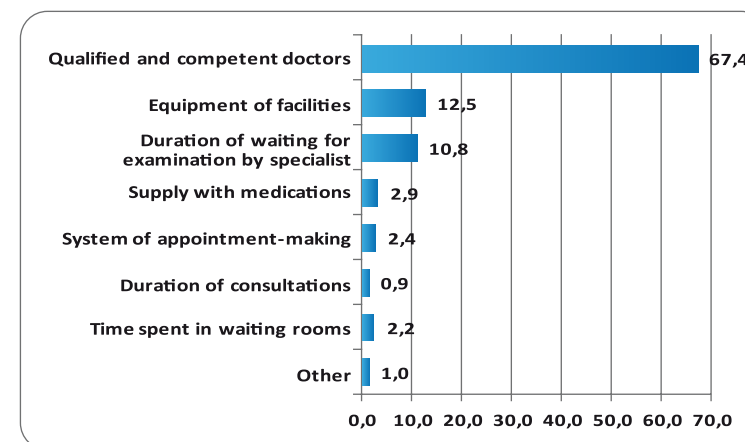
Table 9. The most urgent problem the health care system faces

Problems	No of answers	%
Lack of motivation of doctors	556	18.6
Qualification and competence of doctors	480	16.0
Waiting, queuing	413	13.8
Poor working conditions (working hours, premises)	296	9.9
Lack of equipment in institutions	243	8.1
Service is not efficient enough	197	6.6
Low income of medical staff	188	6.3
Outdated equipment	157	5.2
Shortage of medications in pharmacies	94	3.1
Lack of time for examination and conversation	76	2.5
Large direct payments for use of services	45	1.5
Poor coordination inside the health system	44	1.5
The lack of cooperation between private and public health care	39	1.3
Long working hours for medical staff	35	1.2
Small, overcrowded waiting rooms	29	1.0
Voluminous paperwork	16	0.5
Professional status of medical staff	11	0.4
Often change of doctors	11	0.4
Too many employees	7	0.2
Other	58	1.9
Total	2,995	100.0

In order to improve the current health care system in Montenegro patients mostly specified measures aimed at improving the material and technical conditions in the public health care sector, *“if the private practices can work faultlessly, why cannot public health institutions do the same, when the same doctors work in both of them”*. According to them it is necessary to:

- ✓ Increase salaries, because *“all the good doctors have gone into private practice”*;
- ✓ Improve working conditions;
- ✓ Modernize equipment in public health care institutions;
- ✓ Provide additional forms of education and upgrading for medical staff;
- ✓ Improve organization and coordination between health care institutions, communication between employees, primarily among doctors, and *“that doctors work less on the computer and dedicate more time to patients;”*
- ✓ Reduce corruption and *“the expectation of receiving gifts and money from patients”, etc.*

The importance given to doctor's qualifications and competence at the secondary level of health care by patients is confirmed by the data that for two-thirds (67.4%) precisely this is the most important part of health care. The importance of this segment is recognized by elderly people (aged 66 or over) and by those with a high level of education. A trend is evident here in that as monthly income rises, the number of patients who give more importance to this segment of health care also rises.

Graphic 32. The most important segment of the health care?

4.3. Hospital patient's experience regarding the receiving of medical care

When asked to state whether they had experienced any negative health outcomes due to a failure in the work of employees in public health facilities during the last year, only seven per cent of respondents answered affirmatively. Observed by hospitals, patients who were treated in Brezovik Specialist Hospital, Pljevlja General Hospital and Podgorica Clinical Centre most often had negative health outcomes. In a larger number of cases, patients who underwent surgery had negative health outcomes in comparison with other patients. In the majority of these cases it was a failure in making a diagnosis, prescribed therapy or a long waiting time for examination which resulted in the aggravation of the health condition.

Table 10. Negative health outcomes by hospitals (%)

Name of the hospital	Yes	No
Brezovik Specialist Hospital	14.1	85.9
Pljevlja General Hospital	10.7	89.3
Podgorica Clinical Centre	9.1	90.9
Berane General Hospital	5.8	94.2
Nikšić General Hospital	5.8	94.2
Cetinje General Hospital	5.6	94.4
Kotor General Hospital	3.2	96.8
Bijelo Polje General Hospital	2.5	97.5
Bar General Hospital	2.3	97.7
Risan Specialist Hospital	1.8	98.2
Kotor Specialist Hospital	-	100.0

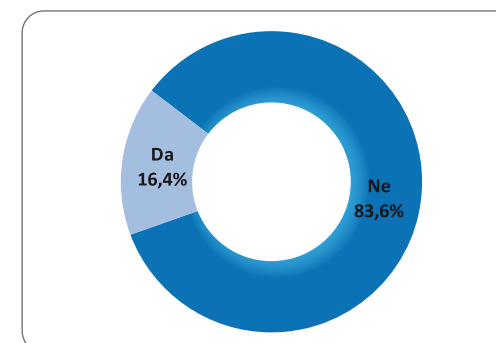
Table 11. Negative health outcomes and reason of hospitalization

Reason for coming	Yes	No
Delivery	4.8	95.2
Surgery	8.8	91.2
Internal medicine	7.4	92.6
Other	8.2	91.8

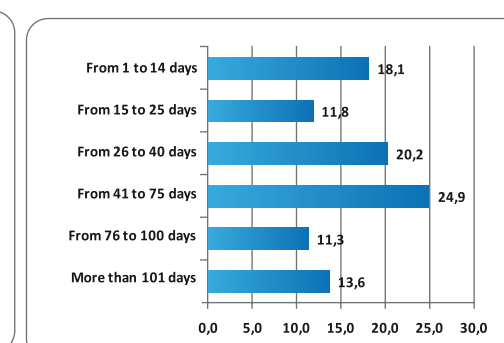
Regarding diagnostic examinations, one out of every six respondents (16.4%) was on the waiting list at some point during the last year. Every fourth (24.8%) and every fifth (20.2%) respondent who was in hospital for surgery and health issues in the area of internal medicine waited for these examinations. In the majority of cases patients who were on the waiting list during the last year were 40 years of age or over. This result can be explained by the fact that the need for health care increases with age, which is not the case for the younger population, who are in a better health condition. Regarding other demographic characteristics, respondents who live alone, who have the lowest monthly income, a lower level of education and retired people also require more health care. Interviewed patients who had negative health outcomes due to a failure in healthworker performance, as well as those who used private health care services to solve their health issues, were on some kind of waiting list that included waiting for specialist examination/treatment.

According to respondents' answers, the average waiting time was 66 days, which varies depending on the type of health service. In the majority of cases patients waited for different types of scanning, surgeries and specialist examinations.

Graphic 33. On a waiting list for diagnostic services or treatment?



Graphic 34. Time of waiting on diagnostic services or treatment



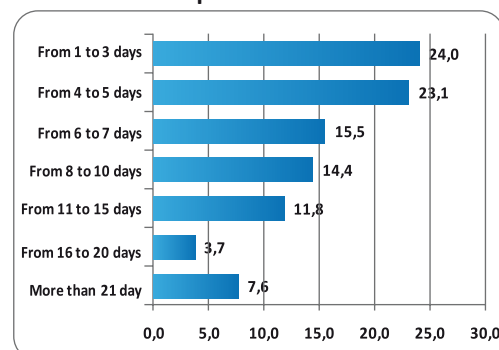
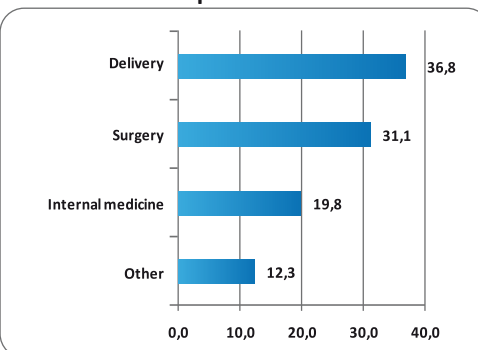
Interviewed patients spent on average two weeks (13.6 days) in hospital the last time they were there. Only 7.6% respondents were hospitalized for over three weeks, while the longest hospitalization lasted 15 years (patients from specialist hospitals). Due to the nature of their illness, patients in specialist hospitals generally spend more time there than patients in general hospitals. The average length of time patients stayed in general hospitals, including the Podgorica Clinical Centre was 8 days, whereas in specialist hospitals their stay averaged 86 days, which is expected given the types of illness that are treated in these institutions.

According to the results, the reason for hospitalization affects the duration of the stay in hospital. Delivery of a child requires the shortest stay of 5 days, while in case of surgery the patients are kept in for up to 11 days.

Table 12. Average stay of patients in hospitals by reason of hospitalization (in days)

Reason of hospitalization	Average stay
Surgery	11 days
Internal medicine	9 days
Delivery	5 days

As an insight into the reasons for hospitalization, it was found that respondents most often stated delivery and surgery as well as different areas of internal medicine.

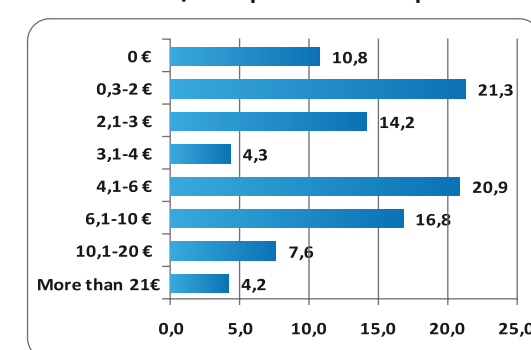
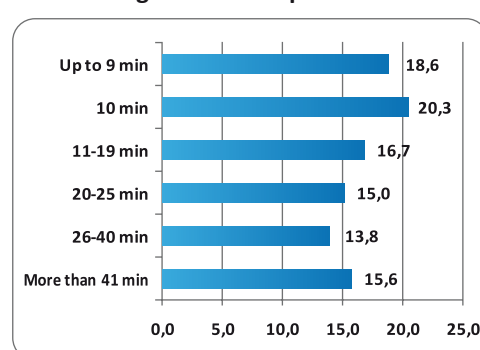
Graphic 35. How many days did you spent in hospital last time?**Graphic 36. What was the reason for your hospitalisation?**

When it comes to internal medicine, it was usually for treatment of cardio-vascular diseases, pulmonary diseases, endocrinology, urology, high blood pressure, etc. In the case of surgical procedures that respondents had undertaken, in the majority of cases they were: abdominal surgery (27.5%), orthopedic surgery (24.4%), cardiovascular surgery (15.9%) and other types of surgery-gynaecological surgery, surgery on breasts, eyes, tonsils, appendix, thyroid, gall bladder etc. (32.3%).

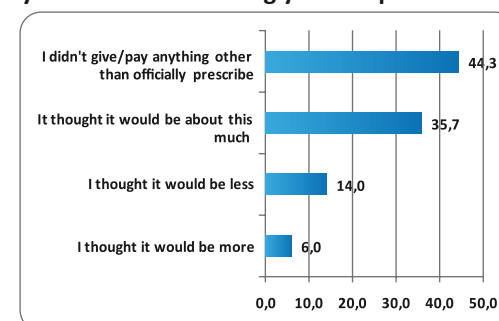
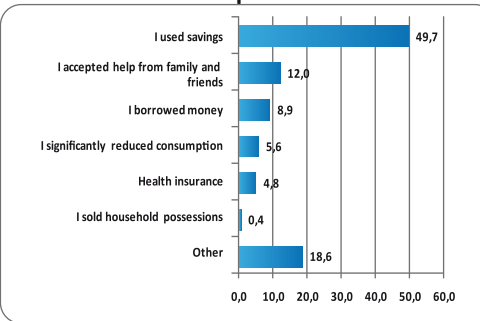
4.4. Health care service costs

In addition to satisfaction with the current reform and overall service available within the health care system in Montenegro, a special subject of the analysis was informal payments, defined as “paying outside official channels to an individual or institutional service provider, in kind or in cash, or any purchase for which expenses should be covered by the health care system. This includes making payments to doctors ‘in an envelope’ and any ‘donations’ to hospitals, as well as the value of medical supplies the patient buys and the value of medications purchased in a private pharmacy that should be covered by health insurance.”

Interviewed patients spent €7.30 on average for a one-time visit/transport to hospital, whereas a tenth of respondents (10.8%) did not have any costs. Patients usually spent €2 (21.3%) or between €4 and €6 (20.9%) for transport to the hospital. In regard to the level of monthly income of households, it can be concluded that the costs mentioned were no major obstacles to the use of health care. On the other hand, transportation costs outside the place of residence are refunded to patients. On average patients spent half an hour getting to the hospital.

Graphic 37. How much did it cost you to come/transport to the hospital?**Graphic 38. How long did it take you to get to the hospital?**

Apart from formal payments, patients gave gifts/money to medical staff (for medicines, supplies and post-hospital care), and the results show that 44.3% of respondents did not pay anything except what was officially prescribed (participation), while 55.7% spent a certain amount of money. For 35.7% of the respondents the money spent was almost the same as planned, which could affect their decision about whether to use health care or not. Half of the respondents (49.7%) financed these costs out of their savings. Providing funds was quite easy for 20.0% of respondents, while for 47.7% of them it was neither difficult nor easy.

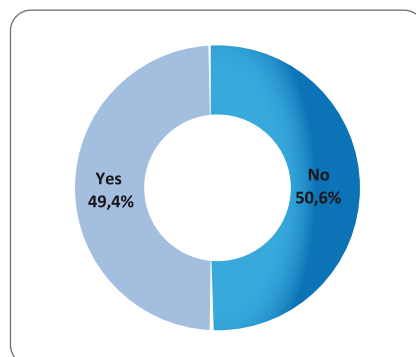
Graphic 39. Did you know how much money you would need during your hospitalization?**Graphic 40. How did you cover the costs of the hospitalization?**

When speaking of gifts/money¹⁵ the patients gave during their stay in the hospital, the research showed that out of 3.000 interviewed patients of secondary and tertiary health care levels, 49.4% gave gift/money to medical staff. According to predetermined research task, which is to identify key points that limit and reduce the availability and the quality of health care service delivery in order to address them on the level of the whole system, and not to determine any collective or individual responsibility. Formulation and the content of the questionnaires, which, according to international methodology were applied in this research, do not provide possibility to determine whether patients gave gift/money to one or more medical workers, or the frequency of giving per patient.

¹⁵ The questionnaire did not distinguish between financial and non-financial giving, but all givings were calculated by their monetary value. Givings included: bouquet of flowers (posy), bottle drinks, chocolate box, fruit and other kinds of gifts, as well as cash.

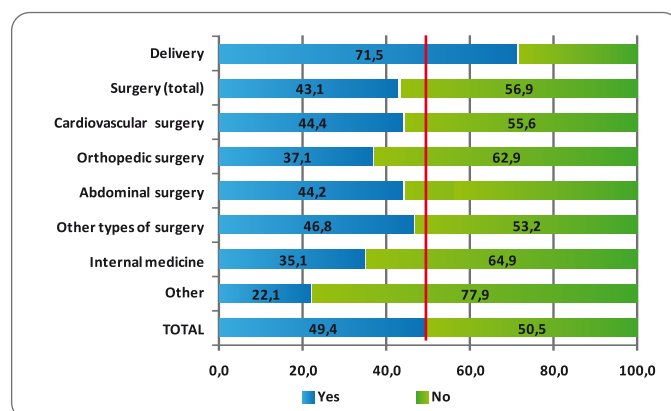
As far as giving gifts or money to medical staff is concerned, 49.4% of respondents did, while 50.5% did not do so. A more detailed analysis of the socioeconomic characteristics of respondents who most often gave gifts or money to medical staff highlighted the following groups¹⁶: (i) persons in the central region; (ii) women; (iii) persons with higher or further education; (iv) persons running a private business, unemployed or employed; (v) persons with a monthly household income above €500.

Graphic 41. Did you or any of your family members give gifts/money to the medical staff during your last stay in the hospital?



According to the results, it was noticed that giving gifts or money most often occurred with patients who were in hospital for a delivery (71.5%). Observing the type of surgical procedure, giving gifts or money was most frequent with surgery of a gynecological type, surgery of eyes, breasts, tonsils, gall bladder, etc. (46.4%), cardiovascular surgery (44.4%) and abdominal surgery (44.2%).

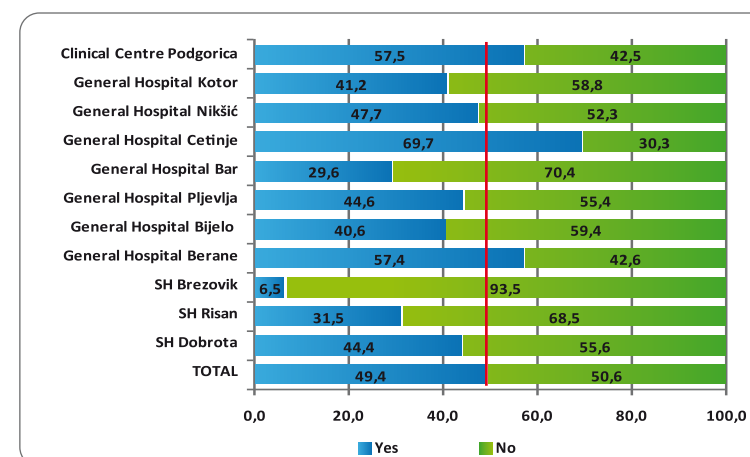
Graphic 42. Giving gifts/money by reason for hospitalization



Observed by hospitals, in comparison to the national average of 49.4%, the largest percentage of hospital patients who gave a gift and/or money to medical staff was in Cetinje General Hospital (69.7%), the Podgorica Clinical Centre (57.5%) and Berane General Hospital (57.4%). In Brezovik Specialist Hospital only a very small percentage of patients (6.5%) said they gave gifts or money to medical personnel.

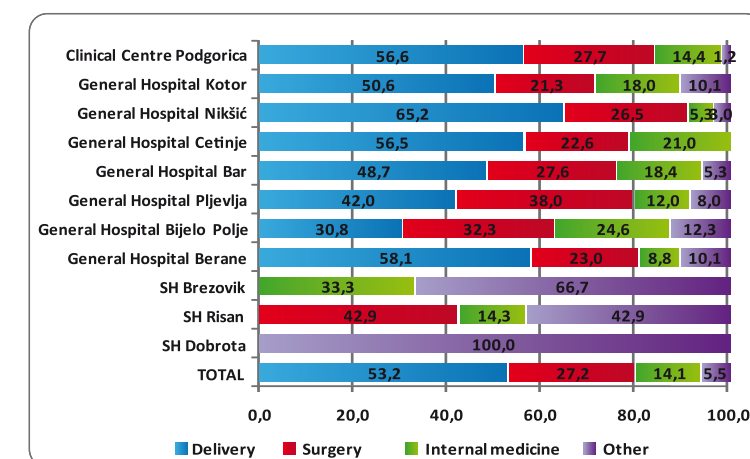
¹⁶ In the mentioned socioeconomic groups giving gifts was more frequent than the national average of 49.4%.

Graphic 43. Giving gifts/money by hospitals



In the majority of cases, patients or their family members who gave money/gifts were in hospital either for a delivery (36.8%) or surgical intervention (31.7%). In Nikšić General Hospital two-thirds of respondents (65.2%) gave a gift or money because of childbirth, while this was the case with a half of respondents in Berane General Hospital (58.1%), Podgorica Clinical Centre (56.6%), Cetinje General Hospital (56.5%) and Kotor General Hospital (50.6%).

Graphic 44. Giving gifts/money by hospitals and reason of hospitalization



After detailed analysis of answers it was noted that interviewed patients most often gave money/gifts to the doctors who treated them (72.3%), nurses (68.1%) and midwives (68.7%), while the money/gifts were the most rarely given to anaesthetists, laboratory workers (93.5%) and radiologists (0.7%). Research results show that interviewed patients of secondary and tertiary health care levels on average paid €60 in gifts and/or money to medical staff, i.e. informal payments. The highest amount of money was given to surgeons (€111.50), and then to doctors (€87.80). Comparing the

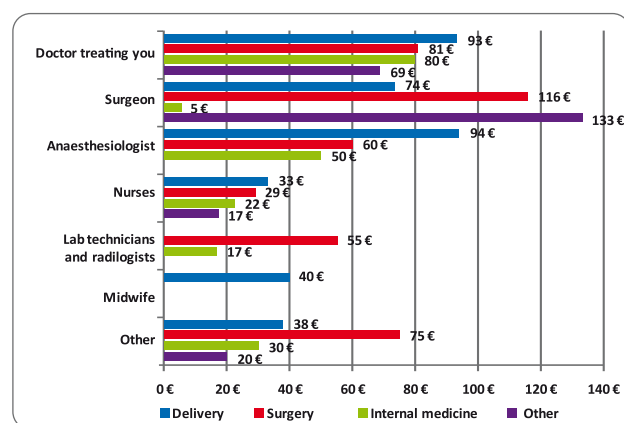
average amount (€60) with the average salary in 2010¹⁷ we can say that informal payments make up 12.5% of average net salary and 8.3% of gross salary in Montenegro. On the other hand, citizens of Montenegro with this amount (€60) increase the average monthly income of doctors of secondary and tertiary health care level by between 5% and 6% on average by one giving, and the income of nurses by between 14% and 15%. Out of the total average amount allocated for health care per capita during one year and which amounts €330, 18% goes on informal payments. Questions from the survey were not able to yield answers about the frequency of giving gifts/money to health care workers.

Table 13. Monetary value of gifts/money given to medical staff (€)

Medical staff	Monetary value (€)		
	Average value	Minimal amount	Maximum amount
The doctor treating you	87.8	3	500
Surgeon	111.5	5	1,000
Anaesthetist	73.0	10	300
Nurses	29.7	2	300
Laboratory technicians and radiologists	44.5	10	150
Midwives	39.6	5	300
Other	38.4	10	100

Moreover, detailed analysis shows that the doctors who monitor pregnancy were given the highest amount of money (€93.50 on average). The highest amount of money was given to medical nurses in cases of childbirth (€33.20).

Graphic 45. Average value of gift/money given to medical staff by reason for hospitalization (€)



Analysis by hospital shows that the highest amount of money and/or gifts was given in Cetinje General Hospital (on average €90), and then in Risan Specialist Hospital (€80).

¹⁷ The average salary in 2010 amounted to €479 after tax and €715 before taxes and contributions, MONSTAT.

Table 14. Average amount of gifts/money by Clinical Centre and General Hospitals (€)

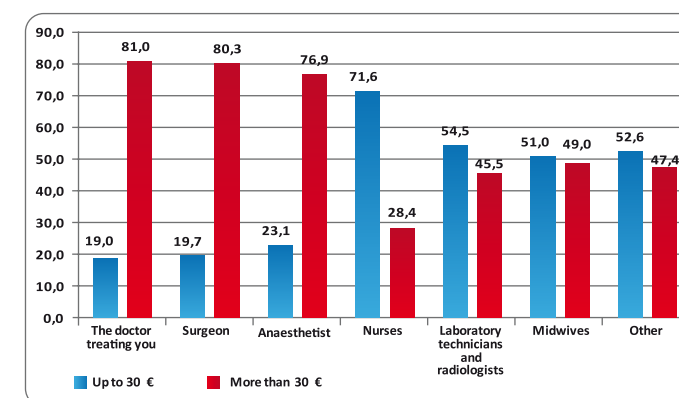
	Clinical Centre	General Hospitals						
		Kotor	Nikšić	Cetinje	Bar	Pljevlja	Bijelo Polje	Berane
The doctor treating you	98	104	83	110	49	22	31	73
Surgeon	127	22	74	145	49	44	35	119
Anaesthetist	83		47	100			10	
Nurses	31	28	31	52	24	10	17	33
Laboratory technicians and radiologists	51		30		20			
Midwives	41	32	40	69	43	120		17
Other	36		36	63	15			20
AVERAGE	67	47	49	90	33	49	23	52

Table 15. Average amount of gifts/money by Specialist Hospitals

	Specialist Hospitals		
	Brezovik	Risan	Dobrota
The doctor treating you	56	62	100
Surgeon		175	
Nurses	14	21	50
Other		60	
AVERAGE	35	80	75

For the purpose of presenting detailed data we assumed that the value of the bottle drinks and chocolate box or the bouquet of flowers is €30. Starting from the category of medical workers, we came to the data that patients in majority of cases gave gifts to nurses in the value up to €30, while the surgeons and doctors were gifted in the least.

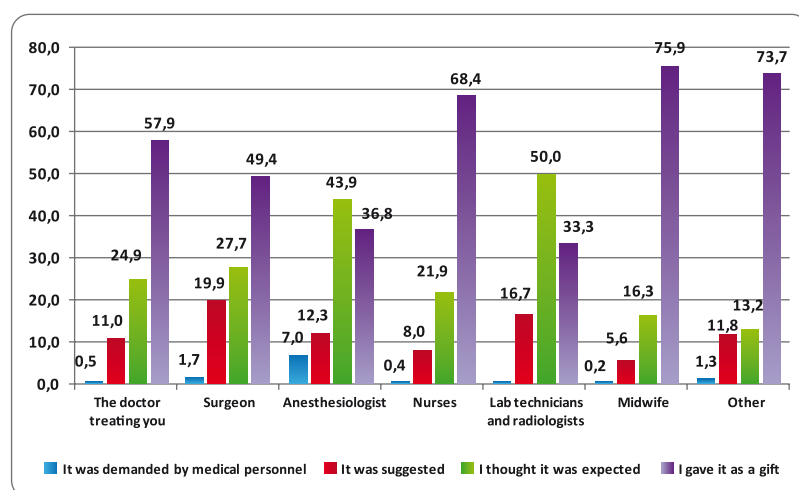
Graphic 46. Value of the gift/money up to 30€ and above 30€ by types of medical staff



Analyzing the reasons for giving gifts/money, according to patients' experiences, the following conclusions were drawn:

- ✓ giving money or a gift is mostly perceived as something that is customary (something the patients were not forced to do, but did out of their free will),
- ✓ a significant number of patients perceive the giving of money as a precondition for receiving higher-quality medical care, especially with reference to anaesthetists, laboratory workers and radiologists,
- ✓ a very small number of patients said that medical staff (most often the doctor himself/herself) actually asked for the money, or that giving money or gifts was suggested by someone else, usually other patients.

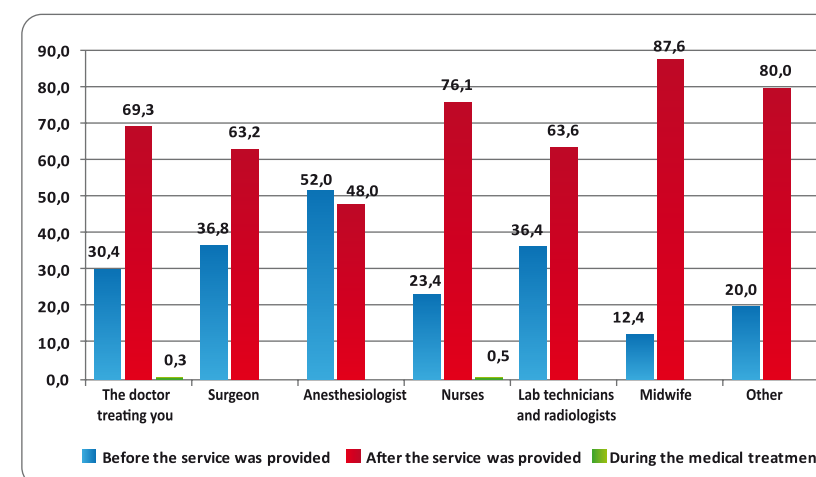
Graphic 47. Why did you decide to provide gift/money to medical personnel?



After examining the details of giving money or gifts, it was found that the gift is given after the health service has been provided. Only in the case of the anaesthetist was the gift usually given before the service was actually provided. Yet in a negligible number of cases it was recorded that doctors and nurses were given gifts and/or money during medical treatment.

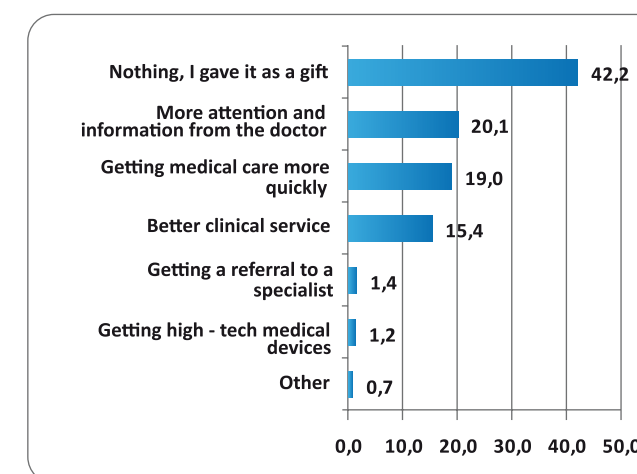
The objective of the research was to determine the number of cases where the bribery or corruption of medical workers occurred. For assessment of this data, it was started from the cases where patients gave gift/money before the health service was provided. In relation to the total number of patients interviewed (3.000 respondents), research results show that 17% of citizens of Montenegro gave gift/money before the health service was provided, in other words bribed some medical worker.

Graphic 48. When did the giving of the money/gift happen?

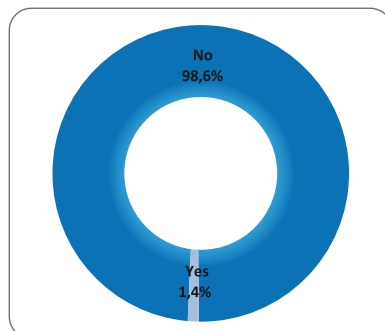
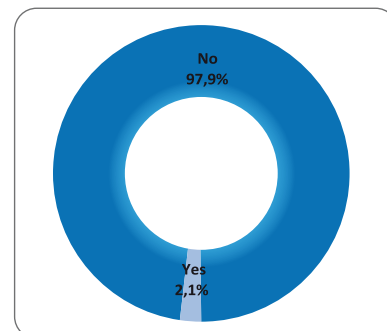


Asked to state what they expected in return for giving money and/or gifts, the majority of respondents (43.5%) stated it was a free-will gesture and therefore they had no particular expectations. Those respondents who did expect something in return, usually stated the following: more attention and information from doctors, receiving medical care more quickly, and better quality clinical service.

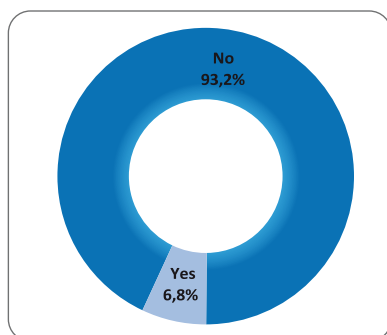
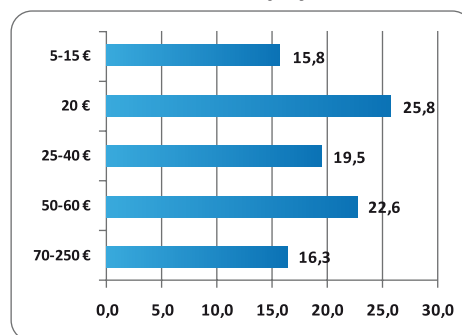
Graphic 49. What did you expect in return to giving gift/money?



Interviewed patients usually decided about the amount of money or the value of the gift in proportion to their ability to give (47.8%) and intuition (36.7%), while only a small percentage (13.3%) consulted other patients. When speaking about prescriptions for medications, only 1.4% of respondents stated that during their stay in hospital they (or their family members) gave money or a gift to doctors or medical staff for that purpose. Regarding the purchase of medical supplies (e.g. syringes, IV tubes, etc.), only 2.1% of respondents said that they personally (or one of their family members) gave money or a gift for this purpose.

Graphic 50. Did you give a gift or money in order to get prescription for medications?**Graphic 51. Did you give a gift/money for medical supplies?**

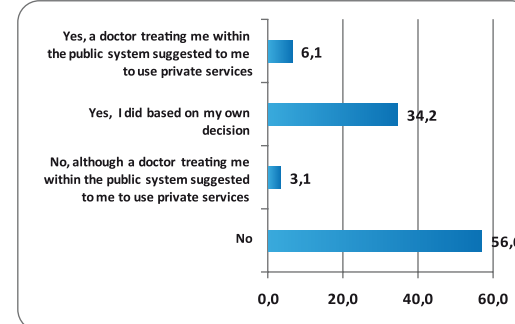
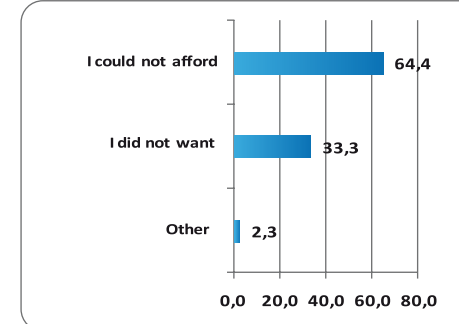
When speaking of services related to post-hospital treatment or house visits to a patient (injections, infusions, administering medicines, bandaging, etc.) 6.8% of respondents stated they gave money or a gift to medical staff. For this purpose €46 was spent on average.

Graphic 52. Did you give gifts/money for post hospital care or house visits?**Graphic 53. If yes, how much did you give/pay?**

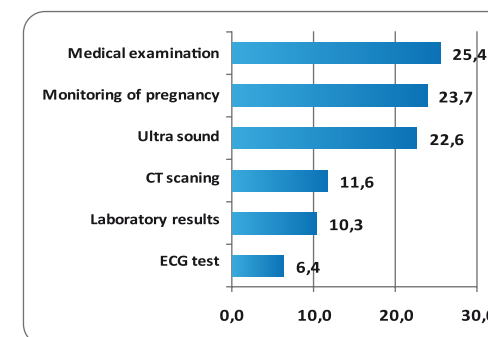
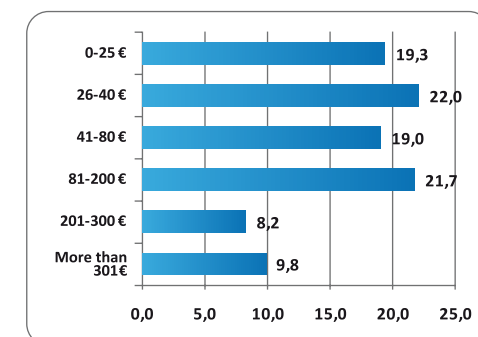
4.5. Use of private medical care services

When asked whether they used the services of a private health care institution, 40.3% of respondents answered in the affirmative. It is worth mentioning that the structure of these respondents was dominated by those who by their own choice decided to do so, as opposed to those who visited private institution based on a suggestion made by the doctor in a public health care institution. However, despite the public doctor's suggestion from a public health care institution, 3.1% of patients did not visit a private practice.

The most important reason for not visiting a doctor in private practice, despite the recommendations of doctors who treated patients, stated by 64.4% of respondents was their financial situation and their inability to cover the cost of private treatment. A third of respondents (33.3%) stated that they did not want to visit a doctor in private practice.

Graphic 54. Have you used private health care services in order to solve health issues?**Graphic 55. Why did you not visit a private practice doctor?**

Those patients, who used the services of private medical practice, usually stated the following services: performing various types of medical check-ups, pregnancy monitoring and ultrasound. By analysing the prices of the abovementioned services, it was found that the average amount for these services was €130, whereas the highest amount recorded was €4,000 (gynaecological surgery, check-ups and monitoring the health condition of a patient). In addition to this, the reduction in total monthly disposable income due to spending on these services amounted to €73 on average, which makes up 15% of the average salary in Montenegro in 2010.

Graphic 56. What type of service was in question?**Graphic 57. What was the price of that service?**

5. SUMMARY OF THE RESULTS - EMPLOYEES

5.1. Demographic characteristics

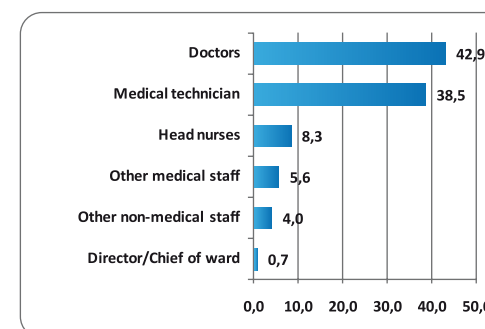
The survey was conducted in the Podgorica Clinical Centre and seven General Hospitals on a sample of 301 employees. According to the previously defined research methodology, the majority of the medical staff interviewed were on the following wards: surgery, internal medicine and gynaecology.

Table 16. Hospitals where the respondents work

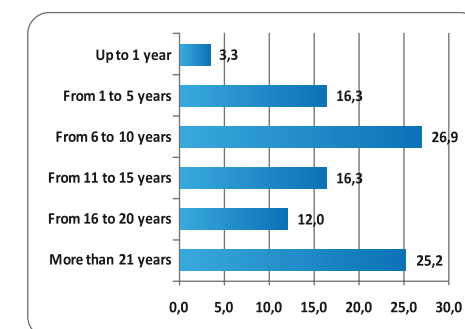
Health institution	No	%
Podgorica Clinical Centre	168	55.8
Bar General Hospital	19	6.3
Berane General Hospital	26	8.6
Bijelo Polje General Hospital	20	6.6
Cetinje General Hospital	13	4.3
Kotor General Hospital	14	4.7
Niksic General Hospital	26	8.6
Pljevlja General Hospital	15	5.0
Total	301	100.0

The largest proportion of medical staff interviewed was employed as doctors (42.9%) and medical technicians (38.5%). Since the questionnaire was answered mostly by respondents who have been employed in these institutions for many years, this additionally contributed to obtaining more qualitative results, which can be considered valid indicators of the current situation and functioning of the health care system. A quarter of respondents (26.9%) had been employed for 6-10 years. The average number of years of employment in the health system is 14 years.

Graphic 58. Occupation

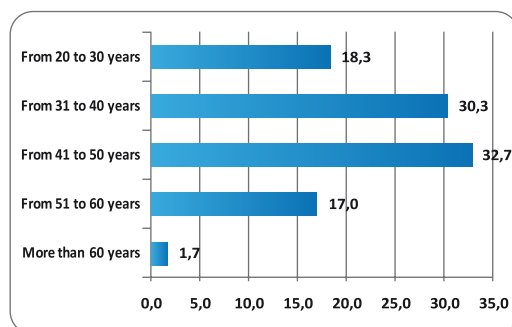


Graphic 59. Years of service

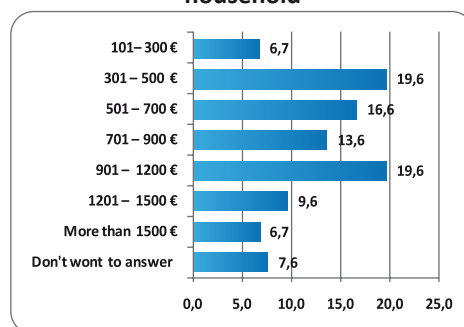


In 64.3% of cases, the respondents were women. The age structure was dominated by respondents aged between 30 and 50 years. In regard to the job positions the respondents hold, the education structure was divided between secondary (51.8%) and higher education – graduate, post-graduate and PhD studies (48.2%). The majority of respondents live in four-member households (38.6%). Almost a fifth of households received a total monthly income of between €301 and €500 (19.6%) and a similar number between €901 and €1,200 (19.6%). The higher level of education and responsibility of the job implies a higher amount of total monthly income for respondent households.

Graphic 60. Age



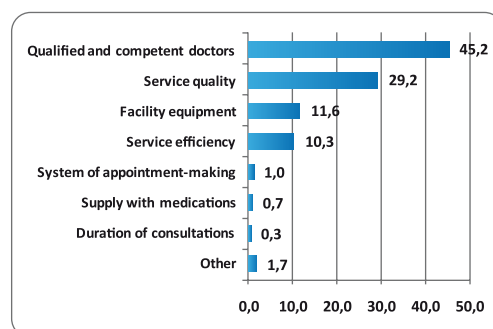
Graphic 61. Total monthly income of a household



5.2. Current situation and health care system reform

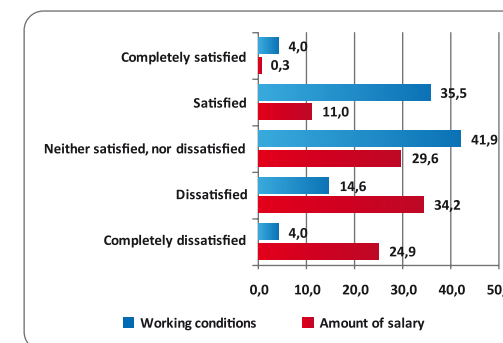
Qualified and competent doctors (45.2%) and, to a slightly smaller extent, service quality (29.2%) are considered the most important segments of health care. Head nurses, in relation to other employees, give priority to service quality. The higher the monthly income earned by households of medical staff, the more important it is that doctors are as qualified and competent as possible. However for respondents with the highest monthly income, service quality has a greater importance in comparison to the former segment.

Graphic 62. The most important segment of the health care system



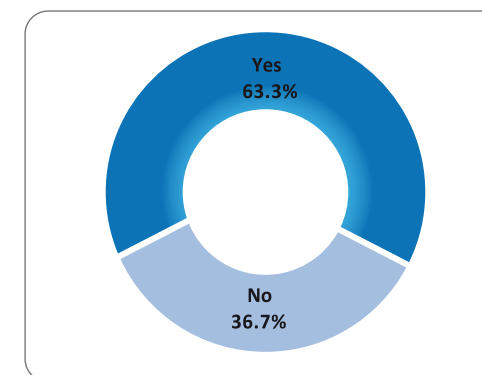
Analyzing the obtained results, it can be seen that employees were more satisfied with working conditions than with their salary. A tenth of respondents (11.3%) expressed satisfaction¹⁸ with the amount of their monthly income, while the percentage expressing satisfaction with working conditions in public health institutions (39.5%) was as much as four times as high. Three out of five respondents (59.1%) were dissatisfied¹⁹ with their salaries.

Graphic 63. Level of satisfaction with the working conditions and salary



Six out of 10 respondents (63.3%) would accept employment in private practice if they were offered better working terms. Slightly above one third (36.7%) would reject such an offer, and as the main reason they cited job security in public health institutions. Observing the job structure, doctors and other medical staff were most ready to work in private practice, while head nurses the least. As monthly household income goes up, the willingness of medical staff to change their job increases.

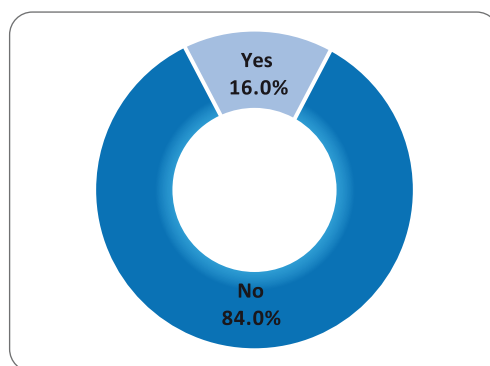
Graphic 64. Would you accept a job in private practice?



Despite the willingness to accept a job in the private health care system, a high percentage of respondents (84.0%) either do not work at the moment or have never worked in private practice.

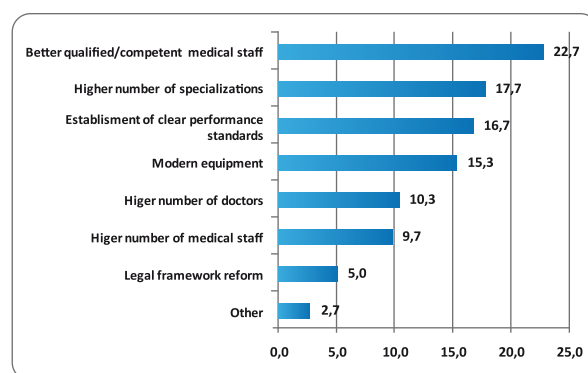
¹⁸ Completely satisfied+satisfied
¹⁹ Completely dissatisfied+dissatisfied

Graphic 65. Do you work or have you ever worked in private practice?



Medical staff gives greatest priority to an increase in qualifications and competence levels of medical staff (22.7%) as the best way to improve performance of the health care system. A higher number of specializations (17.7%) enabling higher levels of competence and qualifications of medical staff correlate with this measure as well. Observing the job structure of the medical staff included in the survey, doctors would give priority to a higher number of specializations. Head nurses also believe that the performance of the public health care institution could be improved if the medical staff were more qualified and better trained.

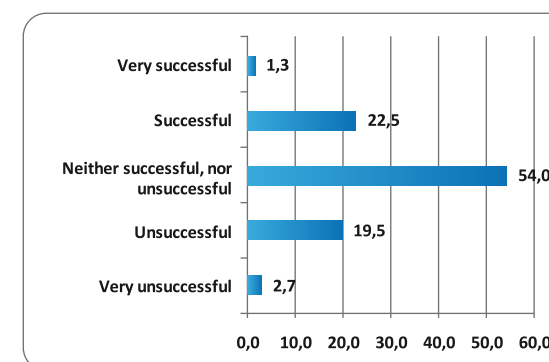
Graphic 66. Measures for improvement of public health care institution performance



5.3. Health Care System Reform

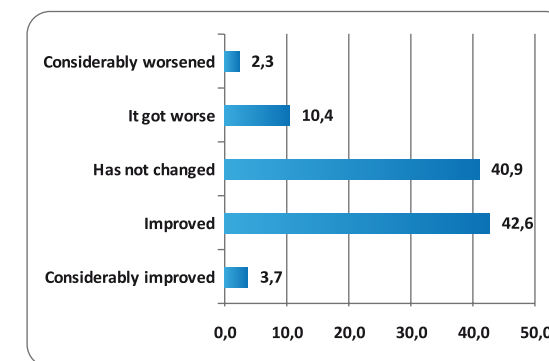
Regarding the successfulness of the health care system reform so far, medical staff are divided in their opinions. Namely, 23.8% of respondents consider the reform as successful, while 22% of them believed the opposite.

Graphic 67. Assessment of the health care system reform so far



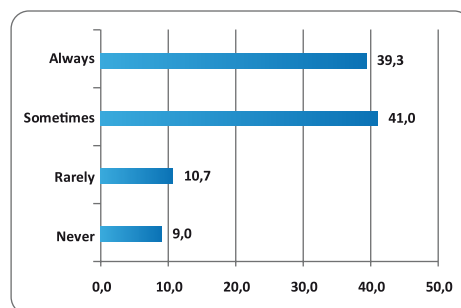
According to 42.6% of the employees in public health care institutions, the service quality improved as a result of the reform implementation. A slightly lower percentage, 40.9%, thought the reform had brought no changes in the quality of the health service.

Graphic 68. Change in the service quality of health care institutions in relation to the period before the reform



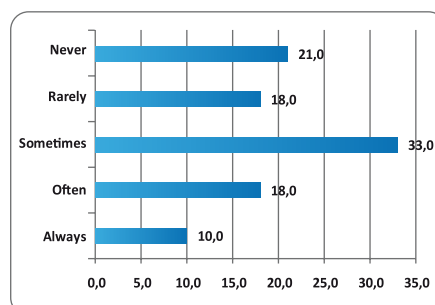
5.4. Use of health care

A number of medical staff stated that working in the public health care system brought some form of different treatment, or an advantage in comparison to other patients. Four out of ten respondents said that there are always advantages received in treatment (39.3%), while 41.0% stated that it happens sometimes. It was noticed that employees with a higher monthly income had a greater advantage in relation to other patients in terms of health care use. A larger percentage of head nurses and doctors say that they have always had an advantage in treatment in comparison to other patients.

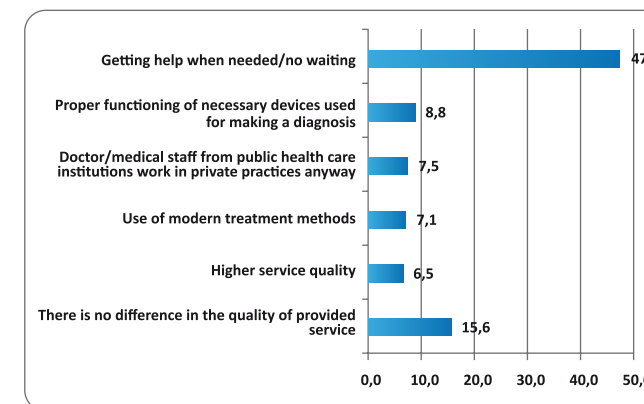
Graphic 69. Different treatment in relation to other patients

During the last year, one third of medical staff (32.9%) used health care services in private practice and most often twice or three times a year. As the main reason employees stated: receiving the service when needed (no appointments and no waiting) – 33.8%; and better and quicker access to a specialist – 19.2%. The level of satisfaction with the service provided in the private health care system was high: 24.2% were very satisfied, and 53.5% were satisfied. Furthermore, there is a high level of alignment between the existence or non-existence of different treatment towards public health institution employees and the use or non-use of private medical care. Namely, health care workers who stated they had no different treatment in relation to other patients used private health care more often. Observing the job positions of medical staff, it is noticeable that head nurses and doctors use private practice to a greater extent than other colleagues within the public health system.

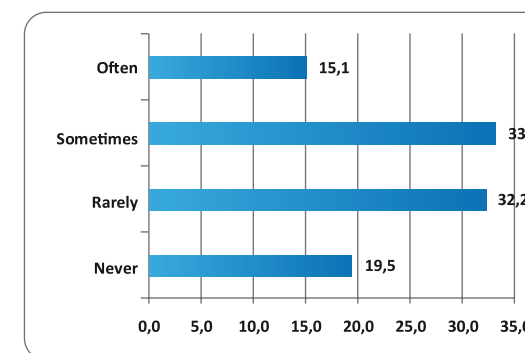
Medical staff to a significant extent would not use the private health care services where their health insurance would cover the treatment costs. Namely, 21.0% of them would never do this and 18.0% would rarely do it. On the other hand, where this is the case, 18.0% would often seek treatment in private health care institutions, while a tenth of employees (10.0%) would always do that.

Graphic 70. If the health insurance would cover treatment in private practice to what extent would you use these services?

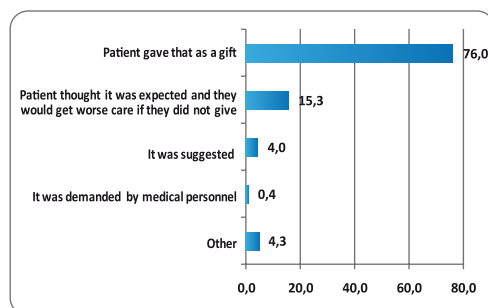
Respondents who would never or only rarely undergo treatment in private health institutions stated as the main reason that there is no difference in quality service between public and private health care. Three out of five respondents who would use this opportunity (often and always) gave the reason as being that they would be able to receive the service when needed (no waiting).

Graphic 71. Main reason for using private health care services, if they were covered by health insurance

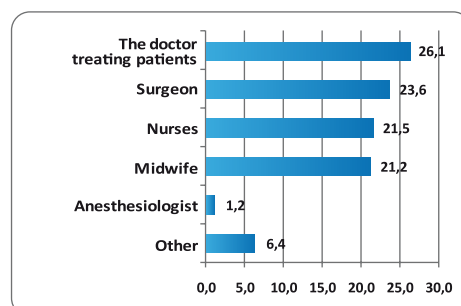
Medical staff said that only in one out of six cases (15.1%) patients often give presents to the medical staff. For one third of respondents respectively, giving gifts happens occasionally (33.25) and rarely (32.2%), while every fifth respondent (19.5%) said it never happens. Observing health institutions, it is noted that more employees in the Podgorica Clinical Centre said that the phenomenon of giving gifts does exist than that it does not. In Nikšić General Hospital, they assess that it never happens. Considering the level of household monthly income, data analysis suggests that medical staff with higher incomes more often mentioned the existence of giving gifts to medical staff. Also, it was noted that other medical and non-medical staff more willingly report giving gifts than is the case with other medical workers.

Graphic 72. Frequency of giving gifts/money to medical staff

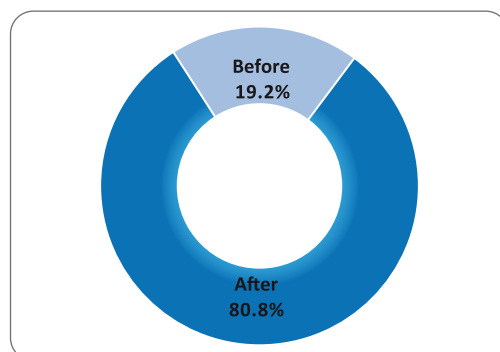
A high percentage of medical staff interviewed stated as the most common reason for giving gifts that it usually happens on the patient's own initiative, who give it either as a gift (76.0%) or to receive better care treatment (15.3%). In addition to these reasons, the medical staff mentioned the gratitude the patients feel for services provided, explaining that "our people's mentality has in its tradition the need to express thanks for a service provided in any sphere of life", as well as that "certain doctors expect the present in an envelope" and "employees' attitude and behaviour gave hints they expect a present".

Graphic 73. The most common reason for giving gifts to medical staff

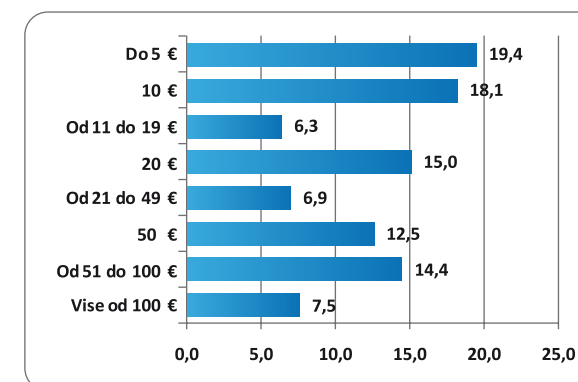
The medical workers interviewed identified staff members who most often received gifts from patients as: the doctor treating the patient (26.1%), the surgeon (23.6%), the nurse (21.5%) and the midwife (21.2%).

Graphic 74. Which patients most often give gift/money to?

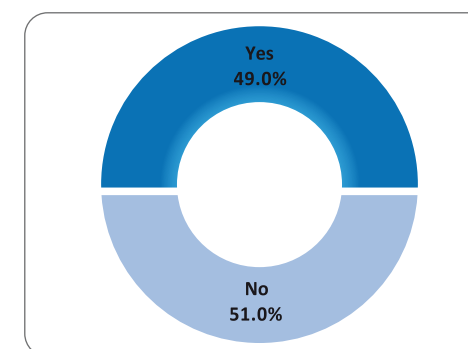
In 19.2% of cases, gifts were given before treatment, while in 80.8% of cases it happened after the patient was provided with medical care. Other medical and non-medical staff usually responded that gifts were given before, unlike doctors, nurses and technicians, who said that this happens after the medical service was provided.

Graphic 75. When does giving of gifts most often happen?

According to the answers, more than a half of medical staff said that the value of gifts was up to €20 maximum. The value of gifts the head nurses most often mentioned was €10, while doctors mentioned €20 or more. In 7.5% of cases, medical staff mentioned amounts higher than €100, for example “nurses receive up to €40, surgeons between €300 and €500, sometimes even €1,000, and gynaecologists between €250 and €300”.

Graphic 76. Value of the gift/money

When speaking of whether they accept the gifts, medical workers are divided. Namely, 49.0% said they accepted the gift, while 51.0% that they did not. Employees who at some point accepted the gift, most often said it was chocolate, coffee or some other beverage. As the most common reasons for accepting, employees stated that “the patients offered it as a gesture of gratitude for their medical care,” “the patients feel offended if you reject the present, or as they say “this small/little thing”.

Graphic 77. Have you accepted gifts/money?

6. SUMMARY OF THE KEY FINDINGS - CONCLUSIONS

Based on the research results, the following key conclusions are presented below and, based on them, future actions should be proposed and developed with the aim of strengthening the integrity of the Montenegrin health system:

- ✓ **Patients at the primary health care level positively assessed the success of the current health care system reform.** Almost 80% of respondents assessed the reform either as successful or partially successful. Satisfaction with the implemented reform is especially pronounced in the northern region, where more than 60% of respondents assessed the reform of primary health care level as successful or very successful. **The important, successful feature of the implemented reform was in improving the quality of health care services provided,** which confirms a high level of correlation between answers about satisfaction with the current reform and the change in the quality of health care service: respondents who confirmed their satisfaction with the implemented reform, confirmed that the quality of health care services at the primary level was improved. Also, 45% of the medical staff interviewed at the secondary and tertiary health care level confirmed the improvement of health services compared to the period before the implementation of the reform.
- ✓ As stated by respondents, **the reform has largely contributed to an improvement in the quality of doctor-patient relations, due to the fact that doctors are more aware of the patient's health condition and medical history.** Also, the reform has contributed to reducing waiting times for an examination, which is the result of introducing compulsory scheduling for examinations in advance. On the other hand, **according to patients at the primary health care level,** the reform implementation brought no changes in **the motivation of doctors or medical staff** as well as in the facilities' equipment for primary health care.
- ✓ Regarding the concept of a chosen doctor, **patients were most satisfied with the chosen doctors' kindness, their devotion to work and their competence.** Even though the respondents stated that the worst problem in the health care system was the lack of motivation of doctors, they find their chosen doctors both competent and devoted to a sufficient extent. On the other hand, **respondents were least satisfied with the availability of the chosen doctor.** Making an appointment often proved to be a problem, because no one answered the phone, and in cases when the chosen doctor was absent, patients complained that the other doctors did not want to admit them. In order to overcome this problem, some patients make appointments with their chosen doctor every week, because they *"do not know when they are going to be sick"*.

In addition, respondents assessed they were not involved enough in decision making regarding their future treatment, there was not equal treatment of all patients and they did not have enough time to ask additional questions during the examination. **Yet, more than 91% of respondents confirmed that they have not changed their chosen doctor so far.**

- ✓ **Among users of secondary and tertiary levels of health care, the level of satisfaction with the functioning of the current health care system in Montenegro is slightly lower than with primary health care users.** Patients in the majority of cases stated that measures aimed at improving material and technical conditions in the public health care system were most needed in order to improve the existing health care system in Montenegro and, according to two-thirds of patients (67.4%), qualified and trained medical staff are the most important segment of health care.

In addition to satisfaction with the current reform and overall service available within the health care system in Montenegro, a special subject of the analysis was informal payments, defined as “paying outside official channels to an individual or institutional service provider, in kind or in cash, or any purchase for which expenses should be covered by the health care system. This includes making payments to doctors ‘in an envelope’ and any ‘donations’ to hospitals, as well as the value of medical supplies the patient buys and the value of medications purchased in a private pharmacy that should be covered by health insurance.”

- ✓ Even though informal payments, regardless of whether they were money or gifts, usually took place after the treatment was provided, **the presence of informal payments in the system is significant.** When it comes to gifts and/or money given by patients to the medical staff during their stay in the hospital (for medications, supplies, and post-hospital care), which do not relate to official payments in terms of participation, the analysis findings suggest the following: (i) 44.3% of respondents did not pay anything other than what was required (participation), (ii) 55.7% gave money or some sort of gift to the medical staff.
- ✓ **The survey showed that both the patients and the medical staff were identified as initiators of informal payments for the treatment provided.**
- ✓ The patients interviewed most often gave a gift/money to doctors who treated them (70.1%[®]), nurses (68.1%) and midwives (27.1%), while gifts/money were seldom given to surgeons (13.7%), anaesthetists (3.5%) and laboratory technicians and radiologists (0.7%).
- ✓ Giving gifts and/or money most often happened with patients who stayed in hospital for childbirth (71.5%). Based on the type of surgery, giving gifts/money was customary in various types of gynaecological surgery, surgery on

the eyes, breasts, tonsils, gall bladder, etc. (46.4%), cardiovascular surgery (44.4%) and abdominal surgery (44.2%).

- ✓ **The most common motive for informal payments was a sense of gratitude,** and this was the case with 60% of patients who gave money or a gift to the doctor who treated them; with 68.4% of patients who gave money or a gift to a nurse and with over 75% of patients who gave money or a gift to a midwife. On the other hand, a significant number of patients perceived giving a gift or money as a precondition for qualitative medical care, especially when speaking of anaesthetists (44% of patients), laboratory technicians and radiologists (50% of patients). As previously stated, the findings point to the conclusion that giving was performed after the treatment had been provided. Only in the case of anaesthetists was the giving usually performed before the provision of the health care service.
- ✓ Patients on average paid **€60 as a monetary gift** to medical staff, or as an informal payment. **The size of informal payments during 2010 amounted to 12.5% of the average net salary, while as a share of gross salary it amounted to 8.3%[®].** On the other hand with this amount (€60), the citizens of Montenegro **increase the average monthly income of doctors at the secondary and tertiary health care levels by between 5% and 6% on average by one gift, and the income of nurses by between 14% and 15%.**
- ✓ The characteristics of respondents who most often gave gifts and/or money to the medical staff were the following[®]: (i) in the central region; (ii) women; (iii) with higher or further education; (iv) running a private business, unemployed and employed; (v) with a monthly household income above €500.
- ✓ In general, the results lead us to an indirect conclusion, when it comes to the perception and attitude of respondents regarding the nature of informal payments, that in a majority of cases, informal payments (whether in form of money or gift) are **an integral part of the Montenegrin tradition and express a sense of the patient’s gratitude for the treatment provided.**
- ✓ **In situations when informal payments occurred either before or during the treatments, it was the same: a confirmation of the expressed belief that this type of payment was directly related to the quality of expected service and recognized as a mechanism of motivation to the medical staff to provide health service with a higher level of responsibility,** either through more attention and information from the doctor, or faster provision of medical care and ultimately better clinical service.

7. RECOMMENDATIONS

As a result of the research conducted and analysis of the collected data, recommendations have been formulated and put forward with the aim of improving the continuation of reform activities within the health care system. Implementation of the proposed recommendations will reduce opportunities for corrupt action, and will also increase the transparency of health care system performance and public trust in the availability of health care regardless of economic or social status.

The experience and lessons learned from the process of the reform of the primary health care will be transferred to the “next generation” of reforms. This will be directed at the secondary level of health care, with the primary aim of increasing the efficiency of hospital treatment with an emphasis on capacity building, improving gynaecological and obstetric units and outpatient services, and providing sufficient resources to finance health care through improved revenue collection and improved availability of services with a guaranteed “basic package” of health care.

Improve the transparency of providing treatment and health care quality

- ✓ The reform of the primary health care system in Montenegro so far is showing satisfactory results, however, since one of the main goals of introducing the model of a chosen doctor was to make health care more accessible and affordable to the wider population, it is necessary to continue with the implementation of informative campaigns for further education and raising the awareness of employees in the health care sector and citizens/insurants about the basic characteristics and functioning of the primary health care system in Montenegro.
- ✓ Also, it is necessary to insist that medical staff consistently follow the code of ethics and, for the purpose of building trust and as a demonstration of efficient work, enable public access and continued insight into waiting lists for specialist examinations, scanning and other medical procedures. The consistent application of the code of ethics will affect the reduction of informal payments, which are currently occurring to a significant extent in this system.

Improve human resource management (competence, specializations, performance quality assessment, and work in both the public and private sectors)

- ✓ In order to strengthen medical staff's competence, carry on with continuing education (specializations, trainings, participation at scientific gatherings) of

medical workers at all levels. “Job security” in the public health care system should not be an excuse for medical staff’s lack of interest in further professional upgrading and development. Defining clear criteria for professional skills that would be the subject of an annual performance assessment would encourage interest among medical staff in further professional upgrading.

- ✓ Clear employment and advancement criteria, as well as disciplinary measures in case of infringements and providing adequate professional upgrading will additionally influence the motivation of medical staff to perform their tasks better.
- ✓ The motivation of medical staff would be particularly affected by the possibility of earning benefits related to performance in such a way that professionalism, productivity and achieved results are properly awarded.

Change in the medical staff payment system

- ✓ As previously mentioned, financial compensation to a large extent influences the motivation of medical staff to diligently perform their tasks and reduces the “space” for informal payments. To this end, it is necessary to inaugurate a new payment system, which instead of inputs, will be based on the promotion of work, results, productivity, efficiency and effectiveness. In this way, the conditions will be made for service providers to ensure decent revenues through a contracting mechanism, adjusted to their level of education, skills and competences, which at the same time would increase the responsibility of medical staff and define disciplinary measures for poor performance.
- ✓ For the purpose of objective and transparent performance assessment of medical staff, it is necessary to develop an integrated information system to monitor productivity and the efficiency of employees, and based on that to determine incentives or disciplinary measures.

Introducing control and ensuring the quality of health service

- ✓ Considering the most important factors of the recognized successfulness of the health care system reform, among which were the competence and motivation of medical staff, it is proposed that there will be conducted an internal control and medical staff performance quality audit, the results of which would affect the amount of monthly revenues and system of awards.
- ✓ In order to further improve the quality of performance, it is necessary to systematically introduce and implement quality control of provided services

in accordance with the defined quality indicators, and build national capacities in this direction.

- ✓ One of preconditions of successful control and quality assurance, besides sustained monitoring of performance and service quality assessment, is the establishment of an integral information system in the health care sector as one of the management tools used.

Strengthening responsibility: supervision and accountability of all health care service providers and introducing disciplinary actions for those violating common and expected practice

- ✓ In order to better manage and reduce informal payments, it is necessary to improve the accountability of medical staff. Management of resources, including human, has to be increased by introducing regular written performance assessments and evaluations (as basic management tools, based on which a reward or disciplinary measure will be defined, depending on the result of the evaluation. To this end, proper control is the basis for developing a more responsible health care system.
- ✓ Within the function of the previous goal is the proposal of higher autonomy of hospitals, including hiring and dismissal of staff based on their performance. A more transparent process of selection and decision making about medical staff advancement will make hospitals less vulnerable to possible abuses.

Participation of the medical and local community in performance assessment

- ✓ To achieve better performance and more qualitative control would additionally contribute to the activities that are strengthening the capacities of citizen representatives and non-governmental organisations. NGOs and citizens are dealing with citizen’s rights and are active in the health care sector in order to become more actively involved in the decision-making process, strategic planning and targeted budget control.
- ✓ As research shows, informal payments are equally initiated by patients and medical staff. Even if it is expected that this practice is aborted only by the action of the state and system institutions, **active participation of the public in strengthening the accountability of the system is critical**. Citizen involvement in performance assessment may be a useful tool in completing regulatory and administrative reform.

Improve the integration between the public and private sectors

- ✓ Patient treatment in private practice for health services that are lacking in a public health care system must be enabled, in order to improve the efficiency and rationality of the available resources aimed at providing qualitative health care service. This would result in strengthening the health care system, improve medical care and ensure prompt and patient-oriented service, i.e. at the moment when needed.
- ✓ Carefully reconsider the possibilities and private sector capacities to participate in the realization of some kind of additional health insurance, as one way to reduce and control informal payments.

Launching the campaign aimed at changing the existing culture/tradition of the need to show gratitude for medical care provided by giving gifts, i.e. informal payments

- ✓ As long as service users do not bring the importance or equity of informal payments into question, but accept them with different explanations, there will be no real change. Therefore, it is critical to promote the concept of professionalization of patient-employee relations and insist on reducing the level of monetary giving or material gifts out of a “sense” of gratitude.
- ✓ Also, it is suggested that promotion of the prevention of a culture of giving/receiving gifts should be continued, and that receiving feedback from health care users on medical staff performance and the functioning of the health care system should be encouraged.
- ✓ Raising awareness of patients and health care workers of the problems and harmfulness of informal payments will contribute to the development of a more effective and reliable system for receiving and reacting to patient complaints reporting malpractice and unprofessional work, or complaints on health care worker performance.

Launching information campaigns about the positive changes that occur as a result of implementing the reform at the hospital level, in order to contribute to raising patients’ awareness of their rights and build trust in the health care system.

- ✓ Willingness of patients, or other people acting on their behalf, to pay for the services provided will not disappear until those people are convinced that they enjoy the same level of treatment as other patients and receive the maximum medical care at a given moment that is realistically possible.

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