ESPN Thematic Report on Inequalities in access to healthcare

Serbia

2018

Ljiljana Pejin Stokic
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Contact: Giulia Pagliani

E-mail: Giulia.PAGLIANI@ec.europa.eu

European Commission
B-1049 Brussels

European Social Policy Network (ESPN)

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Ljiljana Pejin Stokic, Economics Institute, Belgrade

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary/Highlights

Serbia has a compulsory healthcare insurance scheme which in 2016 covered 97.5% of the population; this high rate of coverage has been maintained for several decades. The following categories are included under the compulsory insurance scheme: employed persons with fixed or temporary contracts, farmers and pensioners. There are two insurance funds, the army fund and the republic health insurance fund (HIF), the latter being the main public entity for managing the provision of healthcare.

Serbia does not have a national system of health accounts, and for that reason the only available official data on healthcare expenditure come from HIF financial reports. Data on out-of-pocket payments (outside the state healthcare system) are not available, since the private healthcare sector does not provide this information and there are no official records on over-the-counter spending for pharmaceuticals. Due to the economic crisis and ongoing austerity measures, HIF revenues have been constantly decreasing since 2008. In real terms, revenues in 2017 were equal to half those in 2008. The reduction of resources has had a negative effect on the maintenance of the healthcare infrastructure and conditions of work. Drainage of the healthcare workforce is becoming a serious obstacle to improving the availability of healthcare services in public institutions.

The network of state healthcare institutions is evenly distributed across the country, where primary healthcare centres are the first point of contact. Private healthcare is developing rather randomly, with minimal cooperation with the state healthcare system. Private health insurance is underdeveloped: in 2017 only about 0.02% of the population had private insurance.

Within the compulsory healthcare insurance system, special support is given to vulnerable population groups to ensure proper access to healthcare. For individuals who are not regularly insured, their contribution payments are covered from the state budget. The Health insurance Law sets out a wide range of eligibility criteria for inclusion on the list of vulnerable groups, relating to: financial status, age, gender, ethnicity and medical condition. The majority of the vulnerable population groups are exempted from any co-payments, which are also subject by law to a maximum annual amount. The proportion of persons who have 'self-reported unmet need for medical care' has been decreasing since 2013, and reached 4.5% in 2016, while healthcare comprised 3% of household spending.

Inequalities in access to healthcare are mostly caused by issues which originate outside the healthcare sector. The evasion of compulsory health insurance contributions by employers leaves employees without healthcare protection. The most prominent arrears for contribution payments are those accumulated by public companies and farmers.

Efforts to enhance healthcare accessibility are hindered by the lack of a proper information system to educate patients about their rights. Available research results show that a majority of patients are not well informed about their rights. Another relevant issue is the unlawful practice of 'under-the-table' payments; in 2017 the Ministry of Health established a commission for fighting corruption.

Overall it can be concluded that there is no significant evidence for the presence of inequalities in access to healthcare in Serbia. At the same time, the high coverage of the population with a very broad basic package of healthcare services, when combined with very constrained resources, is affecting the quality of healthcare services. Demographic projections are for a further increase in demand for healthcare, due to population ageing. Under the present conditions it is essential to initiate a reform of the healthcare sector in order to prevent its further deterioration and preserve its sustainability.

1 Description of the functioning of the country's healthcare system for access

Serbia has a compulsory healthcare insurance scheme which in 2016 covered 97.5% of the population.[1] There are two public health insurance funds: the army fund and the republic health insurance fund (HIF). Compulsory healthcare insurance covers every person who is employed under a permanent or temporary work contract, farmers and pensioners. Dependent family members (children, spouses and parents) who live in the same household as the insured person are also covered, if not covered otherwise. The Health Insurance Law regulates the rights and obligations of insured persons.[2]

Those persons and their family members covered by compulsory health insurance are entitled to the full range of healthcare protection services. The insured person attains all rights after three months of continuous payment of contributions, or after six months of contributions payments with interruptions during an 18-month period.

Specific support is given to the healthcare protection of vulnerable population groups. Under article 22 of the Health Insurance Law, "an additional consideration is given for persons who are at higher risk of ill-health, for socially vulnerable persons and for treatments of diseases which have social or medical significance". If these persons are not regularly insured the state supports their coverage and inclusion in the compulsory health insurance scheme (Annex, Table 1). Payment of insurance contributions for these persons is provided by the state budget; in 2016 20% of all insured persons were covered by this provision. Registered beneficiaries of financial social assistance are among those vulnerable population groups included on this list, as well as registered unemployed persons. All persons on this list are also exempted from co-payments for healthcare services or pharmaceuticals.

The HIF adopts 'rules on the contents and volume of rights for healthcare from compulsory health insurance and on participation payments' (the rules) for each calendar year. Insured persons are entitled to the following: (1) healthcare protection; (2) sick and maternity leave payments; and (3) reimbursements of travel costs related to healthcare. The HIF is a public entity which operates through 31 regional branches and their local offices. Its main responsibilities are: (i) collection of compulsory contributions and other revenues; (ii) contracting of healthcare institutions for the provision of services; (iv) approval of the 'positive drug list'; and (v) administration of reimbursements for sick leave and maternity benefits. The Ministry of Health has the following responsibilities: (i) health policy planning and evaluation, drafting of legislation, and planning of education/training; (ii) public health, food and drug safety, environmental sanitation, and related inspections; (iii) capital investments; and (iv) appointment of management staff at healthcare institutions at the secondary and tertiary levels of healthcare (hospitals and clinics).

There are no official data on total national healthcare spending. Estimates provided by the World Health Organization show a decreasing share of current health expenditure (CHE) in gross domestic product: in 2014 it was 10%, and in 2015 9%.[3] CHE per capita in 2014 was US$609 and US$491 in 2015 (at constant 2010 prices).

Capital investment in state healthcare is funded from the state budget, as are payments for healthcare insurance for vulnerable groups defined by the Healthcare Insurance Law. HIF revenues are the main source for funding healthcare for the majority of the population. The HIF collects revenues from the following sources: compulsory contributions from employees and farmers; transfers from the pension and invalidity insurance fund for pensioners; transfers from the national employment service for beneficiaries of unemployment benefits; transfers from the republic budget for persons

[1] HIF statistics at: http://www.rfzo.rs/index.php/nosioci-osiguranja-stat.
[2] RS Official Gazette 10/2016.
[3] World Health Organization, Global health expenditure database.

who are entitled to free healthcare; and payments by patients for services and pharmaceuticals. In the period 2005-2008, HIF revenues grew at an average annual rate of 7.3%, while in the period 2009-2016 there was an average annual decrease of 4.6%.[4] The compulsory contribution rate was reduced in 2013 from 12.3% to 10.3%, which caused a significant drop in HIF revenues. Real HIF revenues, adjusted by the consumer price index, showed a sharp decline in the period 2009-2016: in 2016 revenues were almost half those in 2009 (Annex, Figure 1). The sharpest fall occurred after 2013 when the contribution rate was decreased, while in the same year the wages of public employees were frozen due to austerity measures. Other causes lie in the evasion of contribution payments; in 2013 total outstanding contributions were €818.6 million (59% by public companies); while the revenues collected by the HIF came to €1,875 million.[5] In 2018 farmers' contribution arrears came to €254.2 million.[6] The decrease in funds has had negative effects on the proper functioning of the healthcare system, mainly secondary and tertiary healthcare institutions which have higher operating costs. The majority of these institutions have accumulated debts for medical consumables, pharmaceuticals and utility costs. In 2016 the total debts of healthcare institutions were €218.2 million.[7] Shortage of resources affects the quality of healthcare services, since medical equipment is often out of order due to poor maintenance.

The relatively low wages of healthcare personnel results in a drainage of medical staff. Reports from the association of medical workers show that in the last five years, annually around 2,000 medical workers have left the country to work abroad.[8] A study of healthcare workers in Serbia found that from 2009 to 2016 the number of 'discontented' workers had been rising constantly.[9] The same report shows that 15.5% of all of the workers interviewed said they intended to leave the country and find work abroad (including 19% of medical nurses). Employees expressed the greatest discontent with rates of remuneration, opportunities for continuous education and training, and their sense of being valued in their work.

In 2016 state spending (excluding capital investment) on healthcare was €257.30 per capita, which was among the lowest in Europe.[10] Data from household budget surveys show a constant share of spending on healthcare over the past ten years, at around 3.2% – the same share that households spent on tobacco and alcohol.[11]

Healthcare services financed by the HIF are provided through a network of public healthcare institutions. For some services the HIF also makes contracts with the private healthcare sector; but in 2016 only 0.7% of HIF expenditure was allocated for this. The network of public healthcare institutions covers the whole territory evenly with the following services: primary healthcare (158 centres), secondary care (41 general hospitals, 36 special hospitals), tertiary care (5 clinical centres, 7 clinics), and rehabilitation services. Primary healthcare centres are the gateway for all other healthcare services; they commonly have several units and stations which cover a territory with a radius of 10 kilometres. In 2016, 355 public healthcare institutions (excluding army units) employed 104,000 staff, of which 24% were physicians.[12] The distribution of physicians per 1,000 inhabitants varied significantly between the regions, from 3.88 to 1.86, with a national average of 2.84; these disparities point to spatial inequalities in the accessibility of healthcare services. The number of hospital beds has been decreasing steadily; in 2015 there were 5.6 beds per 1,000 inhabitants, close to the

[4] Pejin Stokic LJ., Nikolic I., 2016.
[5] HIF Financial Report 2013.
[6] News story 13 March 2017, https://naslovi.net/2017-03-13/rtv/dug-poljoprivrednika-185-milijardi-deo-ce-biti-otpisan/19745926.
[7] HIF Financial Report 2016.
[8] News story 2 May 2017, http://rs.n1info.com/a246210/Vesti/Vesti/Odlazak-lekara-i-sestara-u-Nemacku-dobija-razmere-egzodusa.html.
[9] Republican Institute of Public Health, 2017b.
[10] Serbia does not have a national system of health accounts.
[11] Republic Statistics Office, 2018.
[12] Republican Institute of Public Health, 2018.

EU28 figure of 5.14 in the same year. The bed occupancy rate had also been decreasing, to 65%, even though the number of hospital admissions had been on the rise since 2009. The average length of stay in hospitals (for all causes) had improved from 10.3 days in 2006 to 8.6 days in 2016. Development of palliative care has been introduced with the support of IPA[13] funds (€3.3 million), with a plan for the establishment of 30 units.

The compulsory health insurance scheme covers the following healthcare services.

1. Preventive healthcare and early diagnostic procedures.
2. All medical procedures related to pregnancy (including artificial insemination) and for 12 months after delivery.
3. Medical examinations and treatment in the case of illness or injury.
4. Rehabilitation after illness or injury.
5. Dental treatments.
6. Pharmaceuticals and medical supplies.
7. Prostheses, orthoses, and other medical devices.

Since 2006 health insurance coverage for the costs of dental treatments has been limited to the following population groups: (1) children up to age 18 (up to 26 if in regular education); (2) women during pregnancy and maternity (up to 12 months); (3) treatments related to some surgical procedures; and (4) prosthetic treatments for persons older than 65 years.[14]

For the majority of procedures, a co-payment is obligatory for insured persons, unless they belong to one of the vulnerable groups defined by article 22 of the Health Insurance Law. The co-payments are defined annually by the rules, and are in the range €0.5-€10 (Annex, Table 2). Exemption from co-payments for regularly insured persons is subject to household financial status. For a single-member household the threshold is income below 130% of the official minimum wage (€263 per month in April 2018) and for multiple-member households it is equal to a minimum wage per household member of €230. Information from the regional HIF branch Nis shows that in April 2018 around 30,000 patients were exempted (around 10% of this region's population).[15]

There is a cap on the total annual amount of co-payments; it is set at 50% of the patient's monthly wage/pension for the last month of the previous calendar year, or at 50% of the national average monthly wage for those who did not have an income in the previous year.

The Healthcare Insurance Law defines those non-urgent procedures and interventions for which patients can be included on waiting lists. In order to achieve transparency in priority setting for all waiting lists, the HIF has devised a program which allows patients to check their status on the lists, the information being updated at the beginning of every month and posted on the HIF website. It is apparent that the capacity to carry out these interventions is not adequate, since in the period 2012-2016 there was a constant increase in the number of new patients on the waiting lists (Annex, Figure 2). In 2016 the average waiting time increased for all major procedures compared with 2015.[16] In 2016 the waiting time for surgery for age-related cataracts was 324 days and the number of patients on the waiting lists had increased by 17% from the previous year; waiting time for hip and knee replacement surgery was 378 days, 30 days more than in 2015.[17]

[13] Instrument for Pre-accession Assistance
[14] Prior to 2006 health insurance covered the costs for all insured individuals.
[15] News item 30 April 2018, http://novaekonomija.rs/vesti-iz-zemlje/pravo-nepla%C4%87anja-participacije-za-lekove-ostvarilo-30000-ljudi.
[16] Republican Institute of Public Health, 2017a.
[17] Ibid.

The number of private healthcare institutions has been increasing over the past fifteen years. Available data for 2014 show that there were 1,369 private healthcare units, with 3,732 permanently employed physicians.[18] The national health survey 2013 showed that around 15% of the population used private healthcare services.[19] Private healthcare insurance is rather underdeveloped: in 2017 less than 0.02% of the population had contracts for private health insurance.[20]

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The present solutions in the area of healthcare protection cover all aspects related to the equal access to healthcare of Serbian residents. High coverage of the population by compulsory healthcare insurance has been constant for several decades. The most vulnerable population groups are protected from exclusion on the grounds of low income, unemployment or ethnicity. Eurostat data on 'self-reported unmet need for medical care' show that a small percentage of the population was not able to have their healthcare needs met in the period 2013-2016; this share decreased over the period, to 4.5% in 2016 (Annex, Table 3).[21] The highest proportion of the individuals surveyed reported that high costs ('too expensive') were the reason for unmet need for healthcare. This proportion decreased from 5.7% in 2013 to 2.6% in 2016. Secondary analysis of the data for 2013 and 2014 shows the main socio-demographic variations.[22] For both years those with the highest level of unmet need (all reasons) were individuals in the 45-64 age group: 23.8% had unmet needs in 2013 and 20.3% in 2014. Educational attainment was also a relevant characteristic: unmet need was highest, in both years, for the group with the lowest education level (primary school or less). Regarding activity status, unemployed persons had the highest rate of unmet need in both years. As expected, when looking into spatial distribution, unmet need was highest among residents from remote areas, in both years. Individuals with the lowest income also had the highest unmet need, at 26% in 2013 and 22% in 2014, with the share decreasing as income increased.

The health status of the Roma population is at special risk, and the government has implemented the 'programme for improving the health and healthcare of Roma'. From 2009 till 2014 a total of 131,495 Roma were newly registered and covered by health insurance, with the involvement of Roma mediators; 30,018 children and 2,719 adults were immunised. Apart from assistance with healthcare, the mediators gave advice on other social care services available to Roma families. In 2016 the government adopted a strategy for the social inclusion of Roma for the period 2016-2025. Improvements in the health status of Roma, and their access to healthcare, are one of the priority goals in the strategy.

The potential evidence of unequal access to healthcare lies in the area of unlawful behaviour by the users and providers of healthcare. In order to prevent such behaviour, the Ministry of Health has appointed a special anti-corruption team whose role is to prevent all abuses in the provision of healthcare services, both in the state and in the private healthcare sectors.[23]

Even though a number of regulations have been introduced to improve the availability and accessibility of healthcare, it is questionable if these measures have been effectively applied in practice. Research into citizens' attitudes to primary healthcare practice in Serbia in 2016 showed that 58% of those surveyed reported that they were not well

[18] Association of Private Healthcare Institutions, 2015.
[19] RIPH, 2014 Results of the National Health Survey of the republic of Serbia 2013
[20] National Bank of Serbia, 2018.
[21] Eurostat statistical database, 2018.
[22] Social Inclusion and Social Protection Unit, 2017.
[23] http://www.zdravlje.gov.rs/showelement.php?id=13487, accessed on 26 July 2018.

informed about patients' rights, while 49% did not know how to report a potential violation of their rights.[24] Concerning potential corruption and 'under-the-table' payments, about half (52%) of those interviewed expressed the opinion that either 'gifts or private connections' were necessary for the attainment of good-quality services.

In response to the potential abuse of patients' rights, the Law on Patients' Rights 2013 introduced patient counsellors, whose duties are to provide adequate information to patients and to protect their rights upon the submission of a complaint.[25] There are no official reports on the effectiveness of their activities. Research conducted in 54 local communities (38% of the total) in 2015 showed that 57% of the counsellors did not return phone calls (after the fifth call); out of those who had returned calls, only 8% were able to provide useful/correct information.[26]

Currently, those most affected by lack of access to healthcare are the employees of companies who avoid paying healthcare insurance contributions. In 2016 in the city of Belgrade, 47,000 employees were not able to realise their right to healthcare, as their employers had not paid contributions for healthcare insurance.[27] Employees who lose healthcare insurance due to such evasions of the law are obliged to pay full prices for healthcare services, either in the state or the private sector. The situation is more complex with farmers who have accumulated high arrears of all social insurance contributions. Presently the government is looking into ways to write off farmers' debts for healthcare insurance.[28] At the same time, the evasion of contribution payments erodes an already low collection rate by the HIF and has negative effects on the quality of healthcare protection in Serbia.

A constant decrease in HIF revenues and low per capita expenditures for health result in deteriorating healthcare capacities and infrastructure. It is not possible to maintain a satisfactory quality of healthcare and high population coverage with decreasing resources. Future demographic trends, population ageing and a decrease in the size of the working-age population, signal a need for urgent changes. Serbia has been postponing an essential reform of healthcare sector for several decades. Further postponement will jeopardise the functioning of all state healthcare institutions.

Policy recommendations are set out below.

- The human and technological capacities of the healthcare system should be adapted to ongoing population ageing and its effects on future morbidity trends. An increase in the capacities of services that answer the needs of the ageing population will reduce waiting lists and rationalise use of resources.
- The HIF and the Ministry of Health should take a more active approach to reaching out to patients and citizens with information about their rights.
- The HIF should take a more active approach to assisting patients in the realisation of their rights. The regulation which limits annual co-payments is well placed to protect patients from impoverishment during periods of illness. At the same time, the present procedure requires the collection of all receipts and a complicated calculation of the limit, which might be too difficult for some patients during illness. It would be more efficient for the HIF to monitor these payments through the patient's e-health card and to provide this information to them upon request. The whole administrative process has to be simplified and rationalised.

[24] European Policy Centre and the European Movement in Serbia, 2018.
[25] RS Official Gazette 45/2013.
[26] National Parliament [a non-government organisation], 2015.
[27] http://www.novosti.rs/vesti/beograd.74.html:621907-Poslodavci-im-ne-uplacuju-doprinose-Rade-a-lece-se-o-svom-trosku
[28] News story, 19 March 2017, http://www.politika.rs/sr/clanak/376455/.

- Tighter discipline of employers, along with the imposition of the appropriate penalties, would eliminate unlawful evasion of the payment of healthcare contributions.
- The emigration of health workers has to be prevented in order to maintain the quality of care. This could be achieved by changing the remuneration salary structures of healthcare personnel and by promoting a better working environment.

3 Discussion of the measurement of inequalities in access to healthcare in the country

The Republic Institute of Public Health prepares and publishes a number of annual reports analysing: (1) work in out-patient healthcare institutions and utilisation of primary healthcare services; (2) planned and realised service delivery in stationary healthcare institutions; (3) user satisfaction with services in state healthcare institutions; (4) improvements in the quality of work in state healthcare institutions; and (5) contentment among healthcare workers in state healthcare institutions. It also publishes a health statistics yearbook.

The HIF publishes data on the number of insured persons, as well as annual financial reports. The Republic Statistics Office conducts an annual survey on income and living conditions, which includes collecting data on unmet health needs.

All of these data are available on the websites of these institutions. The question is how this information and data are utilised, and whether they help policymakers in decision-making. Presently, Serbia lacks a comprehensive healthcare policy which takes into account the current shortcomings and future trends in the healthcare needs of the population.

Serbia has a rather comprehensive set of regulations to ensure access to healthcare for the most vulnerable population groups. On the other hand, EU-SILC data show that the most vulnerable group is the population on low incomes, as they are the most likely to report 'unmet need for medical care'. The other analysis, quoted earlier, also shows that patients are not well informed about their rights. For this reason, an additional indicator should be included in EU-SILC, which would measure the percentage of patients who apply for exemption from healthcare payments under the available options. This indicator would serve as a measure of the effectiveness of current policies to protect the most vulnerable groups.

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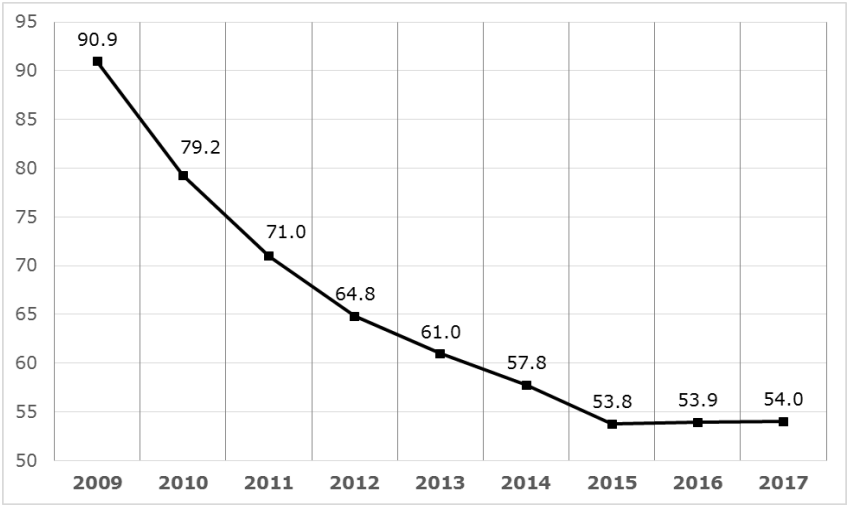
Annex

Figure 1. Real HIF revenues, 2009-2017 (index: 2008=100)



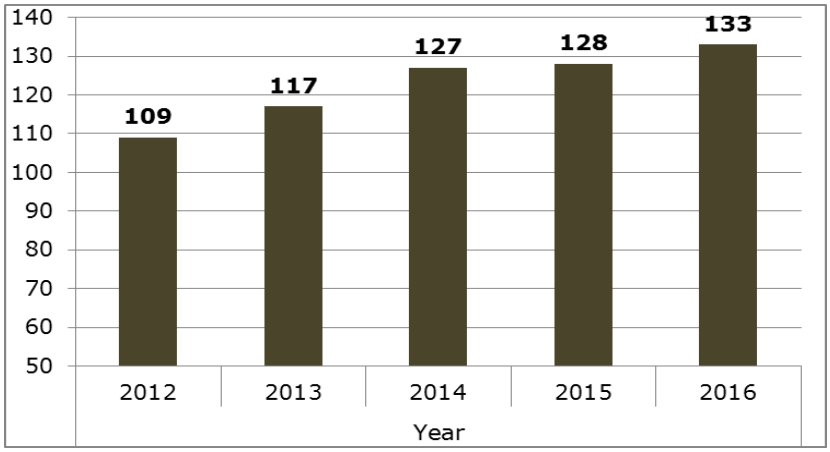
Source: Pejin Stokic LJ., Nikolic I., 2018.

Table 1. List of persons covered by compulsory health insurance, if not regularly insured, under article 22 of the Health Insurance Law.

No.	Eligibility conditions for inclusion in compulsory insurance (if not insured)
1	War invalids.
2	Beneficiaries of allowances for those in receipt of social care.
3	Voluntary blood donors (subject to a number of donations).
4	Children up to 18 years (up to 26 if in regular education).
5	Women: family planning, pregnancy, maternity (12 months).
6	Persons over 65 years of age.
7	Persons diagnosed with the following diseases: contagious diseases, malignant neoplasm, diabetes, haemophilia, cystic fibrosis, multiple sclerosis, auto-immune diseases, rare diseases, addiction, kidney insufficiency and organ transplantation.
8	Beneficiaries of financial social assistance (FSA).
9	Registered unemployed persons.
10	Victims of trafficking and/or victims of family violence.
11	Roma population.
12	Persons covered by compulsory immunisation programmes and preventive screening programmes.

Source: Health Insurance Fund, 2018.

Figure 2. New patients admitted to waiting lists (in 000), 2012-2016



Source: Republican Institute of Public Health, 2017c.

Table 2. Participation payments in state healthcare institutions in Serbia, 2018

Type of service	Participation costs
In-hospital care, per day	€0.5
Primary healthcare per visit	€0.5
Rehabilitation, stationary, per day	€0.5
Diagnostic procedures	€0.5-€10
Surgical interventions	5% of the price; maximum €254
Prostheses	10-20% of the price
Dental services (children)	€0.5
Prescription medicines	€0.5

Source: Health Insurance Fund, 2018.

Table 3. Self-reported unmet need for medical care by detailed reason,* Serbia 2013-2016

Reasons	2013	2014	2015	2016
All reasons	8.7	7.4	6.3	4.5
Too expensive	5.7	4.6	3.8	2.6
Too far to travel	0.9	0.5	0.5	0.6
Waiting list	2.1	2.2	2.0	1.2

*Percentage of population aged 16 and over.
Source: Eurostat, 2018.