



World Health
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REGIONAL OFFICE FOR Europe

GOVERNING FOR HEALTH EQUITY AND SUSTAINABLE DEVELOPMENT IN MONTENEGRO

Current progress and opportunities
for cross sectoral action on social
determinants to improve equity in health





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Key messages

- The government of Montenegro has demonstrated high-level policy commitment to and leadership on health equity and sustainable growth. However, current approaches to health, including noncommunicable diseases, do not consider differences in health and its social determinants. While intersectoral action – including for health and development – has been envisaged in policies and strategies, more needs to be done by the health sector, reaching out to other sectors to ensure health concerns (for example, about noncommunicable diseases) are integrated into relevant development and growth strategies in Montenegro.
- The country has been affected by the economic crisis, as have other countries in the region. The (uneven) impact of the crisis is likely to have furthered existing inequities in health; for example, through an uneven rise in poverty and unemployment, greater increases in such inequities have been experienced in the north of the country.
- Montenegro has achieved increased coverage in health services and is moving towards universal health care coverage. However, even so, growing disparities in health are leading to various population groups facing increased challenges and barriers to access to health services and medication, including poor people, individuals with disabilities, the ageing population and those living in remote areas. The causes of many barriers to health lie outside the health sector, underlining the need for intersectoral action to put health at the heart of the development agenda.
- Given the context of austerity, health inequities will continue to increase and become a considerable challenge and barrier to the country's overall development, unless health equity is considered explicitly. Increasing equitable health and the well-being of all people should therefore be an explicit aim in Montenegro's sustainable growth and development strategies.
- Governing for better health equity as a public good and as an important resource for sustainable growth and development requires focused action on the underlying determinants of health – including daily living conditions, and factors such as employment, income, education and housing. These lie outside the field of health, and are determined by the wider macro-level context, the health and social welfare systems, and the wider society, accumulating over the life-course to produce positive and negative health effects.
- These upstream factors are the causes of the causes that are responsible for the growing challenge of noncommunicable disease in Montenegro, and they underlie the differences in the burden of noncommunicable diseases. Investment in health and development in Montenegro requires an increased focus on prevention of noncommunicable diseases. In particular, emphasis should be placed on prevention methods that consider the underlying determinants and aim to address these upstream factors that originate from outside the health system, along with interventions and policies that are equity sensitive; that is, taking into account the differences in burden of disease and risk among different sections of the population.
- Increasing capacity in public health will be essential to Montenegro's ability to address this challenge of health inequities (including in noncommunicable diseases). This includes developing and harnessing skills to analyse other sectoral policies that determine health, conducting equity impact assessments and analysing required benefits and incentives. It also extends to exchanges and networking with other countries, including through the WHO small countries initiative.
- A whole-of-government approach is required to address these challenges, along with intersectoral action whereby health is recognized as a key input to sustainable development, and as a measure of progress towards inclusive and sustained growth.
- This needs to be supported by inclusive and strengthened governance structures, which enable such interactive collaboration with health equity as a whole-of-society goal. This report recommends the creation of an intersectoral coordination committee to ensure health concerns inform the work carried out by all sectors.
- Governing for inclusive growth allows governments to address the key determinants of quality of life, health and health inequities in a more systematic way. Equally importantly, it enables governments to consider the benefits of improved population health in the attainment of other societal goals and priorities, such as poverty reduction, sustainable development, social inclusion, community resilience and well-being.

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Acronyms and abbreviations

CVD	cardiovascular disease
EU	European Union
EU12	12 Member States of the EU prior to 2004
FDI	foreign direct investment
GDP	gross domestic product
IDP	internally displaced people
IPA	Instrument for Pre-accession Assistance
MDG(s)	Millennium Development Goal(s)
MICS	Multiple Indicator Cluster Survey
NCD	noncommunicable disease
NGO	nongovernmental organization
OOP	out-of-pocket (payment/expenditure)
SDH	social determinants of health
SEE 2020	South East Europe 2020 (strategy)
SEEHN	South-eastern European Health Network
SME	small and medium enterprises
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1. Introduction

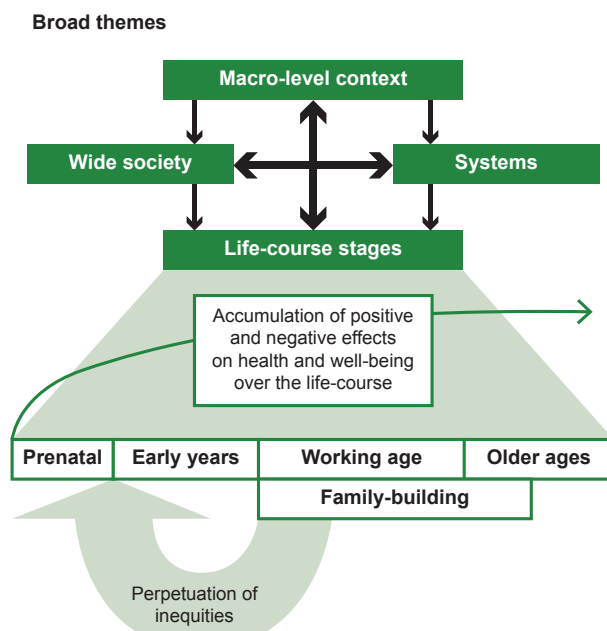
1.1. Governing for health equity

Increasing the equitable health and well-being of all people is an essential part of Montenegro's sustainable growth and development, and critical to realizing its human capital. Governing for better health equity as a public good and as an important resource for sustainable growth and development requires focused action on the underlying determinants of health – daily living conditions and factors such as employment, income, education and housing.

This means levelling up healthy life-years across the whole population, with a focus on producing the most rapid improvements in those individuals with the lowest health and social experiences. This progressive, universalist approach is best achieved through an integrated policy response across sectors and portfolio boundaries, and by demonstrating how health is a shared societal goal across all areas of government.

Achieving the highest attainable standard of health and well-being requires attention to social, economic and environmental factors – the determinants of health – which are often responsible for differences in health between different sections of the population. Many of these, such as education, housing, transport and others, lie outside the field of health and are determined by the wider macro-level context, the health and social welfare systems, and wider society, and these effects accumulate over the life-course (see Fig. 1.1). Therefore, work needs to be carried out cross-sectorally for health to become a whole-of-government and a whole-of-society aim.

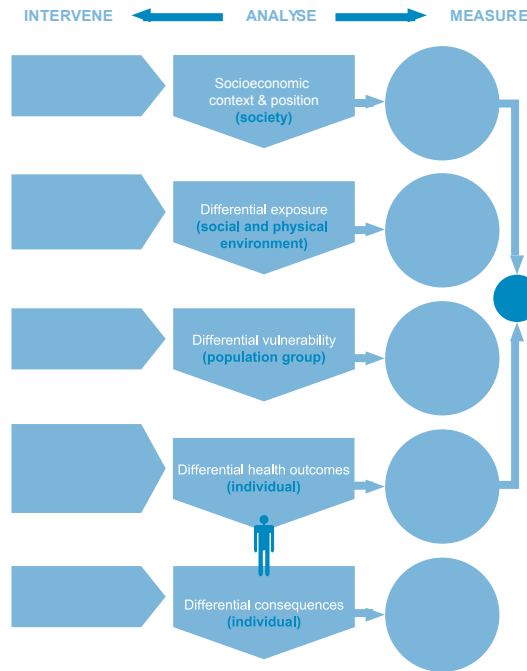
Fig. 1.1. Framework for SDH



Source: UCL Institute of Health Equity, 2013 (reprinted 2014) (1).

Understanding how social and economic differences shape the health of an individual, both in terms of susceptibility to ill health and in the consequences of disease and ill health, in turn helps to identify entry points for action on inequities. Fig. 1.2 and Fig. 1.3 provide a framework to map how social and economic factors impact on health, together with the entry points (interventions, policies and services) to address the equity health impact.

Fig. 1.2. Priority public health conditions analytical framework



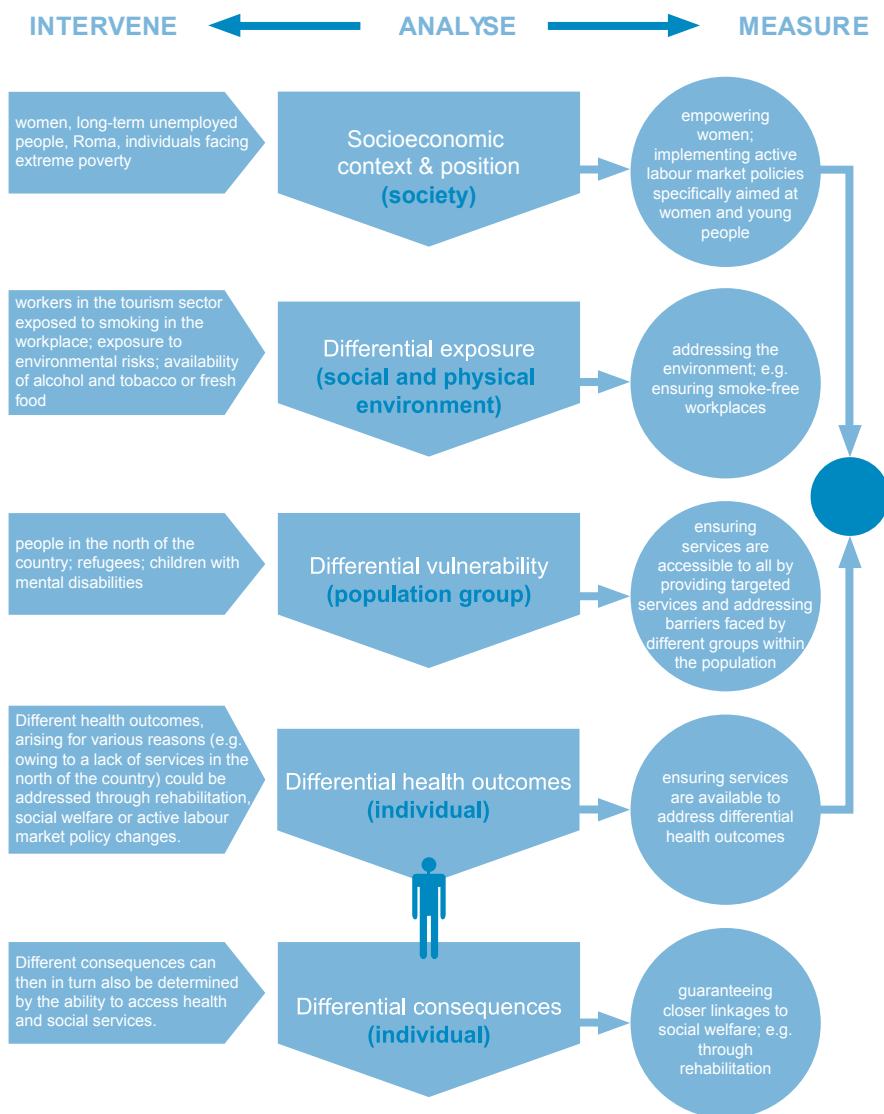
Source: Blas & Kurup, 2010 (2).

This report describes the findings of an appraisal mission on the governance arrangements and approach to addressing the issues of health equity and the social determinants of health (SDH) in Montenegro. The mission was undertaken by a team of policy experts working under the auspices of WHO, between the months of April and August 2013 (see Annex 1 for a list of the team members). It is worth noting that some of the findings reported reflect observations shared with the appraisal team by the individuals interviewed (specifically regarding policy implementation) and may in some places highlight a gap between policy and implementation. For example, where health care users or organizations describe a gap in services for specific sections of the population, this may not relate to a lack of relevant policy but rather underline a shortfall in terms of implementation.

Governing for health and equity was articulated in the European policy for health (known as Health 2020) as “the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health as integral to well-being through both a whole-of-government and a whole-of-society approach” (3).

The Government of Montenegro requested that WHO undertake this appraisal. The organizations previously shown leadership in addressing these issues and has committed to making further progress in improving health in Montenegro. This includes, specifically: reducing avoidable differences in the opportunity to be healthy; and systematically addressing risks and consequences of poor health across the whole population. To achieve these improvements, the need has been recognized to do some things differently; for example: to revisit and adapt existing policies and approaches to improve health; and, in some areas, to undertake new endeavours and actions that will produce desired improvements in health by reducing inequities.

Fig. 1.3 Priority public health conditions analytical framework, adapted for Montenegro



1.2. Scope, purpose and aims of the appraisal mission

The governance for health equity appraisal process supports a country to identify and agree options on how to strengthen its institutional capacity and increase policy focus on the SDH and the social determinants of health equity. It has been developed through a decade of experience by the WHO European Office for Investment for Health and Development (Venice, Italy) in supporting countries to address SDH for greater equity in health and more equitable growth. In addition to the frameworks set out in Fig. 1.1 and Fig. 1.2 (and the adapted version for Montenegro in Fig. 1.3), the appraisal process explores a country's governance through the eight domains described in set out in Annex 2 and described in detail in Brown et al.'s 2013 report on governance for health equity in the WHO European Region (4; 47–50).

The approach of the appraisal process relies on deliberative dialogue with a wide range of stakeholders within the health sector, across government and including community and nongovernmental organizations (NGOs). Engaging with the private sector (profit-making and non-profit-making organizations) is actively pursued, along with the research and academic community, and international donors and partners. Tools to support the dialogue include an external review of existing policies, sharing of European and global evidence and promising practices, inquiry-based meetings and small group interviews.

As a partner country in WHO's Health 2020 policy framework and strategy, Montenegro is committed to working with WHO and other countries to advance improvements in health and reduce inequities, nationally and across the WHO European Region. The Government of Montenegro has indicated in particular its intention to establish a regional centre for NCDs, to support work with other Balkan states in south-eastern Europe. WHO and the country's government agreed that the appraisal mission would be a key activity in this context.

The overarching aim of the mission was to explore current progress, challenges and opportunities relating to strengthening institutional capacity across sectors and society in order to address the social and economic factors of health and health inequities, with a view to contributing more to fair and sustainable development in Montenegro.

More specific aims were identified, such as to:

- review current approaches to improving population health and health equity and how these contribute to achieving Montenegro's national and global commitments to inclusive growth and development (5–8)¹ (noncommunicable diseases (NCDs) were agreed as a main entry point for the review as they constitute the largest avoidable disease burden in Montenegro and are a major factor to be addressed in terms of how health contributes to achieving inclusive growth);
- identify opportunities and constraints to scale up existing policies and activities with a focus on increasing equity and accountability for health within the health sector and across government and society;

1 Alongside the approaches outlined in the published literature (5–8), an unpublished United Nations Development Programme (UNDP) Montenegro concept note/project working document on vulnerabilities in the northern region of Montenegro informed the mission.

- propose policy and good governance options for reducing inequities in health as part of a cross-sectoral approach.

A preparatory mission was carried out on 22–25 April 2013. Exploratory discussions took place with 18 representatives from six ministries or departments and with 24 representatives working within the health sector. These discussions were designed to raise awareness of the SDH and to explore current relationships and coordinated efforts between health and other sectors to reduce social inequities, implement inclusive growth measures and improve population-level health.

During May and June 2013, a so-called desk review of relevant national strategies, laws and secondary literature was undertaken (see Annex 3 for details), which (a) synthesized current approaches to improve population health and health equity, and (b) reviewed commitments to inclusive growth and development. The desk-based research helped to identify entry points and opportunities for addressing socially determined inequities across sectors and was used to inform more specific issues for exploration during the in-country mission, which took place from 30 June to 5 July 2013.

2. Country context and situation analysis

Chapter 1 set out the overall purpose of the appraisal mission, and described its focus on (a) addressing health inequity and NCDs in particular, and (b) doing so in a way that supports inclusive growth and development. It is important to set the mission in context, so this chapter describes some of the key features that have an impact on Montenegro's policies and the likelihood of successful implementation for its people and institutions. The information presented is based on the aforementioned desk review of government documents, websites and other research papers (see Annex 3 for details).

2.1. Political, demographic and economic profile

Montenegro achieved its independence from the former state union of Serbia and Montenegro through a peaceful and democratic referendum in May 2006. The country is located in the south-western Balkans on the Adriatic coast, it covers an area of just under 14 000 km² and has a population of 625 266 people (9). It is a newly sovereign state, and a relatively small country. There are, however, considerable variations in climate and geology, and in the social and economic conditions of the population, particularly between the north and south.

Like other countries in south-eastern Europe, Montenegro has a declining birth rate, estimated as being -0.56%, and as a result is facing the challenge of an ageing population. A total of 61% of the population live in urban areas.

Montenegro operates as a free market economy. There is considerable reliance on tourism as a source of income and as a priority for development.

The Government of Montenegro is the executive branch of the state authority, and is accountable to Parliament. It is headed by a Prime Minister and four deputy prime ministers (two of whom are each responsible for a specific portfolio: political system, foreign and interior policy; and economic policy and finance). There are 16 other ministers, covering the following portfolios: justice; foreign affairs and European integration; the interior; defence; finance; education; culture; economy; transport and maritime affairs; agriculture and rural development; sustainable development and tourism; health; human and minority rights; information society and telecommunications; labour and social welfare; and science. In addition a number of agencies and departmental bodies exist, either within the ministries or established separately.

At regional level there are 21 municipalities (and one has been added since the appraisal was conducted). The municipalities have a number of functions, managed independently of national government, working together on joint decision-making with local administrative/management (and other, elective) bodies, including municipal councils/authorities and the country's Union of Municipalities.

2.1.1. The impact of the economic crisis

During the years preceding the economic crisis of 2008, Montenegro registered a solid economic performance through high gross domestic product (GDP) growth and foreign direct investment (FDI), a budget surplus during 2006–2008, and a reduction of foreign debt. The poverty rate decreased from 11.3% in 2006 to 4.9% in 2008 (10). The crisis hit Montenegro in 2009, whereby growth plummeted from 7% in 2008 to -5.7% the following year (11). Output recovered modestly in 2010 and 2011; however, 2012 brought about another economic recession.

The crisis has not affected all regions of Montenegro evenly. The central region has been least affected in terms of unemployment and poverty. The north has seen the largest increase in unemployment, as well as in nominal values in poverty levels (see Table 2.1).

Table 2.1. Regional poverty rates in Montenegro, 2008 and 2011

Poverty rate	2008 (%)	2011 (%)	% increase
Total	4.9	9.3	90
North	8.9	17.5	97
Centre	3.5	6.3	80
South	2.7	6.4	137

Source: Statistical Office of Montenegro, 2012 (10).

Official unemployment rates have increased overall, but it is important to note the variations between geographic regions (see Table 2.2). Official figures reported both in the Human Development Report (12) and the Statistical Office of Montenegro's Labour Force Survey (13, 14) refer to a high percentage of people that are inactive: more than 50% of all women in Montenegro. The National Strategy of Sustainable Development of Montenegro (15) notes the much higher unemployment rates in the north of the country amongst women and young people. Just half of the working-age population are economically active (49.7%), with the northern region having the poorest outcome at 42%. For women, these ratios stand at 43% (all women) and 35% (in the north).

Table 2.2. Regional unemployment rates in Montenegro, 2008 and 2012

Unemployment rate	2008 (%)	2012 (%)	% increase
Total	16.8	19.6	17
North	24.6	36.7	49
Centre	16.3	15.6	-4
South	8.6	10.8	26

Source: Statistical Office of Montenegro, 2013 (14).

The WHO Regional Office for Europe's *Review of social determinants and the health divide in the WHO European Region (1)* reported unemployment rates of 45% for 18–25 year olds. In addition, long-term unemployment remains a challenge. In 2012, 81% of the unemployed population had been without a job for more than a year, while 68% had not been working for more than two years. Evidence from the review suggests that long periods of unemployment have a long-term, cumulative effect on health over a person's life-course (see Fig. 1.1). This suggests that, in addition to the immediate impact of the crisis on health – such as the reduction in health and social welfare spending – there is potential for longer term negative effects on health and health equity, unless these are addressed as a matter of priority.

Between 2008 and 2012, public expenditures decreased by 8% of GDP (from 51.5% to 43.2%) (16). Measures to achieve this included a freeze in public sector wages, restructuring of human resources including redistribution of workload, and reductions in operational and capital expenditures (17). In 2012 the country's austerity package envisaged the introduction of a temporary crisis taxation of 3%, to be levied on all gross salaries above €416 in 2013. A freezing of the level of pensions and a higher level of value-added tax were also envisaged (18, 19).

In economic terms, automatic stabilizers came into effect, as illustrated by the increase between the years 2007 and 2011 in the social welfare expenditure within the budget, by almost three quarters. Social security transfers also increased by almost 16% between 2009 and 2012 (including pensions, disability and unemployment insurance, and so on) (16).

Budget deficit targets have been repeatedly missed and there is a lot of pressure to reduce the budget deficit to under 3% of GDP and to deal with the increasing public debt.

Table 2.3 shows the country's major priority policy areas and the trend in expenditures from 2007 to 2011. Of the key expenditure areas – social protection – has increased considerably, while health and education have decreased.

Despite the increase in social protection spending overall, it is likely that this rise is due to an increased number in people requiring access to these services, rather than an actual increase in social protection measures. At the time of the appraisal, several policy-makers recounted that the overall level of the package and payments provided for social protection was being reduced as part of austerity measures.

Table 2.3. Development direction policy areas

	Year					% difference from 2008 to 2011
	2007	2008	2009	2010	2011	
	€ (million)					
Business environment						
SME	4 282	8 319	6 546	12 929	7 862	-5.5

	Year					
	2007	2008	2009	2010	2011	
	€ (million)					% difference from 2008 to 2011
Competitiveness (FDI, privatization)	869	1 869	1 544	1 896	1 611	-13.8
Science						
Higher education						
Information and communication technology	22 410	30 355	28 517	27 480	24 440	-19.5
Tourism	13 104	17 655	20 462	23 342	19 851	12.4
Agriculture, rural development and fishery						
Forestry	15 937	25 595	23 885	23 081	23 580	-7.9
Energy	50	51	131	1 138	959	1780.4
Environment (including sustainable development)	4 196	14 010	32 868	10 245	8 996	-35.8
Transport	44 781	65 709	49 044	53 584	54 803	-16.6
Housing and construction	4 418	10 547	20 242	7 970	6 993	-33.7
Labour market	29 849	69 216	52 863	36 895	30 330	-56.2
Education	97 243	121 096	109 538	114 458	115 671	-4.5
Sport	4 785	5 699	6 714	6 276	8 256	44.9
Social protection	282 877	342 353	421 320	400 441	433 586	26.6
Health	153 365	186 199	182 166	175 137	169 403	-9.0

Note. SME: small and medium enterprises.

Source: Ministry of Finance of Montenegro, 2013 (20).

While the impact of the crisis further accentuates the difference between the northern and southern areas of Montenegro, it is worth noting that this geographic division predates the crisis. In addition, lower rates of employment and economic opportunities have led to increasing migration of people from the north to the south, with younger, more skilled sections of the population leaving an increasingly ageing and unskilled population in the north.

At the end of 2011, the Gini coefficient stood at 25.9, up from 25.3 in 2008, again underlining the inequitable impact of the crisis. In 2011 the European Union (EU) coefficient was 30.7 (10).

2.2. Health in Montenegro

Life expectancy in Montenegro is slightly higher than some neighbouring countries and, as already mentioned, the country also has an ageing population. Consistent with this, and with the trend in other countries within the WHO European Region, Montenegro is facing an increasing burden of NCDs, with 86% of life-years lost due to NCDs and chronic diseases (21). Cardiovascular diseases (CVDs) and cancer account for almost two thirds of all deaths. Rates of CVDs – the leading cause of deaths in 2006 – are especially high (56%), affecting men and women relatively evenly. Cancer is disproportionately affecting men (60% of men affected, as opposed to 40% of women). The draft strategy for the prevention and control of NCDs also concludes that “Montenegro is currently in the group of countries with medium rate of mortality from cerebrovascular diseases.”² It highlights that cerebrovascular disease is more prevalent in the older population, while ischaemic heart disease is responsible for a significant proportion of premature mortality. Data on life expectancy among people aged over 65 years also highlight gender disparity, with life expectancy for men over 65 years old increasing at a level that is higher than the average among the 12 Member States of the EU prior to 2004 (EU12), while life expectancy for women aged over 65 years in Montenegro is below the EU12 average and has not improved over recent years.

In terms of risk factors, the following observations are particularly relevant.

- Figures from 2000 indicate a prevalence of hypertension and potential hypertension of 43.4%. The average tobacco smoking rate was 37% (47% men; 28% women) for adults and around 20% for secondary school-aged youth. Estimates suggest that tobacco use accounts for between 800 and 1000 deaths per year.
- Data for other risk factors are not as well established, and therefore the draft NCD strategy relies on estimates. However, there is little reason to believe that the risks associated with consumption of alcohol, poor diet and low levels of activity are any less prevalent in Montenegro than in other countries in the Region.

Montenegro has achieved very low levels of maternal mortality and infant mortality, and immunization coverage of children is high.

2.2.1. SDH

Considerable inequalities persist in Montenegro; specifically, income inequalities, measured using the Gini coefficient, as well as regional differences in poverty rates, evidenced by the data on the impact of the crisis (discussed in the previous section).

The effects of poverty on health and the extent to which these are socially graded are clearly

2 The strategy was not published but the draft remains an internal reference document for action to tackle NCDs in the country.

evident. Recent data highlighted the extent to which malnutrition in children under 5 years of age resulting in stunting is affected by the economic status of the parents of those children. Table 2.4 shows levels of stunting according to parental wealth in selected countries within south-eastern Europe, highlighting a clear relationship between parental income and levels of child development.

Geographic location aside, the main determinants of poverty identified are the size of the family (with households of more than two children at greater risk) and level of education. It is also worth noting that specific groups face greater poverty and exclusion: these include Roma, Ashkali and Egyptian communities, refugees, long-term unemployed people, pensioners, and people with disabilities (22). Analysis presented in the Millennium Development Goals (MDGs) report shows that, outside of these groups, extreme poverty is at a level under 1%.

Table 2.4. Percentage of children aged under 5 years with chronic stunting by household wealth quintile, 2009

	Income quintile ^a				
	1	2	3	4	5
Albania	31.1	23.1	25.8	18.7	14.6
Belarius	6.0	2.9	2.5	1.4	1.9
Bosnia	15.8	11.0	7.2	10.4	7.6
Georgia	19.9	14.5	13.4	11.8	7.7
Kazakhstan	18.1	16.5	17.0	13.1	10.8
Kyrgyzstan	17.6	19.4	12.7	13.3	11.7
Montenegro	10.9	3.8	6.3	2.7	4.3
Serbia	9.8	7.8	5.0	6.5	5.6
Tajikistan	33.6	30.5	32.2	25.6	21.6
MKD ^b	12.2	8.3	10.7	6.1	5.2
Uzbekistan	16.7	18.4	16.7	14.3	13.3

Notes. ^aThe fifth quintile is the highest. ^bMKD: International Organization for Standardization abbreviation for The former Yugoslav Republic of Macedonia.

Source: Falkingham, Evandrou & Lyons-Amos, 2012 (23), based on data from the United Nations Children's Fund (UNICEF)'s Multiple Indicator Cluster Survey Programme (MICS-3).

Available data on child nutrition further underline the extent to which health is socially determined. Similar to income, maternal education is a strong indicator for risk of malnutrition. The comparative data from the *Review of social determinants and the health divide in the WHO European Region (1)* indicate that children whose mothers did not achieve secondary-level education were at four-fold risk of acute malnutrition compared to children whose mothers had received secondary-level education (7.8% versus 2.0%) (see Table 2.5 for further details).

Equally, the analysis of the same dataset by ethnicity revealed that in Montenegro (as in other countries of the WHO European Region) malnutrition in children aged under 5 years was much higher in children of Roma ethnicity compared to children of other ethnic groups. Examining this data by ethnicity showed among children of Montenegrin ethnicity, 5% experience malnutrition, compared to 3.0% of Serbian children, 6.0% of Albanian children, and 13.3% of Bosnian children. By comparison, the malnutrition rate for Roma children was 17.8%, while 14.4% of children from “other” ethnic groups experience malnutrition (1).

Gender inequalities are referred to in several of the documents reviewed. These include differences in levels of formal employment and payment of women, as well as their participation in political, economic and civic life. The latest Labour Force Survey from 2011 indicates some progress, with a greater percentage of women compared to men undertaking tertiary education (24). However, the 2011 MDG update report by the Government of Montenegro’s Ministry of Sustainable Development and Tourism notes that, realistically, the MDGs and their targets will not be reached in Montenegro (25). One of these targets is a female employment rate of 50% by 2015; this is unlikely to be achieved, since the female employment rate in 2012 was 34.1%. The requirement of a gender quota of 30% for members of parliament and councillors was agreed in 2011 as part of a law adopted on gender equality.

Table 2.5. Percentage of children aged under 5 years with malnutrition, by maternal education, 2009

Level of malnutrition	Chronic malnutrition ^a		Acute malnutrition ^b		Underweight ^c	
	None or primary	Secondary or higher	None or primary	Secondary or higher	None or primary	Secondary or higher
Maternal education level ^d						
Albania	31.4	22.7	12.2	6.3	7.1	7.8
Bosnia	12.2	9.4	3.8	3.8	2.1	1.5
Kazakhstan	19.1	15.3	4.1	5.0	6.7	5.1
Montenegro	9.9	4.5	7.8	2.0	7.2	1.2
Serbia	10.5	5.9	5.4	3.6	4.3	1.1
Tajikistan	31.6	28.7	7.7	8.2	17.7	17.9
MKD ^e	10.7	5.4	3.4	1.9	3.3	1.1

Notes. ^aChronic malnutrition (height for age): percentage of children severely or moderately stunted. ^bAcute malnutrition (weight for height): percentage of children severely or moderately wasted. ^cUnderweight (weight for age): percentage of children severely or moderately underweight for their age. ^dThe numbers of children whose mothers have less than secondary education were negligible in Belarus, Georgia, Kyrgyzstan and Uzbekistan, so have been excluded here. ^eMKD: International Organization for Standardization abbreviation for The former Yugoslav Republic of Macedonia.

Source: Falkingham, Evandrou & Lyons-Amos, 2012 (23), based on data from UNICEF’s MICS Programme (MICS-3).

While these observed inequities have not been explicitly cross-referenced with health status in Montenegro, equally there is little evidence to suggest that the correlations between these determinants and health – that have been identified in major international studies – would somehow not apply in Montenegro. The available data from comparative studies within the WHO European Region underline the extent to which health inequities exist.

2.3. Current policy approaches to health equity, equitable growth and SDH

The Government of Montenegro has a wide range of policies of direct relevance to this governance appraisal. Two documents of specific importance discussed here are:

- the draft strategy for prevention and control of chronic NCDs (the draft NCD strategy);
- the National Strategy of Sustainable Development of Montenegro (15).

2.3.1. The NCD strategy

The government commitment to addressing the growing burden of NCDs is clearly evident within the country's development plans and strategy documents, and is specifically outlined in the NCD strategy, which covers the period up to 2020.

While the NCD strategy in particular refers to specific determinants of health, current approaches reviewed in the literature seem to have two key characteristics, as described here.

- Even where behaviour and determinants of addressing NCDs are considered, the health system or health services are seen as the critical entry point. The need to work with other sectors on a conceptual level is acknowledged – notably in the NCD strategy – and reference is made to the upstream factors, but this is less evident in action planning. Responsibility is firmly placed on health services with a call for their greater attention to and focus on behaviours, lifestyles and determinants. This includes calls for funding of public health and prevention activities within the health system.
- There is a marked focus on changing the behaviour of individuals, through interventions targeting individuals, or focused on the immediate determinants of individual behaviour or risk. Less attention is paid to the more complex societal changes required. An example here would be a focus on tobacco control through smoking cessation counselling within the health services, rather than on taxation or implementation of a smoking ban.

The NCD strategy is conceived as a high-level national strategy, with a related action plan. The documents do not provide details about targets, human resources or financing measures that would enable greater accountability in terms of measuring implementation. Reference is made to the intention to establish specific expert working groups to draw up detailed programme and action plans relating to the key areas of the strategy.

From the general action areas that are outlined in the NCD strategy, the following points are worth noting.

- There is a strong commitment to whole-of-government action on NCDs, in terms of positioning

prevention and control of NCD as the priority areas of importance for all sectors of the society aimed at strengthening the productivity, social cohesion and economic progress of the entire society. The NCD strategy states that government regulation will be used to establish responsibility across government for NCD prevention and control.

- Regulation features strongly as the primary strategy for enacting multisectoral actions for NCD prevention. A comprehensive list is provided, with specific examples of areas in which legislation could assist with NCD prevention, including actions most likely to have an impact on reducing population inequities in NCDs (for example, tobacco and alcohol taxation, food in schools). Nutrition interventions feature strongly in the list of actions described, including marketing restrictions, promoting production of healthy food, voluntary industry product reformulation, and food labelling.
- In terms of actions to address the more upstream SDH, improving working conditions and improving the quality of the built environment are both stated as areas in which regulation could be used as a strategy.
- The intention to use the media to raise awareness of the link between SDH and NCDs is mentioned, as well as the intention to launch health education campaigns in mainstream education.
- Improving universal access to primary health care is also mentioned as a key strategy.

Equity does not feature as an explicit commitment in the NCD strategy. The strategy does adopt the five principles of the WHO European Strategy for the Prevention and Control of Noncommunicable Diseases as guiding principles. These include health for all, addressing inequities and equity, intersectoral collaboration and action on determinants; however, there is no discussion about what these general principles might mean in the context of Montenegro.

All data on Montenegro's burden of NCDs (deaths and morbidity) quoted in the strategy refer to total population data, with breakdown by sex for some indicators, but no other equity stratifiers. Similarly, in the discussion of the prevalence of key NCD risk factors (smoking, alcohol, physical inactivity, obesity) there is no reference to any socioeconomic differences in Montenegro, other than describing risk factor prevalence separately for men and women. The strategy notes the need to strengthen Montenegro's data collection and health information system for NCDs, and to monitor NCD prevalence, mortality and key NCD risk factors. It also states that it is critical to collect more and higher quality information about key socioeconomic determinants.

From 2014 Montenegro will implement a new health statistics mechanism, which is intended to enable better monitoring of morbidity and mortality, including links to individual characteristics. Such data will enable better understanding of inequities within the burden of NCDs and other diseases in Montenegro and will enable policy responses to be guided accordingly.

At the time the appraisal mission was carried out, no evaluation or status report on the NCD strategy was available.

2.3.2. Growth and development

Other national policies and strategies include a strong commitment to inclusive growth and development. Montenegro's National Strategy of Sustainable Development states that the

country's vision for sustainable development includes: “[a] social vision, which encompasses poverty reduction and protection of the worst off population groups, as well as ensuring a more equitable share of benefits from economic development across all segments of society” (15; p. 20).

This places equality and inclusive growth at the heart of the development agenda. Two aspects are seen as critical to sustainable growth: first, education, which is seen as a strong predictor of inclusion. Of those with primary education, only 21% (that is, one in five individuals) are active in the labour market (working or actively seeking employment) and the unemployment rate for those with primary-level education is 35.2%. On the other hand, 75% of those with tertiary-level education participate in the labour market and the unemployment rate of those with tertiary education is 10.4% (26). The second factor that is crucial to sustainable growth is the environment, including climate change. The latter is of particular concern, as sustainable tourism is a central part of the country's economic development strategy. Documents such as the National Strategy of Sustainable Development of Montenegro (15), a report on its status, and the Human Development report place great importance on education and knowledge. Education and lifelong learning are seen as being key to the economic development in a knowledge-based economy.

In the strategic documents reviewed, the equity focus is explicitly on geographic inequity, especially between the north and the south of the country; gender inequity, in terms of both level of employment and pay; and differences in levels of income. In addition, there is a specific focus on Roma and internally displaced people (IDP), and on people with disabilities, as marginalized groups. Social protection programmes are clearly targeted towards these sections of the population and a number of specific policies exist, aiming to integrate various sections of the population, including those living with disability, IDP, the Roma population, and children at risk. This includes programmes in specific areas of social policy, such as employment, housing and education.

Montenegro's main development aim is further economic growth and development, and the main political process through which the country is hoping to achieve this is EU accession. It is apparent in the policy documents reviewed that Montenegro's strategy for economic growth and development is centred on the country's potential as a tourist destination. The emphasis and a key driver in the government strategies is therefore sustainable growth, focusing on environmental sustainability. In this context, the focus for less-developed, rural areas (currently dominated by agriculture) is to develop a model of so-called agri-tourism, similar to that of other countries in the Mediterranean region.

Policy attention is thus focused on environmental health and climate change, as well as the environmental sustainability of tourism development. While these mention some linkages between the environment and health, explicit links between upstream determinants and health are not explicitly made.

Health is acknowledged as being central to the country's development and the link between an individual's health and their potential to contribute to national development is explicitly made. However, the additional societal gain from greater health equity is not articulated; that is, the benefit from better health for all, for the health of all, beyond an individual's contribution has not (yet) been stated.

3. Key challenges and opportunities in governance for health equity and sustainable growth

This chapter outlines key challenges to health equity encountered by the appraisal team, sets out governance issues which emerged as being particularly pertinent to fostering greater health equity and addressing the SDH, before highlighting specific opportunities for equitable growth and sustainable development; ultimately, to allow Montenegro to realize the potential of its human capital.

3.1. Equity challenges

The rural–urban/north–south divide is a key equity challenge for Montenegro. As indicated in the situation analysis, the geographic divide within the country means that people in the north and in rural areas face multiple aspects of exclusion and vulnerability. There are fewer economic opportunities, higher rates of poverty, greater distance to health centres and fewer available services. These structural factors thereby further compromise an existing poor situation in which an ageing population remains subject to lower quality care in rural, northern areas, while more skilled and younger people migrate to urban areas and to the south. The link between certain determinants – such as poverty and employment – and health is described in the preceding sections, and these structural factors are likely to affect health further in the future. In addition to these inequities in the determinants of health, the appraisal team were told specifically of areas in which differences exist between the north and the south of the country. These related to a lack of clarity around the decentralization of health care, which has formally taken place, but with little understanding at municipal level of the responsibilities that this entails and therefore limited action relating to health has been able to take place. In addition, the health system reform processes were separate from the decentralization process that took place more widely across the administration. Municipal actors in the north of Montenegro reported that there had not been a related shift in resource allocation to mirror the decentralization programme. Second, barriers to health services appeared to a much greater degree in the north, compared to the south. Despite these inequities, which were widely acknowledged, there were no specific targeted interventions to redress these imbalances and reverse the trend. Doing so will require targeted action, including specific actions from within the health sector.

Montenegro has progressively increased the coverage of its health system, as the country moves towards the goal of universal health coverage. However, barriers remain in terms of access to the health system. A health system reform programme is under way, and the findings provided here should be seen against the backdrop of a rapidly changing policy context. While changes may have occurred since this appraisal took place, a variety of stakeholders reported barriers impeding access to services. Some reported unintended negative consequences in Montenegro's work towards universal health care access, suggesting challenges in implementation, rather than the legislative framework. These were more found to be pronounced in the north, and included those listed here.

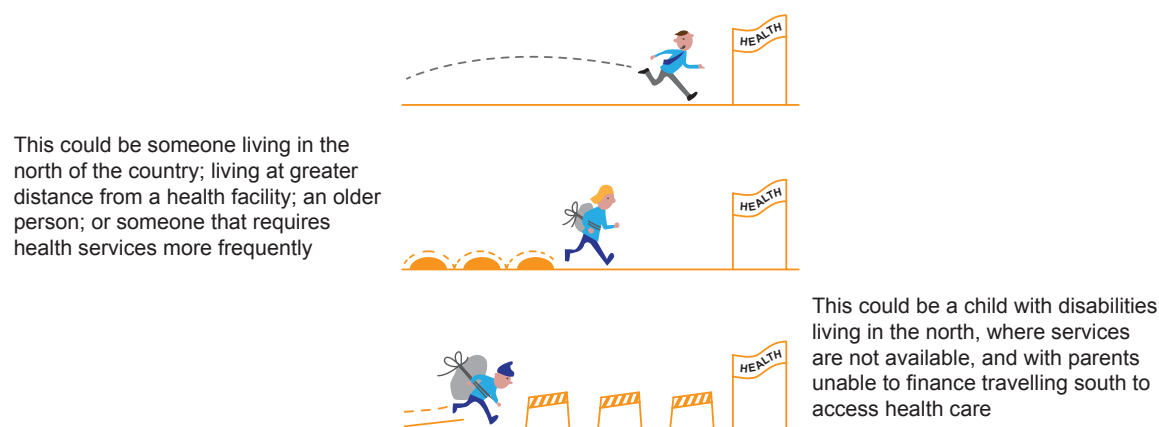
- Increases were observed in out-of-pocket (OOP) payments, or rather a decrease in services covered through the National Health Insurance Fund, resulting in services being out of reach for some individuals. Several organizations working with specific vulnerable groups

mentioned that an increasing number of specialist services entailed OOP payments, which made these prohibitive for most of the population.

- Equally, the social welfare hardship funds in the municipalities that were visited reported that most of the applications they received were to cover cost of medication, and most often for children.
- Organizations working with refugee populations and IDP reported an increase in people accessing emergency services provided by NGOs, since the onset of the economic crisis, reflecting a growing demand for free health care services.
- Limited resources to pay for transport-related costs were reported, and distance to services (mainly in rural areas in the north) was cited as a challenge. Distance to health facilities in rural areas and the associated transport costs were cited as barriers for poor individuals and especially the ageing population. This could even imply that specialist services are even further removed from the population.
- While some specialized services for people with disabilities exist, even more are needed, including dental care for children and services for people with learning disabilities, especially in later life.
- In urban areas, it was reported that the so-called choose your doctor system – as the primary care entry point to the health system – had in many places resulted in patients being unable to access care within a reasonable time frame. Patients reported a lack of available appointments and having to resort to the private sector. This could be a temporary issue, as reforms are being implemented, but is worth noting that this was cited as one of the key challenges.
- Many physicians work in both the public and the private sectors, given the relatively low public sector salaries (reports of between €300 and €700 per month were recorded during the appraisal). The effect of this on public sector provisions is not clear, but a lack of incentives for physicians to treat patients in the public sector was apparent.
- Incidental reports were also collected of challenges resulting from patients being denied access to health services if they did not have a health identification card.

Fig. 3.1 highlights the journey (with differing levels of challenges) that various people face to reach the same goal, in terms of health care and services received.

Fig. 3.1. Barriers to health in Montenegro



Source: adapted from Government of Norway, 2007 (27).

The challenges reported in Montenegro are not uncommon in terms of the context of implementation of ongoing reform. They serve as an example to highlight need for greater analysis, ongoing learning and capacity building. Specific actions should include those listed here.

- To ensure access, services should be based on need, including the needs of those facing the greatest marginalization and exclusion. Without an explicit equity focus, services are not accessible to all. An equity focus includes the need for continued equity-sensitive monitoring of access to health services and of outcomes, to understand better how health is determined and shaped by factors outside of health, and to understand where barriers may emerge.
- Most importantly, it was clearly evident that these challenges lay in the implementation, rather than the policies in Montenegro. There was no clear mechanism through which these user experiences could inform continuous policy development. In this context, there is a need to focus health systems performance to deliver equitable outcomes, not only to concentrate on equity in access. Again, regular use of monitoring tools, equity assessments of reforms and analysis of the changing context are required.
- Using health systems access as an example highlights the challenges faced in implementation and the need to strengthen and build new public health capacity that will enable this type of equity-sensitive monitoring and analysis of policies.

Focus on prevention outside the health sector was found to be limited, in terms of addressing inequities in health, especially in NCDs. While there is some awareness within the health sector of the growing burden of NCDs, the focus of prevention was limited to health services interventions aimed at behaviours, rather than the underlying determinants of behaviour, including education, work and working conditions, poverty and housing. There is significant scope to extend public health action and capacity at national and local levels, building on the steps already taken and the work under way to strengthen public health capacity.

People with disabilities face great challenges through limited service provision and lack of service integration. In the various municipalities visited, many actors reported pockets of excellent service provision, including in social welfare centres and NGOs. Yet, across these municipalities, implementation varied widely and a lack of integration and collaboration between services was observed, leaving people with disabilities vulnerable and at risk of not receiving the care they required. For some services and specialist care, patient co-payments were required, or travel was necessary to receive certain services, to be initially classified as disabled and to receive reimbursement, or even to be granted access to services. While provisions exist within the legal framework, individual challenges in implementation were described, again highlighting the need for building capacity at all levels of governance.

The overall impression gained was that, while individuals were carrying out good work, the systems and structures were not in place to ensure that all people with disabilities were able to receive the care they need. This seemed at least in part to be owing to a disconnect between different government departments, including social welfare and health, and between various levels (such as national level and municipality level), which hinders implementation of services. At municipal level, lines of responsibility and accountability did not seem to be clearly established.

Gender inequities, including in the employment sector, in level of pay and in women's political participation, was repeatedly highlighted and acknowledged as a concern, insufficiently

addressed or addressed only by tokenism. One way to redress this issue would be through active labour market policies. Montenegro has had great success in its reduction in maternal and child deaths and it seems opportune to build on this through targeted policies aimed at women. Health policies such as the NCD strategy do not currently consider differential impact on men and women, or target these gender groups specifically. This highlights the importance not only of monitoring equity impact but also of considering the differential impact of policy design and policy actions and interventions. The differing trends in life expectancy for women at age 65 compared to men highlight the existing health effects of gender inequities. Their consideration is particularly important given the differences in employment and poverty rates between men and women.

The economic crisis and social welfare is a further equity challenge to be considered.

The economic crisis is having significant effect on (a) social welfare, (b) expenditure on health, and (c) the SDH. Data and analysis presented here highlight the effects on health equity and growth. While the commitment and entitlement to social welfare exists, actors met as part of the appraisal mission repeatedly reported that the absolute levels of welfare payments had been reduced to such an extent that these services were no longer sufficient to address need. Health and health equity need to be central to Montenegro's response to the economic crisis and its overall sustainable development strategy.

3.2. Key challenges and opportunities in governance for health equity and sustainable growth

Implementation is one of the greatest governance challenges encountered; specifically, the implementation of policies and plans, as well as guidance. Montenegro has an impressive array of policies and strategies for sustainable growth. However, implementation and translation of plans and strategies into action appeared to be a challenge, including at local level. The appraisal team used NCDs as a tracer issue in discussions to explore governance issues relating to health equity and SDH, and their results highlighted that knowledge of the NCD strategy at local level and among delivery institutions was low. The strategy indicated an intention to set up structures in support of its implementation. These included a National Office for Prevention and Control of NCDs, an intra-sectoral commission at government level, and specific expert commissions for the areas covered by the strategy. The appraisal team did not find these mechanisms to exist in practice, and only limited infrastructure was in place to plan, oversee and coordinate the implementation of the strategy. Challenges in implementation related specifically to a lack of clear mechanisms, accountability and capacity, especially at municipal level. Each of these areas offer opportunity for immediate action and are discussed in further detail in the remainder of this chapter.

Lack of clarity in roles and responsibilities at municipal level are a problem for the Montenegrin health system, including in terms of the collaboration between sectors for equitable and sustainable growth (only one of which is the health sector). Reference was made by several different actors to the policy on decentralization; the extent to which this policy had been fully implemented and was working remained unclear to the appraisal team. There was a lack of clear responsibility for intersectoral policy among municipal-level actors. How bridges are built between the health system and municipal actors – and among municipal actors themselves, such as welfare

centres and education – remained ambiguous. Governance between levels, including clear lines of responsibility and defined processes of implementation from national to municipal level, were also unclear. Limited collaboration and interaction were reported between sectors at municipal level and mechanisms for collaboration between municipalities and the health sector were not always clearly established. This is a concern from the perspective of addressing inequities, which require local responses and engagement in identifying solutions that need in turn to be supported and facilitated by national structures and instruments (4). The clarification and strengthening of mechanisms at this level will be essential to enable any policy action.

Capacity and incentives were found to be lacking. Limited capacity was cited as a challenge to all governance functions; foremost, implementation at local level. Yet, the appraisal team felt that this lack permeated all aspects of governance. Leadership and implementation need to be clearly incentivized at all levels, including through training and a review of public health functions, in order to establish requirements for building human resource capacity. The health care reform provides an opportunity in this respect, to identify human resource needs and introduce strategies which will align systems, individual incentives, and career development with health equity goals.

Health intelligence is an issue that merits attention. At the time of the appraisal mission, two surveys of health status based on gender and age status had been conducted. However, it was not immediately evident whether or not the provision of health care services (or indeed other sectoral policies) was based on an analysis of needs, including the wish to redress inequities. For example, NCD programmes did not consider different vulnerabilities or exposure to risk factors within the different sections of the population. Similarly, funding allocations were not found to be made on the basis of the burden of disease or health equity. Actors frequently mentioned an apparent mismatch between service needs, staffing, equipment and availability of medicines, and a common observation was that the current planning and resource allocation systems lead to an ad-hoc response in terms of service provision. However, several positive initiatives were also mentioned. In 2012 the Institute of Public Health statistical information system was designed. It was introduced in 2013 as an integral component of the overall health intelligence system and allows for health reporting by gender, age, social and economic determinants. However reporting challenges still persist with regard to disaggregated data for the Primary Health Care and hospital health care providers'. These challenges relate to reflect sub optimal practices in data entry. Further trainings and development/upgrade of the system is required. The availability of better data in future provides an opportunity for planning that is proportionate and sensitive to needs in health and other sectors that impact on health. This will go a long way towards addressing the barriers to access to health services already mentioned. Cross-referencing health status and social and economic factors will be essential to addressing health inequities and for sustainable growth, including in the prevention of NCDs. Montenegro participates in the South East Europe (SEE) 2020 growth strategy (8), which references health activities as an indicator for inclusive growth; for this purpose (among others), health data are urgently needed, differentiated by social and economic status. This will enable important relationships to be built between health and other sectors supporting inclusive growth, such as education, employment, agriculture and rural development.

Policy coherence requires a whole-of-government and whole-of-society approach to health equity and sustainable growth. The actions or impacts of other sectors, including

on the determinants of health, are currently only considered to a limited extent. Where other sectors have considered impact on health, this seems to have been within the confines of the specific sector. For example, within the agricultural sector, health is considered from a technical, phyto-sanitary perspective and in terms of health insurance coverage of a section of agricultural labourers who are not otherwise insured. This is in part because health issues are currently predominantly understood and conceptualized as medical interventions and policies to be implemented within the health system. For example, implementation of the NCD strategy was considered only within the health sector and mainly focused on health systems interventions, such as smoking cessation counselling by doctors to patients in primary care settings. Wider aspects of co-production between the environment, agriculture, nutrition and health remain to be explored. Greater emphasis on and better collaboration between sectors in Montenegro could provide some of the greatest opportunities for health's contribution to equitable growth and sustainable development.

The appraisal team also heard reports of successful examples that Montenegro can develop when further building momentum for a whole-of-government approach to health. These make the connection between NCDs and the wider determinants of health. First, an initiative was undertaken to address salt content in food, involving successful collaboration with food producers. Second, the education sector has been working to improve the health and nutritional status of children through health education. It has also worked over several years to improve integration of children with disabilities within the education sector. In some cases, activities outside of the health sector were clearly contributing to greater health equity, such as the programmes on nutrition in schools, but these were (a) not articulated explicitly, and/or (b) not harmonized with the overall policy frameworks.

Real opportunities exist to articulate further the contribution (including economic) of health to other sectors, as well as to highlight the health effects of other sectors. The appraisal team heard a great deal about the willingness and interest of other sectors to engage with health, which indicates great opportunity. Collaboration with tourism, agriculture and the environment seem to be particularly salient in their potential for co-production with health, given their overall importance to the country, and the success of initiatives such as agri-tourism in other Adriatic countries, which are particularly relevant and helpful in addressing the determinants of NCDs and inequities. New instruments and public health skills are needed to better focus policy analysis and to generate and test policy options for interventions with other sectors. Equity-focused health impact assessments and cross-sectoral budgeting are additional policy-making tools that may be of particular value in this context.

Very little evidence was found of civic or service user engagement; such practices were not found to be commonplace and had not been formally adopted by either national government or the municipalities. The nongovernmental, third sector agencies met with by the appraisal team had – almost by definition – a closer relationship with their client populations than any level of government. That said, these organizations felt disconnected from governmental departments and agencies. A compelling case exists for introducing a more structured approach to engaging civil society in general (and user groups in particular) in policy decisions. Examples from many countries highlight the importance of and potential success in engaging user groups, including in policy-making and the provision of services, and in mitigating the impact of the economic crisis. Introducing user engagement measures will also lead to greater accountability.

4. Conclusions and options for action

Despite real and strong political commitment by the Government of Montenegro and various sectors, health equity, the SDH and the contribution of health to sustainable growth and development are currently not explicitly considered within policies and development approaches in the country. This limits its potential for inclusive growth and realization of human capital.

Given the (external and internal) context of the economic crisis and financial constraints, as well as the capacity-related challenges experienced, immediate action on health inequities is required. The incidental evidence from this appraisal suggests that health inequities are growing in Montenegro. Given the budget decisions and current policy direction, these will continue to grow and become a greater challenge to the overall human and economic development of the country.

The Government of Montenegro has already recognized and taken some initial steps in highlighting its policy commitment and leadership, by setting up a new centre to tackle NCDs. Montenegro also is a partner country in the implementation of Health 2020, the European health policy framework which has at its centre the aims to address inequities in health and focus on governance. This provides a window of opportunity for making the whole-of-government and whole-of-society approach to inequities a reality. The key to this will be to operationalize and translate the policy commitment into strategies and policies which are then implemented.

Providing the same basic service package for the entire population will not be enough to stop and reverse the trend in health inequalities; it will require specific action to address them as a whole-of-government and a whole-of-society priority. Cross-sectoral action and the governance arrangements will be critical to achieving this, including the health sector reaching out to other sectors, monitoring health and equity impact, and positioning health as a force for development and growth within Montenegro's plans.

The country has the opportunity to redress inequity and tackle and prevent the rise in NCDs through increased, equity-sensitive prevention measures. The drafting of the new NCD strategy provides a platform for operationalizing this agenda.

To address these challenges, further strengthening of public health capacity will be required, including through support by external partners, and working in partnership with other countries through shared platforms and networks, along with ensuring adequate national resources for public health.

An essential part of this capacity building – defined further in the recommendations that follow – is the need to engage other sectors and to enable participatory governance.

4.1. Health equity for growth and development

4.1.1. Option for action 1. Policy commitment to health equity should be further articulated and integrated, including within the Government's approach to sustainable growth and development

Although the intention to address health equity is visible in policy terms, particularly to those in the public health sector, it is equally clear that awareness of health equity is limited, and the

linkages between other sectors, the SDH, equity and sustainable growth and development are not well developed or understood.

The political commitment demonstrated by Montenegro can be used to improve the health equity situation. The creation of a Regional Health Development Centre on NCDs, the Presidency of the South-eastern European Health Network (SEEHN), and the country's commitment as a partner in implementing Health 2020 all provide opportunities to increase momentum for further action on health equity.

The re-drafting of the sustainable development strategy (currently under way) provides a practical entry point for health equity as a contributor and as a whole-of-government aim. Health equity should be articulated as a specific aim and an indicator of sustainable development. In this context, the Ministry of Health should:

- a)** act as an advocate for health and equity with other sectors, through continued engagement in policy planning and implementation of health (and other sector) policies;
- b)** highlight health's contribution to Montenegro's realization of its human capital – this will require specific and new skills, such as policy and economic analysis that can highlight the contribution of health to other sectors and show the impact of other sectors on health;
- c)** analyse and then outline the relationship between health equity and Montenegro's economic strategy (especially the commitment to develop and expand tourism); in particular, the potential of agri-tourism should be explored as a means of addressing economic development and providing different entry points for employment;³
- d)** develop and formalize the Ministry of Health's responsibility for ensuring that other governmental sectors and departments are fully aware of both the costs to the country of health inequity, and the benefits of tackling it;
- e)** ensure greater sensitivity to health equity effects in other sectoral policies, through equity-focused health impact assessment for new policy initiatives;
- f)** ensure that ongoing health care reform considers equity impacts, including proactively addressing barriers to services and ensuring specific services exist for vulnerable people
- g)** increase focus on and strengthen prevention activities (including outside the health system), which address health inequities through action on the SDH.

The new strategy for NCDs provides further opportunity to put these suggestions into action, providing an equity focus throughout all activities. This includes the need for an action plan to outline implementation, including clear steps for ongoing monitoring and evaluation of implementation and equity impact of the policy. Moreover, the action plan should set out clearly capacity and training requirements to implement an equity-sensitive strategy on NCDs and steps to address this need. This will likely include further strengthening of public health capacity.

All activities outlined should be informed and evaluated in the policy cycle, through regular monitoring of morbidity and mortality rates, differentiated by social status and population group.

3 This would need to be supported by investments in SME development and trade tourism infrastructure, but it would be a good fit with the priorities of the SEE 2020 growth strategy and related funding through the Instrument for Pre-accession Assistance (IPA-II).

4.2. Governance structures and arrangements

4.2.1. Option for action 2. Governance arrangements should be strengthened for greater health equity and sustainable growth in Montenegro, through the creation of a designated policy platform focusing on intersectoral action and health in all policies

This body should have strong political leadership (possibly from the Prime Minister) and ownership and facilitation through the Ministry of Health and membership from all relevant sectors and line ministries. It should: (a) consider health impact and implementation of national (non-health sector) policies and strategies, focusing on their impact on health equity; and (b) work with other sectors in the implementation of strategies and policies primarily aimed at addressing health and well-being but also relying on other sectors; (c) be responsible for overseeing and monitoring the implementation of intersectoral action for health equity; and (d) proactively develop new policy action for health equity as part of sustainable growth and development. The new body itself should be time limited, including outcome and process evaluations after a three-year period in order to assess whether the terms of reference have been fulfilled.

Specific further actions should include those listed here.

- **Implementation** should be strengthened by clarifying roles and responsibilities for health (including outside the health services) at municipal level, and allocation and provision of specific budget lines.
- **Capacity building** should be increased at local and national levels, including professional development and greater incentives for staff retention in health and local administration at municipal level. Leadership capacity should be developed to promote awareness and understanding of health equity, explain the contribution of health to sustainable development and impart how to engage all sectors across government. Participatory planning and models of delivery should be considered, as established in other countries, including Finland, Scotland, Slovenia and Spain.
- **Public health capacity** should be built to monitor and address health equity, focusing less on data collection and more on analysis and use of data to support the generation of policy options and intervention choices. This should include:
 - increasing capacity for economic analysis, using new models to estimate returning investment, through interventions across government that address social determinants and reduce inequities;
 - mandating the Institute of Public Health to conduct equity-based policy assessments, including those of other sectors (which will require building and strengthening capacity to conduct health policy analysis and undertake assessments).
- **Data systems** should be strengthened to monitor status and trends in morbidity and mortality, differentiated by social and economic status. A process should be developed to ensure the data collected inform the provision and development of health services in a way that ensures these address need.
- **Accountability arrangements** should be improved throughout government systems. A strong need exists to ensure expectations placed on departments, services and professionals are better articulated and mechanisms are in place (and adhered to) that ensure regular

reporting on progress. Implementing equity-sensitive targets can be a good incentive instrument to achieve this, which can be reinforced by more supportive mechanisms, such as access to data and training for civil servants and professionals in the health sector and all sectors of public administration.

- **Policy coherence and intersectoral working** should be strengthened, including through intersectoral budgeting and routine equity-focused health impact assessments of all policies. This includes adopting a health equity target as key indicator for the new sustainable development strategy and agreeing common targets for measuring inclusion across all sectors. This performance management approach has been used to good effect in several European countries, including England and Norway.
- **Capacity** should be built for intersectoral working. The Ministry of Health and public health practitioners will need further skill development to engage other sectors in order to effectively action a health equity and sustainable growth strategy. This includes, for example, skills building in health diplomacy, and learning and sharing through networked approaches, such as the WHO Small Countries Project.
- **Greater and routine participation of civic engagement** should be ensured, specifically to engage women, as well as groups facing marginalization and exclusion. In this respect a need exists to expand partnerships at the national and local levels and to introduce new approaches to community engagement and co-production. Such approaches would need to be formal and systematic to ensure engagement of NGOs and communities in policy-making and decision-making. This will also increase health literacy. Interventions and investment which support and stimulate the social economy would also be worth exploring.
- A **realistic development plan** should be produced that determines how Montenegro will develop and sustain its human and institutional capacity to match the policy aspirations it has set.

4.3. Inequity in access to health services

4.3.1. Option for action 3. Current challenges and barriers to access within the health system should be addressed

Addressing challenges and barriers to access should be carried out by:

- building capacity to analyse and address health inequities in access and outcomes of health on an ongoing basis;
- providing targeted services for those in greatest need, on the basis of monitoring data;
- using opportunities presented by the current health system reform process, to develop the necessary capacity development for human resources and to outline the new revised functions of the health sector;
- developing equity-sensitive indicators to monitor the implementation of health system reform and health system processes;
- redressing geographic inequities in access to services, and barriers such as costs relating to transport, through targeted interventions in rural areas and those inhabited by poor

populations;

- ensuring that referral to specialist services (where this entails transport and related costs) does not become a barrier to access, through ongoing monitoring, enabled by consulting and engaging patients and patient advocates (this will ensure, where implementation of policies becomes a challenge, that the problems are identified and addressed);
- ensuring all health facilities are accessible for people with physical disabilities;
- ensuring adequate service provision, including for adults with mental disabilities;
- ring-fencing the health budget and excluding health from further cuts.

4.4. Mechanisms for support and development

Based on the assumption that some, if not all, of these options for action will be accepted, a process should be agreed with the Government of Montenegro that would allow for a series of externally facilitated workshops or events to be held, aiming to help the relevant actors in Montenegro to develop and articulate realistic action plans. These action plans would specify the measures to be taken and the arrangements to be put in place to ensure multisectoral working and effective accountability mechanisms for the country's health (and other, related) systems.

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ЗДРАВООХРАНЕНИЯ ЕВРОПЕЙСКОЕ
РЕГИОНАЛЬНОЕ БЮРО

Medium-term priority 2008–2013 “Strengthening governance for socioeconomic determinants of health to address health inequities”
BCA 2012–2013, priority 1, “European Health Policy, Health 2020”

Republic of Montenegro Governance for Health Equity appraisal

Version 1

Republic of Montenegro, 30 June to 5 July 2013

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Annex 2. Functions and characteristics for governing for equity in health through action on social determinants

Table 5.2. Functions and characteristics important in governing for equity in health through action on social determinants

Domain	Systems characteristic	Exemplified by
1. Political commitment	<ul style="list-style-type: none"> • Clear political commitment 	1.1 Ministerial accountability for governance and delivery of SD/HIa 1.2 Specific political roles for SD/HI at national, regional and local levels 1.3 Cross-government committee for SD and Equity 1.4 Explicit budget for SD/HI management 1.5 Institutional and legislative framework for equity in health and development
2. Intelligence	Evidence and information to: <ol style="list-style-type: none"> a) inform policy and investment decisions b) monitor progress c) hold stakeholders to account. Specifically, in terms of: <ul style="list-style-type: none"> • research and intelligence on SD/HI trends and policies; • the effectiveness of governance and delivery systems; • metrics, i.e. targets/indicators for improvement in health equity and distribution of SD at European, national and local levels 	2.1 SD/HI as a core work and funding stream in research budgets 2.2 SD/HI evidence systematically reviewed and publicly reported 2.3 Dedicated health intelligence and analysis services producing open access data 2.4 Input, output and outcomes data published on SD/HI at local, national and European levels 2.5 Agreed minimum data sets/reporting requirements, on SD, equity and health inequities for national and local levels
3. Accountability structures and systems	<ul style="list-style-type: none"> • Legislative structures and systems enabling intersectoral action on SD and health inequities at European, national and local levels • Statutory “governance boards” capable of holding all stakeholders to account • Legislative structures and systems enabling formation and action of NGOs and civil society groups as partners in action to reduce inequities and monitoring progress 	3.1 A legal framework involving a duty placed on all health and non-health stakeholders, to collaborate and report on SD/HI actions and outcomes 3.2 Community health status/outcome (SD/HI) boards, established with explicit powers to review data/progress of policies, review options/solutions for improving health equity and to hold all stakeholders to account 3.3 Statutory roles with a formal duty to reduce inequities through action on SD, i.e. empowered to publicly mandate action at European, national and local levels (public health minister, chair of parliamentary development committee, prime minister, ombudsman)

Domain	Systems characteristic	Exemplified by
4. Policy coherence across government sectors and levels	<ul style="list-style-type: none"> • A formal and explicit framework setting out stakeholders and policy action for improving equity in health and development (SD) • Framework will be linked to ministerial portfolios and budgets, nationally and locally • Government policy audited through health impact assessment and equity impact assessment • Instruments which institutionalize collaboration across sectors and levels of government 	<p>4.1 Coherence of sectoral actions (national and local) on agreed SD and equity targets</p> <p>4.2 Outcomes, explicitly defined for all government and sectoral spending, nationally and locally</p> <p>4.3 Specific agreements with the private sector (industry/commerce) on their contribution to delivering equity targets</p> <p>4.4 Outcomes assessed and published by all ministries/directorates at all levels of governance</p> <p>4.5 Impact assessments, which should be public domain documents, challengeable through accountability mechanisms</p> <p>4.6. Systems for joint accounting for results in place, including pooled budgets, shared targets, joint review and reporting on progress, integrated intelligence systems</p>
5. Involving local people	<ul style="list-style-type: none"> • Commitment to participation of local people and subnational authorities in policy design and review • Instruments and systems which secure community involvement in solutions • Intelligence and data on health, equity and SD made accessible within the public domain – locally, nationally and across Europe 	<p>5.1 Mechanisms, organizational design and capacity building to enable diversity of voices and perspectives from the community and local level in local decision-making and solutions</p> <p>5.2 Representatives at all levels of SD/ HI governance, who should be equal members alongside professional members of decision-making committees</p> <p>5.3 Tools, instruments and support at the local level to define local problems and solutions, informed by local data</p> <p>5.4 Public reporting of actions and progress to allow access to and debate on results and new challenges, by and with community/third parties</p>
6. Institutional and human resource capacity	<ul style="list-style-type: none"> • Capacity development, including: <ul style="list-style-type: none"> - development of competent and trained SD/HI staff - institutional processes - formal accountability, annual publishing of progress results 	<p>6.1 Programmes supporting political, civic and professional leadership of SD/HI within different institutional and social systems of society, locally, nationally and in Europe</p> <p>6.2 Curriculum modules on equity, health and SD in professional and vocational training, within and outside the health sector</p> <p>6.3 Formal protocols defining institutional arrangements and expectations related to SD/HI in all sectors</p>

Domain	Systems characteristic	Exemplified by
7. Modernized public health	<ul style="list-style-type: none"> Review and modernization of public health training and practice 	7.1 Revised descriptors and competences for national public health practice 7.2 Revised descriptors for domains of public health intervention (with an increased focus on the use of new social media technology, management of social change and citizen mobilization) 7.3 New/updated training for public health professionals
8. Learning and innovation systems	<ul style="list-style-type: none"> Commitment to continuous improvement in understanding of SD, equity and the efficacy of policies and interventions to reduce inequities Commitment to ongoing performance review/improvements in governing for equity in health, through action on SD 	8.1 Stronger learning transfer systems within and between countries, in order to accelerate uptake of promising policies and governance instruments 8.2 Enriched national and European capacity to tackle inequities in health through establishing multi-country innovation programmes, live demonstration sites/exchanges, along with documented and disseminated learning 8.3 Established European registry of policies and governance systems addressing inequities through action on SD

Source: Brown et al., 2013 (4).

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