

## 6. SOCIAL INSURANCE AND PROTECTION

### A. INTRODUCTION

**6.1. The social protection system in BH includes social insurance schemes funded from payroll social security contributions and programs funded from general revenues.** The social insurance systems are set up at the level of the entities, while general revenue funded programs exist at both the entity and the sub-entity levels of government. For both entities, the social insurance system provides pensions (old-age, disability and survivor), unemployment benefits and health insurance. In the RS, the system also provides child allowances and maternity benefits. While the child benefit system in the RS has been assessed as one of best-administered benefit programs in BH, the rationale for funding it from payroll contributions is questionable. The programs funded from general revenues provide benefits for veterans and surviving families, social protection and, in the FBH, child and maternity benefits.

**6.2. Substantial challenges face the entities' systems of social insurance, including health, and the programs financed from general government revenues.** Social insurance schemes suffer from large noncompliance, reflecting pervasive evasion and poor collection, as well as low and falling formal sector employment. With revenues falling short of legal entitlements, social insurance schemes regularly benefit from general revenue transfers. Moreover, social security contribution rates tend to be higher than in most NMS and OECD countries, underpinning the substantial informalization of the economy. Moreover, the contribution rates and bases differ substantially across the entities, a feature that hinders labor mobility.<sup>1</sup> As proposed and demonstrated in this chapter, reducing social security contribution rates and harmonizing the tax base across the entities should be a priority for the governments.

**6.3. Non-insurance social transfers in BH are high by international standards and remain dominated by spending on veterans' benefits.** Only a small fraction of general revenue financed transfers are means-tested with the explicit goal of alleviating poverty. Further, in the FBH, social welfare and child protection remain *ad hoc*, with payments in most of the cantons below legally-mandated benefits and even the latter are too low to help the poorest members of society. Given overall fiscal pressures and fairness concerns, BH should aim to reduce the share of resources allocated toward social transfers, while restructuring the system to ensure that it provides an effective social safety net.

**6.4. The rest of the chapter is organized as follows.** Section B presents the background data of the overall level of social spending. Section C discusses the level of social security contribution rates and makes recommendations for reducing the rates and harmonizing contribution bases. Section D examines the social insurance schemes and section E focuses on general revenue funded programs.

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<sup>1</sup> In the RS, the taxable base includes non-wage benefits and all social insurance contributions are paid by the employer. Overall, contributions amount to 42 percent of net wages, with 24 percent for pensions, 15 percent for health, 1 percent for unemployment and 2 percent for maternity and child benefits. In the FBH, the taxable base excludes non-wage benefits, and contributions are split between employers (11.5 percent of gross wages) and employees (32 percent of gross wages). The total FBH contribution rate is 43.5 percent of gross wages, of which 24 percent is for pensions, 17 percent for health and 2.5 percent for unemployment.

## B. OVERALL SPENDING ON SOCIAL INSURANCE AND PROTECTION

**6.5. BH's overall spending on social protection is somewhat larger relative to GDP than in the faster growing transition countries but is broadly similar to the average in the NMS.** The composition of spending is substantially different from most other European countries, however, the NMS included (Table 6.1). Social insurance outlays are smaller than among the NMS largely on account of lower pension outlays and despite much larger health expenditures. Spending on social welfare and child protection is larger than among the NMS, meanwhile, thanks to larger categorical benefits, mostly for those affected by the war. With due understanding of the exceptional circumstances BH faced as a result of the 1992-95 war, outlays on war veterans' and families of surviving soldiers crowd out outlays on targeted spending to the poor. As a result, means-tested transfers account for a smaller share of social spending than in any other CEE country. While both pensions and veterans' benefits do have a poverty alleviating effect, they are not well targeted to the most vulnerable groups. This is understandable for pension benefits, which aim as much at smoothing income over time as at averting old age poverty. However, the utilization of categorical grants is a poor mechanism to effectively reach the most vulnerable. One in five individuals in BH benefits from some type of social transfer, but social transfers reach only one-quarter of the poor and have a smaller poverty alleviating effect than in Croatia or Bulgaria.

Table 6.1. BH and NMS: Expenditures on Social Protection, 2004 1/  
(In percent of GDP unless indicated otherwise)

	RS	FBH	BH	NMS
Total	14.9	17.7	16.8	17.6
Social Insurance	11.6	13.7	13.0	15.2
Pensions	7.4	6.5	6.8	9.9
Unemployment Protection	0.2	0.7	0.6	0.6
Health	3.9	6.6	5.7	4.7
General revenue programs	3.3	4.0	3.7	2.4
Family, Child and Social Assistance	0.6	1.0	0.9	1.6
Benefits for Refugees and IDPs	0.5	0.3	0.4	0.0
Veterans Benefits	2.1	2.7	2.5	0.0
Other	0.0	0.0	0.0	0.8
Social Protection Spending (In percent of total spending)	44.1	52.3	46.5	45.3

Sources: Ministries of Finance and World Bank staff estimates.

**6.6. Benefit types and the funding arrangements under the social protection system are similar across the two entities, but shortfalls among some insurance programs have**

**required general government transfers to keep payments broadly in line with legal entitlements and prevent the accumulation of arrears** (Table 6.2). Moreover, the actual availability of funds to finance benefits differs considerably within each entity. The FBH has recently witnessed a proliferation of benefits with considerable fiscal implications and concerns about how this multitude of benefits can be administered most effectively.

## C. SOCIAL SECURITY CONTRIBUTION RATES

**6.7. Social security contribution rates are higher than in most OECD countries and substantially higher than in the faster growing transition economies, contributing to the large informalization of the economy.** Chapter 2 discusses the level of contributions in more detail. Moreover, the contribution rates and bases differ substantially across the two entities, a feature that hinders labor mobility.

**6.8. To reduce the government burden on the economy and facilitate the formalization of economic activity, reducing social security contribution rates and harmonizing and broadening of the contribution bases needs to become priority for the governments.** First steps could be taken quickly and recommendations are proposed at the end of this section.

Table 6.2. BH: Summary of Social Protection Benefits and Financing Sources

Benefit	Primary Financing Source	
	RS	FBH
Old age, disability and survivor pensions	Social Insurance	Social Insurance
Unemployment benefits 1/	Social Insurance	Social Insurance
Health	Social Insurance	Social Insurance
Social welfare 2/	Municipal budgets 3/	Cantonal budgets 3/
Maternity benefits	Social insurance	Cantonal budgets 3/
Child benefits and child birth grants	Social Insurance	Cantonal budgets 3/
Benefits for refugees and displaced	Entity budgets	Entity budgets Cantonal budgets
Benefits for civilian victims of war 4/	Entity budget	3/
Veterans disability and survivors benefits	Entity budgets	Entity budgets
Benefits for war medal holders	None	Entity budget
Disability benefits for non-war disabled	None	Entity budget

Sources: BH authorities and World Bank staff estimates.

1/ Includes active labor market policies.

2/ Includes social assistance, carer's allowance and social services.

3/ Where cantonal or municipal budgets carry primary financing responsibility, benefits are often not realized due to budgetary shortfalls.

**6.9. In the near term, there is scope for reducing contribution rates, with revenues from the VAT likely to be substantially larger than projected.** Further, the new corporate (CIT) and personal income tax (PIT) laws likely to be implemented from the start of 2007 will probably be revenue positive (See Chapter 2). Since the objective of the tax reforms is to establish a modern tax system and not raise the tax burden, offsetting reductions in contribution rates would be warranted.

**6.10. Determined efforts to improve collection of social security contributions and reduce exemptions would provide more room for cutting contribution rates in the medium term, as would fundamental reforms of the pension and health financing systems.** As the analysis below demonstrates, evasion is pervasive, with informal employment accounting for 41 percent of overall employment, or as much as formal non-government employment. Legal exemptions, moreover, are large, with the effect that one-half of those who receive health insurance do not pay contributions.

**6.11. As part of fundamental reforms of pensions and health, the authorities should seriously consider the relative merits of funding social insurance from social security contributions vs. general revenues.** Some countries, including New Zealand and Denmark, have high personal income tax rates and very low contribution rates. Others, notably Germany, France and the CEE countries, have much higher social security contribution rates. Given that BH's personal income tax rates would be at the

lower end of practices around the continent, an intermediate option would be to move toward a modest increase in income tax rates to enable yet further reduction in contribution rates.

**6.12. The following paragraphs list specific near-term recommendations for reducing and harmonizing social security rates and bases.**

- Broaden and harmonize the **contribution base and rate** across the entities for all insurance programs. For **pensions**, based on broadening the base by including non-wage benefits, reduce the pension contribution rates in the FBH.

- Reduce further the **pension contribution rate** by shifting the responsibility for financing the health insurance contributions of pensioners from the pension insurance funds to the entity budgets.

- In the FBH, reduce the **unemployment contribution rate** by curtailing and better focusing spending on active labor market policies, together with financing of the social program for enterprise restructuring from general revenues rather than from unemployment insurance contributions. The analysis below demonstrates that the FBH unemployment contribution rate could be reduced from 2.5 percent of gross wages at present to 1.5 percent.

- Reduce further the **unemployment contribution rate** by discontinuing the practice of offering free health insurance for all those who register as unemployed. Limit the duration of free health insurance to the duration of unemployment benefits and subsequently link eligibility for free health insurance to strict means-tested criteria in coordination with the social protection system.

- Reduce and harmonize **health insurance contribution rates** by moving progressively toward a system in which entity budgets pay the contributions for legally exempt individuals. To limit the costs to the entity budgets, reduce legal exemptions from payment of contributions.

- In the RS, consider shifting the financing of child benefits from the social insurance system to general revenue financing and combining it with other poverty benefits in the medium term. This should enable the authorities to eliminate the 2 percent **contribution rate for child benefits**.

- Move to unify the **base for personal income taxation and social security contributions** and unify the administration of the two.

## D. SOCIAL INSURANCE

### D.1 PENSIONS

**6.13. The pension system in BH inherited all the characteristics of the typical transition country pension system, including relatively high acquired rights and contribution rates and sharply**

Table 6.3. Core Parameters of BH Pension Systems

	FBH	RS
Standard Retirement age (men/women)	65/65	65/60
Earliest permissible retirement age	Any time with at least 40 years of work history	Any time with at least 40 years of work history
Minimum	20 years	20 years
Accrual schedule	2.25% for first 20 yrs, 1.5%	2.25/2.75% for first 20 yrs,
Maximum	75 percent	75 percent
Valorization	Wage indexation	Wage indexation, one-year lag.
Indexation	Discretionary (cash-rationing) with a target of wage indexation	Discretionary (cash-rationing) with a target of wage indexation
Assessment Base	Gross covered wage for best 15 years, increasing to 40 by 2010	Net covered wage for full career
Contribution Base	Gross wage without allowances	Net wage plus allowances
Contribution rate (employer/employee)	24 percent (7/17)	24 percent (24/0)

Sources: FPIO and RSPIO.

**declining contributory coverage.** Three pension funds were set up after the war, one for each of the three ethnic groups. In January 2002, the Mostar and the Sarajevo funds were merged into the FBH Pension Insurance Fund (FPIO), and the Fund was brought under the supervision of the FBH Ministry of Labor and Social Protection. The Mostar and the Sarajevo funds continue to maintain separate IT systems and databases, however. The RS Pension Insurance Fund (RSPIO) remains separate, under the overall supervision of the RS Ministry of Labor and Veterans' Affairs. Both entity pension systems are pay-as-you-go, publicly managed defined benefit schemes funded via payroll social security contributions, but core systemic parameters differ between the two (Table 6.3).

**6.14. To help prevent the accumulation of pension arrears, the OHR amended both entity pension laws in November 2002 and introduced the so-called coefficient rule.** The rule requires that if monthly revenues of the PIOs fall short of the funds necessary to pay benefits and administrative expenses, then administrative expenses and a portion of pension benefits equal to a legally set minimum take precedence over all other expenditures. The portion of individual pension benefits in excess of the protected minimum is then reduced by applying a coefficient so that benefits equal the revenues not yet allocated to administrative expenses and the protected minimum pension. Under the coefficient rule,

pension entitlements are revalued every month in light of the available resources, thus ensuring that there can be no gap between legal entitlements and actual payments.

**6.15. The coefficient rule has prevented further accumulation of arrears since 2002, but has two peculiarities.** First, the rule mandates pension funds to pay out all their revenues, net of operating expenses, on pensions in the same period revenues are received. As a result, entity governments are only bound by the availability of current resources and can thus increase benefits arbitrarily without regard for the longer-term sustainability of the pension system. Second, the coefficient ruling results in more equitable pensions in the RS than in the FBH. When calculating the total nominal value of pension entitlements, the FPIO adds up pensions at their nominal value at the time of retirement while the RS valorizes pension entitlements before summing them up to arrive at the nominal pension entitlement value. After applying the cash rationing coefficient to the nominal pension entitlements, the FBH increases or decreases nominal pensions by the same percentage, regardless of the year of retirement.

**6.16. As the pension coefficient moves closer to one, appropriately legislated pension indexation becomes an important ingredient of a fiscally prudent pension system.** In the RS, the coefficient has gradually increased, rising to 0.94 by November 2005 from 0.85 in 2003, largely reflecting political pressure despite the need to boost transfers from the entity budget to the pension fund. In the FBH, the coefficient has also been raised and is currently equal to 1.18. In Europe, pensions are increasingly indexed to consumer price inflation or to an average of price and wage changes. Introducing indexation would not reduce pension expenditures, but would create a transparent and predictable mechanism that could be used to contain pension expenditures as a share of GDP over the medium term. This, in turn, may allow for a reduction of contribution burdens or for the build-up of reserves in the FPIO<sup>2</sup> and for limiting the transfers from the RS entity budget to the RSPIO. Given BH's fiscal constraints and lack of reliable data on wage developments in any case, price indexation appears to be an effective and socially responsible measure to contain pension expenditures.

## Pension Revenues and Expenditures

**6.17. The revenues of the FBH pension fund have consisted almost exclusively of contribution payments, while the RS pension fund has relied substantially on transfers from the entity government in meeting pension obligations.** Budget transfers to the RSPIO have amounted to an outsized one-fourth of pension expenditures, even as paid pensions have been lower than entitlements.

**6.18. The current fiscal position of the FPIO is more favorable than that of the RSPIO** (Table 6.4). In the RS, contribution revenues lower than pension expenditures has meant growing reliance on transfers from the entity budget to the RSPIO. The FPIO, by contrast, has managed to maintain its balance. All told, pension outlays rose to 6.8 percent of GDP in 2004 from 6.2 percent in 2003. The strong growth in pension expenditures has reflected several factors, including: (i) political and social pressures to increase the pension coefficient to unity or above; (ii) the coefficient rule, which obliges funds to spend all revenues regardless of the source, thus encouraging transfers from the entity budgets to directly finance politically expedient pension increases; (iii) and the substantial rise in formal sector wages and contribution revenues in both entities.

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<sup>2</sup> Accumulating reserves not exceeding 10 percent of pension expenditures is also stipulated in the FBH pension law.

## KEY PENSION ISSUES

### 6.19. High dependency ratios and low coverage rates in both entity pension systems are a threat to their financial sustainability, so far ensured by application of the coefficient rule.

The FBH pension system has 292,200 beneficiaries and 466,000 contributors, with a high system dependency ratio of 0.63. In the RS, the ratio is somewhat lower at 0.6, with 174,000 beneficiaries and 294,000 contributors. High system dependency ratios are due to low overall labor force participation and

low insurance coverage rates. Some 62 percent of BH's population aged 15-64 do not accrue pension rights and more than one-fourth of the active labor force is not covered by pension insurance. Low coverage will further increase the share of the population not qualifying for pension rights in the future.

### *Disability Pensioners*

**6.20. The share of disability pensioners is high, mostly due to the impact of the war. The share of disability pensioners in BH is twice the level in most other countries.** Old-age pensioners, as a result, account for a smaller share of the total number of pensioners in the BH, or 43 percent of the total vs. 70 percent on average in most European countries. In BH, the share of disability pensioners is broadly similar across the entities (Table 6.5). Although no data are available, there is a concern that many disability and survivor pension beneficiaries may be receiving multiple benefits for the same reason. This applies particularly to beneficiaries under the veterans' benefits system that also allocates generous benefits to disabled war veterans' and extended families of deceased veterans.

Table 6.5. Composition of Pension Beneficiaries  
(In percent of the total number of beneficiaries)

	FBH	RS
Old Age	41	46
Disabled	22	19
Survivor	37	35

Sources: FPIO and RSPIO.

### *Retirement Provisions*

**6.21. Statutory retirement provisions are broadly in line with regional best practice in both entities but the low effective retirement age is cause of concern.** Legal provisions for early retirement and the high uptake of disability pensions affect the effective retirement age. Both entities allow for early retirement for certain categories of workers or for persons with at least 40 years of contributions. In addition, the FPIO had until the end of 2005 a transitory arrangement allowing men (women) to retire at the age of 60 (55) with at least 35 (30) years of contributions. Given high employment rates before 1990, these provisions effectively lower the retirement age to 60-55 years for many people. The FBH government is also considering introducing legislation that would allow workers to "purchase" insurance periods of up to three years. Furthermore, the FBH government is considering legislation to temporarily lower the statutory retirement age to 63 years of age until 2010. **These measures should not be**

Table 6.4. BH PIOs: Revenues and Expenditures, 2003-2005  
(In millions of KM)

	2003	2004	2005
<b>RSPIO</b>			
Contribution Revenues	244	296	332
Government Transfers	66	86	103
Pension Expenditures	310	382	434
<b>FPIO</b>			
Contribution Revenues	731	801	865
Government Transfers	0	0	0
Pension Expenditures	688	744	831

Sources: RSPIO and FPIO.

adopted, as they would further reduce the effective retirement age in the FBH, which in turn would increase the dependency ratio and put additional strain on the FPIO.

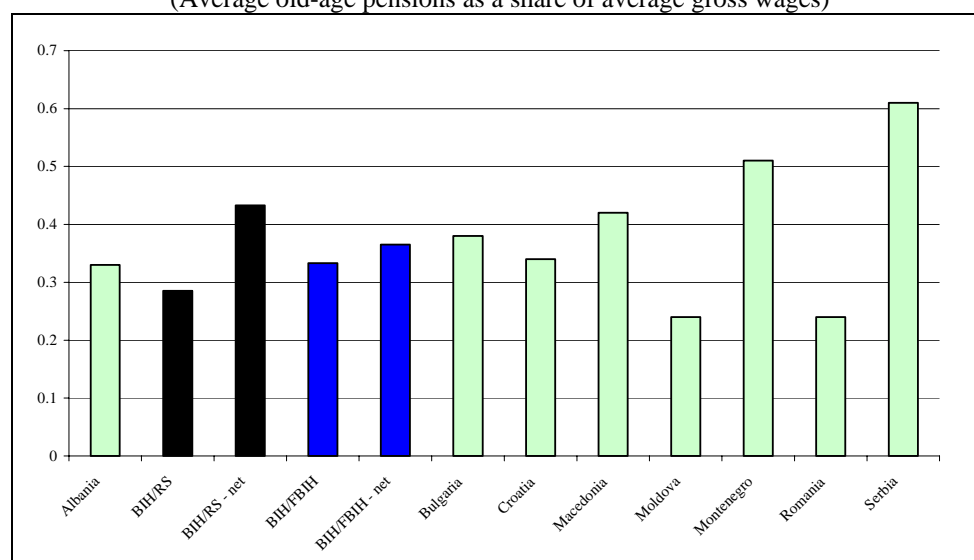
**6.22. In the RS, the retirement age regulations are less diluted than in the FBH. There are only two concessions.** Firstly, workers with long contribution histories (40 years for men and 35 years for women) can retire at anytime, regardless of their age. Secondly, workers who spent at least 15 years in harmful or hazardous conditions can retire at 55 years of age for both men and women. Since neither the additional rights nor the longer beneficiary periods for early retirees are reflected in the contribution rates, these entitlements ultimately lead to increased pension liabilities requiring more budgetary resources, as in the RS, or to an internal redistribution within the system to the benefit of early retirees, as in the FBH.

**6.23. To help reduce the dependency ratio and improve the system’s fiscal sustainability, all regulations allowing for early retirement should be withdrawn.** It is recognized that certain professions will continue to require early retirement provisions, but the list of these professions will have to be revisited. It is also desirable that early retirement provisions be treated separately either by charging actuarially fair additional contributions to the employers, while keeping these benefits within the general social security scheme, or by setting up occupational early retirement schemes to bridge the gap between the standard and the concessional retirement age.

**6.24. Replacement rates are in line with regional averages, but rates are likely to fall going forward unless longer-term challenges are tackled.** Replacement rates of the average old-age pension in the FBH are currently equal to 48 percent of the average wage, compared to a pension contribution rate of 34 percent of gross wages. In the RS, replacement rates for old age pensions are somewhat higher – 53 percent of the average net wage, while contribution rates are 24 percent of the net wage (Figure 6.1).

**6.25. Accrual rates, the minimum eligibility criteria and early retirement provisions provide incentives to withdraw from formal employment after short contribution histories.** The current accrual schedules result in a marginal replacement rate that becomes smaller after the first 20 years of contribution in both entities. Thus, every additional year of formal employment lowers the average return on contribution. **In order to promote longer contribution-covered careers, it is essential that the**

Figure 6.1. Replacement Rates for Selected Countries  
(Average old-age pensions as a share of average gross wages)



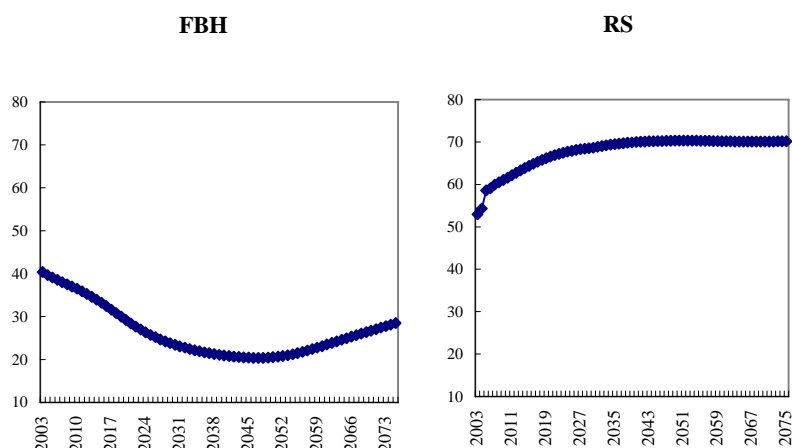
Sources: FPIO, RSPIO and World Bank staff estimates.

current accrual schedule (which is “concave”) be replaced with a schedule that rewards the first periods of contributions less relative to later years (“linear” or “convex”). In practice, such amendments would mean a lower pension to people with 20 years of contribution but a steeper replacement schedule with the respect to consecutive years.

## Pensions: Outlook

**6.26. In the years to come, both entity pension systems will face reduced numbers of contributors, a relatively large beneficiary population and a declining size of cohorts joining the labor force.** If the entity pension systems stay the current course, the average replacement rate in the FBH will be substantially reduced over the next 35 years. Preliminary projections show that the level of pensions in the FBH may fall from the current average of 40 percent of the average wage for all types of pensions to 20 percent in the next 35 years (Figure 6.2)<sup>3</sup>. **Such a low level of pensions will provide insufficient old-age protection against poverty and will undermine contribution incentives.** As early as 2015, pensions in the FBH as a percent of the average wage are likely to be lower than the contribution rate. Individuals will have no incentive to contribute the equivalent of 34 percent of net wage for 40 years in order to receive pensions worth only 33 percent or less of the average wage for 15 years. In the RS, reaching and maintaining a coefficient of 1 will result in a rapidly growing deficit of the RSPIO that will require substantial transfers from the entity budget.

Figure 6.2. BH: Pension Replacement Rates 1/  
(Average pension in percent of average salary)



Source: World Bank, BH Pension Policy Note, Draft, 2006.

**6.27. Averting a substantial drop in the FBH replacement rate, and reversing the widening RSPIO deficit would require fundamental pension reform.** Detailed discussion of potential structural changes and the implied measures go beyond the reach of this report and will be presented in a separate BH Pension Policy Note. This chapter provides only a short summary of possible long-term reform measures and the recommended short- to medium-term parametric reforms to make them possible. Pension reforms take hold with a long lag and cascade through the stock of contributors and beneficiaries. Therefore, parametric adjustments will be necessary regardless of which structural pension reforms are pursued. Parametric reforms alone are unlikely to set the pension system on a sustainable path, however, making it key for the authorities to also consider deeper structural reform options.

**6.28. Available structural reform options will depend largely on whether the coverage and compliance of active cohorts can be increased to a level allowing the public pension schemes to**

<sup>3</sup> Projections were made using the World Bank’s PROST pension model and were prepared by a World Bank team as a part of ongoing work on a World Bank Pension Policy Note for BH.

**continue to fulfill a consumption smoothing function.**<sup>4</sup> Otherwise, those functions of the public pension scheme that go beyond averting old-age poverty should be rolled back over time. Addressing old-age poverty can be done through a variety of instruments, including means-tested social assistance, non-contributory flat rate citizen’s pensions (a so-called “demogrant”) or guaranteed minimum pensions. None of these options contain earnings-related benefits. If benefits were independent of earnings, contributions would also not need to be related to earnings, as the implied redistribution under such a scheme would discourage compliance at all income levels above the statutory minimum. Thus, a basic pension pillar could in principle be established if decision makers were ready to gradually phase out the remaining mandatory, earnings-related contributory scheme. The shift toward a flat rate pension system would also require substantial transitional financing, as workers who would only be eligible for the basic pension could no longer be expected to contribute to the old system, while pension entitlements earned under the old system would need to continue to be financed. The financing gap would require substantial general revenue transfers and the speed with which such a reform could be implemented would largely depend on the available financing.

**6.29. Another reform option would be to add mandatory and voluntary funded pillars to the public scheme.** This is a path followed by many ECA countries. Without exception, such reforms have left the overall level of social security contribution rates and mandated savings largely unchanged. Emerging evidence suggests that the so-called “three pillar reforms” have not improved compliance and it is not expected that BH would be different. Furthermore, BH does not appear to meet at present any of the pre-conditions necessary for the successful introduction of a multi-pillar system.<sup>5</sup> Another option which will be discussed in the BH Pension Note is the introduction of a so-called “notional defined contribution” system. Such a system tracks individual contributions during the contribution period and pensions are linked to individual contributions, thereby mimicking a fully-funded system.

**6.30. Regardless of the long-term reform path chosen, there will be a need for further parametric reforms in the current system and for increased harmonization between the two entity pension systems.** The recommendations on the pensions system are summarized in the following paragraphs.

### **Pensions: Recommendations**

- **Make administrative improvements to increase collection efficiency and to contribute to a transparent system where the consequences of tax-compliance are clear to all.**
- **Abolish transitory arrangements related to old-age pensions that allow for retirement before the age of 65.**
- **Introduce CPI-based, legally anchored pension indexation.**
- **Limit recognition of pension rights to those whose contribution history has been fully covered.**
- **Modify the accrual schedule so that it either becomes a linear or convex function of the years of contribution history to give more weight to the later years of contributions.**

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<sup>4</sup> Pension systems have two objectives: protecting the elderly against poverty and making sure that individual's consumption levels do not fall abruptly after retirement (consumption smoothing). Pension systems strive to first achieve the first objectives and, if there are sufficient resources, the second.

<sup>5</sup> Pre-conditions include the readiness of financial markets, the existence of proper regulatory framework and the capacity and state of the public pension pillar.

## D.2 UNEMPLOYMENT INSURANCE

**6.31. Employment services are the responsibility of the entity and sub-entity governments.** In the RS, there is a single Employment Institute (RSEI) with 6 regional branch offices and 55 municipal offices. In the FBH, the employment service network comprises the entity-level Federal Employment Institute (FEI) and ten cantonal Employment Services (ES) with 79 municipal offices. The RS and FBH employment services have substantially different revenues because of differences in the contribution rates and the contribution bases. In the RS, the employment contribution rate is equal to 1 percent levied on net wages including allowances. The contribution rate in the FBH is 2.5 percent levied on gross wages, which is equivalent to 4.2 percent of net wages. Of the contributions collected in the FBH, 30 percent accrue to the FEI and 70 percent to the cantonal Employment Services. The former is distributed to the cantons on a solidarity basis.

**6.32. The employment services provide passive and active labor market programs.** Benefits under these programs include: (i) cash unemployment benefits for registered unemployed with paid contributions, (ii) health insurance coverage for all registered as unemployed and pension insurance coverage for recipients of unemployment benefits; (iii) active labor market and job placement programs. In addition, the employment services in the FBH plan to launch a social program for workers who become unemployed because of bankruptcy or liquidation. In both entities, legislation requires the EIs to use available resources to finance unemployment benefits first. Active labor programs get financed only if there are resources to spare.

### Unemployment Benefits

**6.33. The generous treatment of the unemployed in the FBH tends to discourage the unemployed from searching for work. It is not as much unemployment benefits as free health insurance coverage for all registered unemployed that has been a major incentive to register with the employment services.** As a result, the registered unemployment rate has been more than double the true unemployment rate, as measured according to the ILO definition.<sup>6</sup>

**6.34. Unemployment benefits in the FBH are also one of the most generous in the broader region.** In a reversal of a previous good practice, the FBH amended the employment law in May 2005 to provide for cash unemployment benefits equivalent to three months of wages for an insurance period of 8 months to 5 years, rising gradually to 24 months of wages for service longer than 35 years. The unemployment benefit replacement rate is a uniform 40 percent of the average net wage paid in the FBH in the previous three months, irrespective of the number of years of service. While a replacement rate of 40 percent is not excessive by ECA standards, the maximum duration of 24 months places the FBH at the top end of the ECA countries.<sup>7</sup> Given high and growing informalization of economic activity and employment, such a long duration of unemployment benefits is likely to lower further the incentive for finding formal employment.

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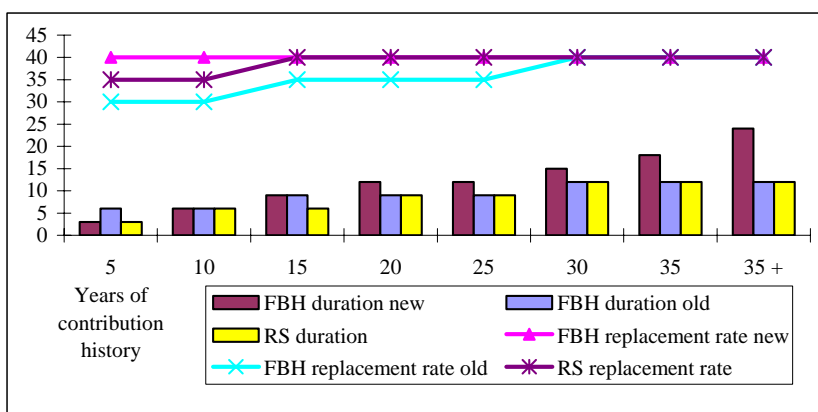
<sup>6</sup> According to the ILO definition, the "unemployed" comprise all persons who during the reference period are without work (i.e., neither in paid employment nor self-employment), are currently available for work and are actively seeking work (i.e. had taken specific steps in a specified recent period to seek paid employment or self-employment).

<sup>7</sup> Under the old FBH provisions, unemployment benefits were paid for six months in the amount of 30 percent of the average cantonal salary for an insurance period of 8 months. That increased to payments for 12 months of a sum equivalent to 40 percent of the average cantonal salary for an insurance period longer than 25 years.

**6.35. The unemployment benefit coverage in BH is lower than in almost all other countries in Europe.** In 2004, only 2 percent of the registered unemployed received cash benefits, compared with 12 percent on average among the SEE countries. The recent expansion of benefit duration in the FBH should boost coverage but without an underlying improvement in contribution compliance.

**6.36. In the RS, unemployment entitlements remain more in line with international good practice and fiscal affordability.** Entitlements, comprising cash payments, health insurance and pension/disability insurance, can be received for three months for an insurance period of up to five years,

Figure 6.3. BH: Employment Replacement Rates  
(Months of duration to replacement rate, in percent)



Sources: BH governments and World Bank staff estimates.

**of informality and a major drain on public resources.** Roughly two-thirds of all registered unemployed receive health insurance while only two percent qualify for cash benefits (Table 6.6). Entitlement to free health insurance for the duration of unemployment registration provides an incentive to stay in the informal sector and avoid paying social insurance contributions. Moreover, these arrangements have contributed to creating an unsustainable health insurance situation where only one-fourth of those who get health insurance coverage actually pay contributions. The EIs pay health insurance for all registered unemployed in both entities, and pension insurance in the RS for those who receive cash unemployment benefits.<sup>8</sup>

### Active Labor Market Programs

**6.38. The current mix of active labor programs is limited and appears to have little impact in improving the job prospects of the unemployed.** This unfortunate outcome has resulted in part from the emphasis until recently on programs providing subsidized credits to enterprises, as well as wage subsidies, developments that

rising to 12 months for an insurance period of more than 25 years (Figure 6.3). Unemployment benefits amount to 35 percent (40 percent) of the individual's average salary over the preceding 3 months for those with ten years (more than ten years) of insurance.

**6.37. As in the FBH, eligibility for free health coverage for all registered unemployed in the RS has been a key incentive to register and has represented both a driver**

Table 6.6. BH: Registered Unemployed by Beneficiary Category, 2005  
(In actual numbers)

	FBH	RS
Registered unemployed	341,650	153,474
of which:		
recipients of cash benefits	5,725	3,429
receptients of health insurance	201,599	103,028

Sources: Employment Institutes, FBH data for May 2005, RS for April 2005

<sup>8</sup> In case they do not receive health protection through another means, such as being a family member of an insured person.

contributed to supporting unprofitable enterprises and practices that typically destroyed value and increased inefficiency.<sup>9</sup> The issue is particularly acute for the FEI, which finances a large number of activities with little impact evaluation, including extending credits to enterprises for employment promotion via the Federation Investment Bank (FIB). Similarly, cantonal ES, most notably the Sarajevo ES, continue to extend direct credits as active labor market policies.<sup>10</sup> Simpler and more cost effective programs such as job counseling and basic job brokerage have been neglected and remain largely ineffective. The RSEI, by contrast, has justifiably terminated all credit programs and in recent years limited active labor market policies to job referral activities.

**6.39. Larger resources enable the FEI to meet entitlements of unemployment benefits with only one-third of its resources, while the RSEI spends one-half.** The FEI further spends as much as 45 percent of its budget on active labor market programs, compared with 18 percent for the RSEI and 20 percent in the EU on average (Table 6.7 and Figure 6.4). The FBH employment services, moreover, run periodic surpluses and have substantial cash reserves.

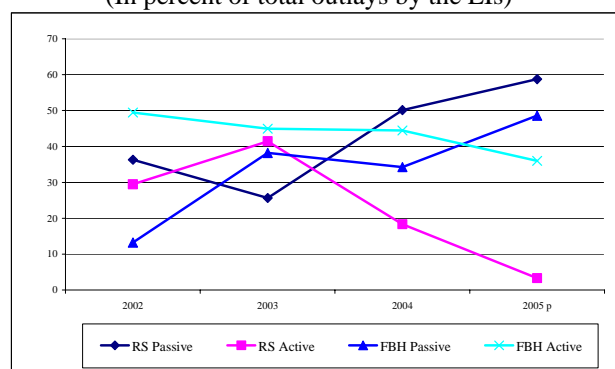
**6.40. The RSEI suffered a financial shock after the introduction in mid-2004 of a social program in support of corporate restructuring.** While contribution revenue increased by 20 percent in 2004, expenditures on unemployment benefits jumped by 136 percent and the RSEI required substantial transfers from the entity government to help meet its obligations. The RS government subsequently abolished the right of social program beneficiaries to unemployment benefits, limiting their rights instead to health and pension insurance contribution payments. The 2006 RS budget provides KM20 million in transfers to the RSEI to fund these entitlements.

Table 6.7. Entity Employment Institutes, 2004  
(In millions of KM)

	RS	FBH
Revenues	12.5	120.4
Contributions	11.2	78.0
Other revenue	0.2	4.6
Grant income	1.0	1.9
Repayments of credits		7.3
Expenditures	12.5	84.3
Administration and capital outlays	3.9	18.0
Assistance to the unemployed	6.2	28.9
Unemployment benefits	5.7	12.5
Health insurance contributions	0.2	12.4
Pension insurance contributions	0.3	0.7
Other social protection		3.4
Labor market programs	2.3	37.5
Subventions		19.1
Credit Programs		18.4
Balance	0.0	36.1

Sources: Entity Employment Institutes.

Figure 6.4. BH: Outlays by Active and Passive Employment Programs 1/  
(In percent of total outlays by the EIs)



Sources: Entity Employment Institutes  
1/ 2005p refers to planned expenditure as published in the Institutes' annual program for 2005.

<sup>9</sup> See Betcherman, Olivas, and Dar (2004) "Impacts of Active Labor Market Programs: New Evidence from Evaluations, with Particular reference to Developing and Transition Countries," The World Bank.

<sup>10</sup> The FIB has taken over the outstanding portfolio of subsidized loans approved by the FEI.

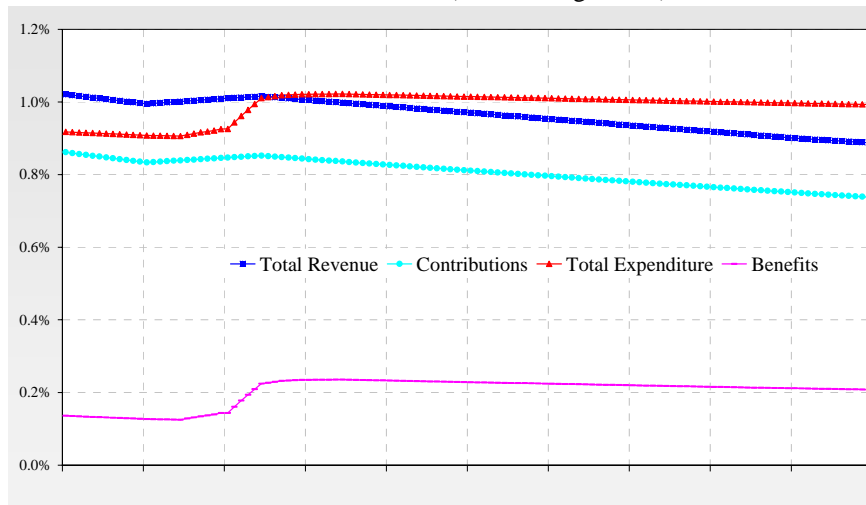
## Employment Services: Outlook

**6.41. The FBH and RS employment insurance systems face different outlooks.** The evidence provided above suggests that the employment contribution rate in the FBH is overly high and the FBH system is substantially overfunded. The fiscal situation of the RSEI is much tighter, by contrast, and is likely to remain that way over the medium term.

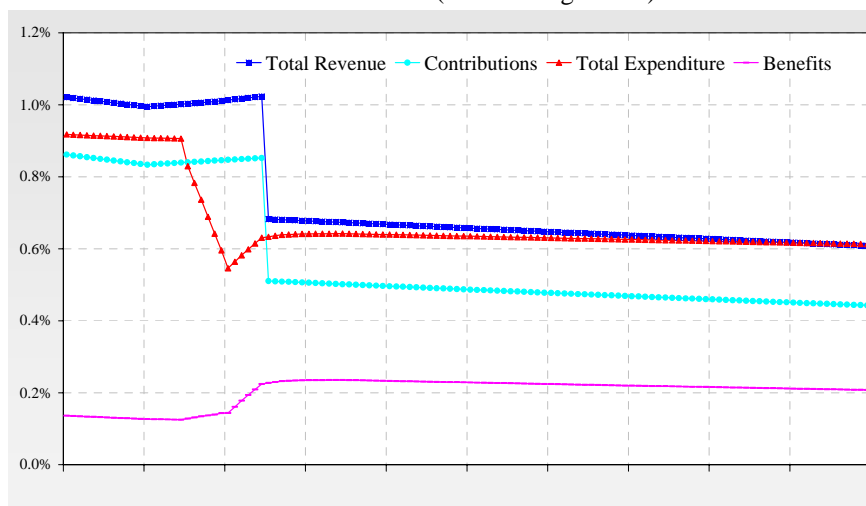
**6.42. A scale-back of currently inflated expenditures on active labor programs in the FBH would allow for a reduction in the unemployment insurance contribution rate even with an increased inflow of unemployment benefit claimants.** The system could accommodate a jump in the share of unemployment benefit recipients relative to the overall total unemployed from 1.7 percent to 3.5 percent and a cut in the contribution rate from 2.5 percent of gross salary to 1.5 percent. This would be possible provided expenditures on active labor market programs are cut from the current 0.6 percent of GDP to 0.2 percent (Figure 6.5). Savings could also be realized from a reduction of the recently extended maximum benefit duration from 24 months back to 12 months.<sup>11</sup>

**6.43. The RS employment services face a different challenge.** The system is tightly financed and any shocks would need to be

Figure 6.5. FBH EI: Revenue and Expenditure Projections 1/  
Current Parameters (2004 through 2013)



Reform Scenario (2004 through 2013)



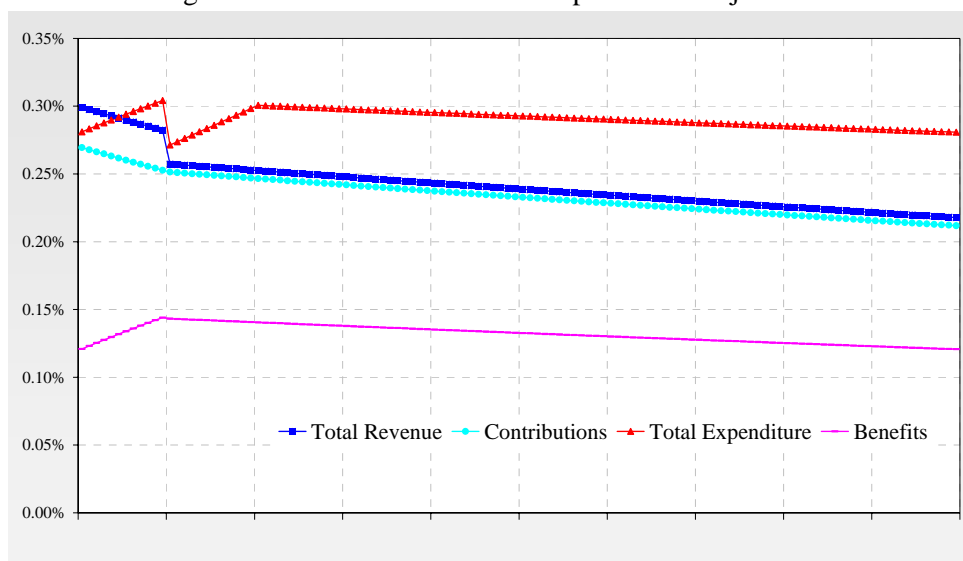
Source: World Bank staff estimates.

1/ Top figure: projections under current parameters. Bottom figure: projections assuming a doubling of unemployment benefit claimants in 2006, a cut in the contribution rate from 2.5 percent to 1.5 percent from July 2006, and spending on active labor market programs cut to 0.2 percent of GDP from January 2006.

<sup>11</sup> Simulations were carried out using UISIM, an unemployment insurance simulation model developed by the World Bank.

cushioned either through increased transfers from the entity government or through a reduction of benefits. Assuming an increase of unemployment benefit claimants from 2.2 percent of the registered unemployed to 3.5 percent from 2006 onwards and no change in benefits, the RSEI would need an additional transfer from the entity government of less than 0.1 percent of entity GDP a year (Figure 6.6). Medium-term policy options in the RS unemployment insurance system will depend on whether the number of the recipients of unemployment benefits will increase and whether this increase will be temporary or permanent. Accelerated corporate restructuring makes it more likely that any increase will be temporary. Therefore, it appears prudent to rely on budgetary transfers to cover financing gaps and not consider increasing contribution rates.

Figure 6.6. RSEI: Revenue and Expenditure Projections 1/



Source: World Bank staff estimates.

1/ The figure shows the projected revenue shortfall, assuming an increase of the unemployment benefit claimants to 3.5 percent of registered unemployed in 2006, an unchanged contribution rate of 1 percent of net salary, and non-unemployment benefit spending of 0.07 percent of GDP.

## Employment Services: Recommendations

- **Rescind the recent changes to the FBH Employment Law and limit the maximum duration of unemployment benefits to 12 months.**
- **In the FBH, reduce expenditure on active labor market programs that are not targeted and unevaluated and focus these programs on cost-effective job referral and counseling.** Fully discontinue enterprise credit programs by closing the credit lines currently administered by the FIB and the Sarajevo ES.
- **Introduce impact assessment as an integral part of the activities of the EIs to inform management and staff and to influence development of effective active labor market programs.**

## D.3 HEALTHCARE

**6.44 The health system is fragmented and burdened with substantial duplication, excess employment and inefficient use of available resources.** Access to healthcare, moreover, is inequitable, with informal payments larger than legally-mandated co-payments, implicit rationing and limited portability of insurance being the main causes. Substantial differences in resources and small risk pools in the FBH are also a factor. Preventable and high-cost diseases such as heart disease and cancer rank highly in the burden of disease. Challenges will further increase as the population ages rapidly. The incidence of tuberculosis is comparatively high and, combined with relatively low utilization of reproductive care and immunization, suggests that lower-income groups tend to be excluded from quality care. Inefficiencies in the organization and delivery of care further contribute to concerns about equity in access.

**6.45 To address these challenges, the authorities need to rationalize the structure of the healthcare sector and improve the efficiency of use of available resources.** To this end, legally-mandated benefits and available resources need to be realigned, the financing system strengthened and procurement rules for pharmaceuticals revamped. Measures should also be implemented to prevent the further accumulation of arrears. Moreover, the network of health facilities should be reorganized and rationalized and human resources in the health sector profiled and rationalized to increase productivity. The key further challenge for the governments would be to implement this ambitious agenda while reducing prohibitively high contribution rates.

### Health: Institutional and Policy Background

**6.46 The administration of the healthcare system is fragmented and inefficient.** The DPA stipulated that the entities should be responsible for healthcare legislation and organization, financing and service delivery. In the FBH, the responsibility for health services has been further delegated to the cantons. The FBH health sector, as a result, includes the FBH Ministry of Health (MoH), the 10 cantonal MoHs, the Federal Solidarity Health Insurance Fund (HIF), the 10 cantonal HIFs and the 11 Institutes of Public Health (IPH). Fragmentation and inefficiency are further exacerbated given that the responsibilities of the institutions within the entity or even within the cantons are not clearly defined. By contrast, the RS health system is centralized at the entity level, with a single HIF (HIFRS) responsible for pooling, paying and contracting healthcare providers. The small District of Brcko with a population of less than 200,000, also has a Department of Health and a separate HIF.

**6.47 Excess employment is substantial and, together with the institutional fragmentation, is one of the key reasons for the inefficient use of resources.** In 2004, the 13 MoHs, HIFs, IPHs and other health authorities employed about 2,200 employees, or 5.7 employees per 10,000 population, considerably more than in most European countries, including the Netherlands (4.8) and Poland (0.7)<sup>12</sup>. Two-thirds of all staff is employed at the cantonal or municipal level. As shown below, wages account for a full one-half of overall health expenditures, crowding out other needed outlays. To improve administrative efficiency and facilitate a better use of available resources, the authorities should consider consolidating and streamlining policy and administrative functions across the cantons and the entities. Such a consolidation could aim to reach the moderate Dutch staffing levels, for example, and would result in a reduction of about 350 public administration staff. Assuming a gross monthly wage of KM1000, this measure would help save about KM4.2 million a year.

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<sup>12</sup> See EU, 2005, *Functional Review of the Health Sector in BH, Final Report*.

**6.48 As in other countries in the region, BH operates publicly administered health insurance funded primarily via payroll social security contributions.** There is a purchaser-provider split, with the legal arrangements providing for the HIFs to contract with public and private health providers. In the FBH, the Federal Solidarity HIF created in 2002 provides for high-cost tertiary care, expensive drugs and immunization, while the cantonal HIFs are responsible for financing all other levels of healthcare. The HIFs are not active purchasers of services according to contractual obligations but pay healthcare facilities based on expenditures submitted by the healthcare facilities, with little control over the level of spending or quality of care.

**6.49 Fragmentation has limited the risk pools, especially among the cantonal HIFs and has resulted in inefficiencies and varying availability of healthcare.** Four cantonal HIFs have fewer than 100,000 members and operate at a considerably higher risk level thereby limiting members' access to

Table 6.8. HIF Revenues, 2002-2004 1/  
(In millions of KM unless indicated otherwise)

	2002	2003	2004
HIF RS	182	203	205
Contributions	158	152	172
Transfers 2/	25	51	33
Per capita RS (In KM)	121	135	136
HIFs FBH	517	546	594
Contributions	508	540	582
Transfers 2/	9	6	12
Per capita FBH (In KM)	222	235	255

Source: Annual Reports HIFs FBH and RS.

1/ Excludes capital revenues and copayments.

2/ Entity budgets, pension and employment funds.

**however, legislated entitlements in excess of ability or willingness to pay, together with inefficient spending, have put a pressure on the extrabudgetary HIFs.** The HIFRS receives transfers from the entity government and other extrabudgetary funds, most of which cover health insurance contributions for exempt individuals (Table 6.8). Without the ability to borrow, the HIFs have resorted to accumulation of arrears, notably in the RS, and to the implicit rationing of service.

**6.51 Lack of adjustments to legislated entitlements and poor collection of social security contributions have kept contribution rates high.** Collection has been poor because of the large share of the informal economy, rampant evasion and substantial legal exemptions from paying contributions. The healthcare contribution rate in the FHB is 17 percent of the gross wage (4 percent of the wage paid by the employer and the rest by the employee). In the RS, the rate is 15 percent of the net wage, all payable by the employees. These rates are substantially higher than in other European countries, including France (13.6 percent of gross wages), Bulgaria (6 percent), SaM (12.3 percent) and Albania (3.5 percent). Contribution bases vary across the entities, and for some categories of contributors, even among the cantons<sup>13</sup>. The Solidarity HIF in the FBH receives 8 percent of collections and the cantonal HIFs receive the rest.

<sup>13</sup> Farmers pay either 10 percent of the minimum wage or a flat amount in some cantons. Health insurance contributions for pensioners are paid by the pension insurance fund.

care. To improve efficiency and access to healthcare across the cantons, while decreasing the financial risk related to adverse selection and moral hazard, it is recommended that the functions of cantonal funds be redefined. The authorities should work towards the longer term goal of transforming the cantonal funds into branches for membership issues and case control, with all other insurance functions merged in an entity level HIF.

## Healthcare Revenues and Spending

**6.50 Social insurance contributions collected by the HIFs are the main source of financing of healthcare. As in other areas of social welfare and protection,**

**6.52 Higher contribution rates and higher average wages result in larger per capita revenues for the FBH HIFs.**

Even within the cantons, however, there is a substantial variation in revenues per capita, ultimately limiting the ability of the HIFs in the poorer cantons to provide adequate care. The FBH HIFs are almost fully self-sufficient, with a negligible transfer from the entity budget. The HIFRS receives transfers from entity governments and extrabudgetary funds, most of which cover health insurance contributions for exempt individuals.

**6.53 Arrears in the health sector amounted to 0.9 percent of adjusted GDP in 2004.**

The issue is particularly acute in the RS, where sizable past-due hospital liabilities have boosted the stock of arrears to 1.9 percent of adjusted entity GDP, equivalent to one-third of RS health spending (Table 6.9). Arrears in the form of unpaid salaries to staff are relatively small, but these create incentives to take bribes. Validating and settling outstanding arrears over the medium term, and ensuring that new arrears do not arise, should be priorities for the governments.

**6.54 Government health expenditures are larger than the average among the CEE countries and second only to Croatia in SEE.<sup>14</sup>**

At 5.7 percent of adjusted GDP, government spending is also above the level in Poland, Slovakia, and the average for SEE (Table 6.10). In addition, survey data suggests that out-of-pocket payments amounted to some 2 percent of adjusted GDP in 2004, but anecdotal evidence suggests that these payments could be higher. Overall health expenditures amounted to at least 7.7 percent of adjusted GDP in 2004, higher than in Poland, Hungary and SaM, provided the latter's GDP is properly adjusted for the nonobserved economy.

Table 6.9. BH: Health Sector Arrears, 2004  
(In millions of KM unless indicated otherwise)

	RS	FBH	BH
Total	104	54	158
(In percent of total health spending)	31.4	6.1	13.0
(In percent of GDP)	1.9	0.5	0.9
HIF	12	9	21
Clinical centers	0	19	19
Hospitals	75	9	84
Others (Health centers, pharmacies)	17	18	35

Sources: BH governments and World Bank staff estimates.

Table 6.10. Health Outlays, Selected Countries, 2004  
(In percent of GDP) 1/

	Public	Private	Total
BH			
official GDP	7.4	2.6	10.0
adjusted GDP	5.7	2.0	7.7
NMS	4.7	...	...
SEE, official GDP 1/	5.9	...	...
SEE all adjusted 2/	5.0		
of which:			
FYR Macedonia 3/	5.9	...	...
Albania 3/	3.7	...	...
SaM 3/	5.7	2.9	8.6
Croatia 3/	6.6	2.4	9.0
Lithuania	3.8	...	...
Slovenia	6.8	...	...
Slovakia	4.4	...	...
Poland	4.1	2.0	6.1
Ireland	6.4	...	...
Malaysia	2.0	3.0	4.0

Sources: IMF staff reports and selected World Bank PEIRs.

1/ All relative to official GDP unless indicated otherwise.

2/ See Chapter 1 and Table 2.5. All countries adjusted differentially, so that the cumulative adjustment for NOE in each country's GDP is 30 percent of the observed economy.

3/These numbers are not adjusted.

<sup>14</sup> The ratio for SaM is relative to official GDP.

**6.55 Inequity in health financing and the high share of out-of-pocket spending, most of it informal payments, raise concerns about access to care.**

Independent of their insurance status, more than 80 percent of patients incur out-of-pocket expenditures. Poor households' healthcare expenditures account for one-tenth of their overall expenditures, with the share falling to 5 percent for the richest households.<sup>15</sup> Informal payments in violation of the law are common. Comparing survey data with official co-payment suggests that informal payments are twice or three times as high as officially required co-payments. Informal payments are a substantial barrier to accessing care and threaten the integrity of the system.

**6.56 Wages account for one-half of healthcare expenditures in the FBH and probably for a similar proportion in the RS.**<sup>16</sup>

As in other areas, the large share of wages crowds out investment in capital improvements and maintenance (Table 6.11). Most importantly, health facilities appear overstaffed with non-medical staff. Non-medical staff amounts to one-third of all health employees, higher than in SaM (28 percent) or the UK (13 percent) (Table 6.12).<sup>17</sup> The ratio of non-medical staff per 100 occupied beds amounts to 67 in BH, substantially higher than a target of 39 under a medical rationalization plan currently implemented in SaM. Applying the same ratio to BH would imply a reduction in

Table 6.11. FBH Health Expenditures, 2002-04 1/  
(In millions of KM)

	2002	2003	2004
Total Health Expenditures	647	750	825
Wages, salaries	316	360	392
Goods, services	279	335	375
Transfers 2/	23	21	25
Capital	29	35	33

Source: National Health Account Reports FBH.

1/ Includes out-of-pocket expenditures.

2/ Sick leave and treatment abroad.

Table 6.12. BH: Number of Health Workers, 2002 and 2004  
(In actual numbers unless indicated otherwise)

	2002			2004		
	RS	FBH	BH	RS	FBH	BH
Medical	7,177	15,795	22,972	7,889	15,727	23,616
Non-medical	4,034	7,816	11,850	3,578	7,973	11,551
Health workers	11,211	23,611	34,822	11,467	23,700	35,167
Average gross wage 1/				710	719	715

Sources: HIFs and IPH.

1/ In KM per month.

Table 6.13. BH: HIF Membership by Enrollment Category, 2004  
(In thousands, unless indicated otherwise)

Category	RS	FBH	BH	In % of all members
Total members insured	1,093	1,990	3,083	100
Required to pay contributions 1/	606	943	1,549	50
Exempt from paying contributions				
Pensioners	237	426	663	21
Unemployed	204	418	622	20
Disabled, veterans	15	88	103	3
Other (refugees, foreign insured)	31	115	146	5

Sources: FBH and RS HIFs and World Bank staff estimates.

1/ Includes employed, self-employed and farmers.

<sup>15</sup> See: The World Bank, 2003, *Poverty Assessment, Bosnia and Herzegovina*.

<sup>16</sup> Such a breakdown is not available for the RS, as the NHA are not institutionalized and the RSHIF does not collect information on spending in health facilities by economic categories.

<sup>17</sup> The government of SaM recently launched a program to further reduce the share of non-medical workers. See Cochrane, David, 2004, *Human Resource Strategy for Support Services*, Final Technical Report, Ministry of Health, Serbia and Montenegro.

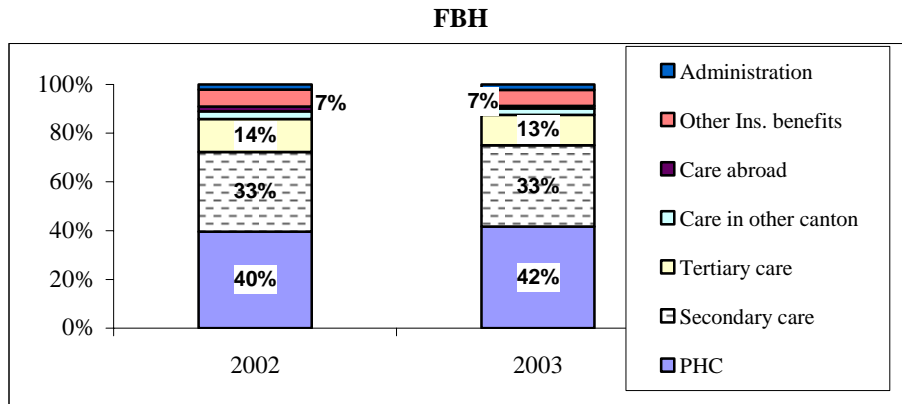
nonmedical staff by 20 percent. Were this to be implemented, wage outlays would be reduced by KM17 million a year. Part of the savings will be offset by the need to pay contractual staff, as in the UK and other European healthcare systems where large numbers of non-medical staff have been contracted out and no longer appear as public employees.

**6.57 Healthcare revenues and spending are sizable relative to GDP, but the fiscal sustainability of the healthcare system is far from assured.** Small risk pools, pervasive evasion and large exemptions from making health insurance contributions are among the key threats. About one-half of those who receive health insurance coverage are exempt from paying contributions (Table 6.13). These include pensioners, the unemployed, the disabled and the war veterans. The health insurance for these categories is financed via transfers from other extrabudgetary funds (the PIO for pensioners, the EI for the unemployed) and from general revenues (for the disabled and for war veterans). Other threats include generous benefits packages and inefficient hospital system (see below).

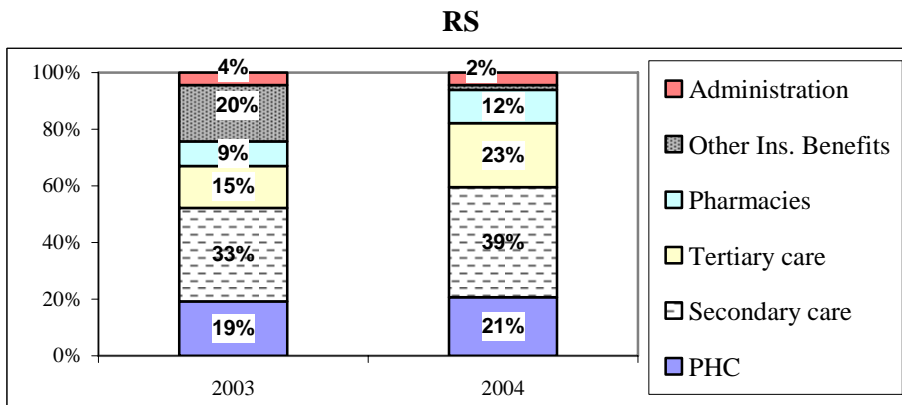
### The Delivery and Utilization of Healthcare

**6.58 Improvements have been made over the last several years, but service delivery remains inefficient, reinforced by still large outlays on costlier secondary and tertiary healthcare.** The

Figure 6.7. BH: HIF Expenditures by Functional Categories  
(In percent of the total)



Source: Annual Reports HIFs FBH.



Source: Annual Reports HIF RS.

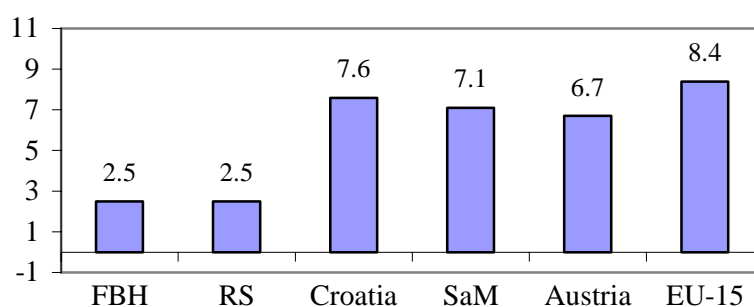
pattern is particularly pronounced in the RS, where only a fifth of total spending is for preventive and primary healthcare (PHC) (Figure 6.7). By contrast, more effective PHC have not been sufficiently emphasized. In the RS, 61 percent of HIF outlays are on in-patient care, substantially higher than in the FBH (49 percent), the Czech Republic (36 percent), Slovakia (35 percent) or Hungary (29 percent).<sup>18</sup> The RS also spends an additional 12 percent for tertiary care abroad (mainly to Serbia) compared to 1 percent in the FBH. The high share of RS spending on treatment abroad deserves the authorities' attention. Rules for sending patients abroad need to be more strictly defined, and case audits carried out. Treatment abroad should be contracted based on transparently executed tenders, not based on individual invoices without pre-agreed prices.

### Preventive and Primary Healthcare

**6.59 The utilization of PHC is substantially lower than among other countries, notably three times as low as in neighboring Croatia and SaM (Figure 6.8).<sup>19</sup>**

Combined with over-staffed health facilities, low utilization translates into low productivity. The 2,099 physicians in PHC facilities report a load of 18.6 patients per physician per day in the RS and 20 in the FBH.<sup>20</sup> These numbers compare with 33 visits in the USA, a level that is reasonable to apply as a standard for capacity.<sup>21</sup> Moreover, PHC physicians in BH resolve only about one-half of the PHC cases in BH and refer the rest to the more expensive secondary and tertiary care level.<sup>22</sup> Such referrals are often unnecessary. Efforts to improve preventive care and to resolve a large number of cases at the primary level by adhering to standard referral protocols should help improve productivity.

Figure 6.8. Annual Outpatient Contact Rates, Selected Countries



Source: WHO and World Bank staff calculations.

Table 6.14. Number of Beds and Physicians, Selected Countries, 2003

	RS	FBH	BH	Finland	Mexico	LMIC 1/
Beds 2/	258	358	319	228	110	225
Physicians 3/	1.18	1.62	1.45	2.6	1.5	1.75

Sourcess: Entity HIFs and IPHs and WHO.

1/ Lower-medium income countries, as per the World Bank classification.

2/ Per 100,000 population.

3/ Per 10,000 population.

<sup>18</sup> WHO: Health For All, In-patient spending in percent of total health spending.

<sup>19</sup> WHO: European Health for All Database, <http://data.euro.who.int/hfad/>

<sup>20</sup> Of the 2,099 PHC physicians, 857 are in the RS and 1,242 in the FBH.

<sup>21</sup> The US full capacity norm for PHC physicians is 33 visits per day. See: US Department for Health and Human Services, <http://bphc.hrsa.gov/>

<sup>22</sup> Cain, J. et al, 2002, *Healthcare Systems in Transition: Bosnia and Herzegovina*, European Observatory on Healthcare Systems, 4(7), <http://www.euro.who.int/document/E78673.pdf>

## *In-Patient Care*

### **6.60 The hospital sector displays signs of considerable inefficiencies.**

The number of hospitals per population in BH is twice as high as in other countries in the region, notably SaM, and the more efficient EU healthcare systems such as Sweden and Finland (Tables 6.14 and 6.15).<sup>23</sup> A considerable number of hospitals are too small to benefit from economies of scale and ensure efficiency, and many of them serve a catchment area too small to ensure efficient utilization of the facility.

BH, and especially the FBH, has more hospital beds per population than many other lower middle-income countries and some more efficient EU countries. To reach Swedish and Finnish bed levels, BH would need to close 3,666 beds (526 in the RS and 3,140 in the FBH); and adjust infrastructure accordingly. Such restructuring of beds and facilities requires a health sector rationalization strategy, substantial strengthening of the primary care system and a shift to day care surgeries.

**6.61 The human resource situation in hospitals needs to be rationalized.** While the average number of physicians per population is similar to other countries, BH physicians report extremely low productivity with an average of 1.7 patients discharged per physician per week. This could indicate that physicians spend a substantial portion of their time working in private practices while being on the public payroll. Increasing the patient load to a moderately higher 2.2 patients discharged per physician per week would reduce the number of physicians working in hospitals by 766 (118 physicians in the RS and 648 in the FBH). Assuming a gross average salary of KM1,050 a month, this would result in annual savings of KM9.7 million. Further analysis is needed to develop a human resource strategy and rationalize the manpower mix in hospitals.

**6.60 To improve hospital productivity, the average length of stay should be shortened, bed occupancy increased and the number of beds reduced.** Hospitals in BH report relatively low admission and occupancy rates but substantially longer average stays (ALOS) suggesting that patients are kept hospitalized for longer than necessary (Table 6.16). The ALOS in hospitals can be reduced by improving admission management, facilitating earlier discharge and strengthening coordination among levels of providers, including from inpatient to outpatient.

Table 6.16. Hospital Productivity, Selected Countries

	BH	Croatia	FYR M	SaM	Finland	EU-15
ALOS 1/	10.4	11.2	11.8	11.0	4.3	7.5
Percent of beds occupied	71	90	54	69	75	73

1/ Average Length of Stay.

**6.62 The lack of centralized planning for high-cost tertiary care and medical technology (MT) results in inefficiencies and inequalities in the supply of and access to MT.** Investment in high-cost medical equipment occurs in different hospitals within BH, often resulting in duplication and insufficient patient loads, with negative implications for effective utilization of such investments, quality of care and patient

<sup>23</sup> Comparing with other countries in former Yugoslavia is a useful benchmark, but most of these countries need to carry out their own health reforms, including hospital rationalization.

safety. The relatively low production volume per treatment per hospital results in high costs per treatment paid both by the HIF and the patient, inefficient use and idle resources. With MT being a major drive of healthcare costs throughout the world, controlling costs and ensuring patient safety would require the authorities to consolidate high-cost MT into one or two tertiary hospitals and ensure an efficient referral system.

Table 6.17. Registered Private Providers, 2004

	RS	FBH	Total
Total	537	776	1,313
Pharmacies	162	193	355
Wholesalers,	45	46	91
Clinics (registered)	330	537	867

Sources: MOH, IPH and HIFs.

### *Private Healthcare*

**6.63 There is no oversight, regulation or information on healthcare delivered by private establishments** (Table 6.17). Private providers are registered, but not regulated or subject to quality inspection. While private sector care is not covered by the public health insurance, the large and growing number of private providers, combined with low utilization rates in public facilities suggests that a significant proportion of the population uses private providers. The private sector appears to be either offering a combination of better service and shorter wait-times, or is benefiting from referrals from public sector physicians to their own facilities.

### *Pharmaceutical Procurement*

**6.64 Inefficiencies in healthcare spending are further illustrated by the fragmented process of drug procurement.** Most pharmaceuticals are imported, with 91 private wholesalers in BH involved in the process. In the FBH, the FBH Solidarity HIF procures all high-cost drugs, while the cantonal HIFs procure other medication. Each of the 13 HIFs in BH has its own drug procurement rules, procedures and positive lists. Given small volumes, decentralized procurement results in substantially higher prices, with prices often substantially different across the cantons or the entities. Some cantonal HIFs are too poor to have even moderately innovative drugs on their lists.<sup>24</sup> Providers in the poorer cantons, moreover, often ration drugs, favoring patients who are able to pay informally. The government is advised to follow the good practice established in the Tuzla canton and ensure transparent and effective procurement on a central level with a single positive list to offer quality drugs to all patients in BH.

Table 6.18. Estimated Pharmaceutical Expenditures, 2004 1/  
(In millions of KM unless indicated otherwise)

	RS	FBH	BH
Total pharmaceutical spending	44	136	180
(In percent of health spending) 2/	13	15	15
HIF to pharmacies	24	94	118
In- and out-patients	20	42	62

Sources: BH authorities and World Bank staff calculations.

1/ Includes payments by HIF and the population. HIF payments for pharmaceuticals in health facilities are not included.

2/ Of the entity or BH overall.

**6.65 The unequal access to pharmaceuticals is amplified by the established inefficient system for pricing and procurement, which combined result in lack of transparency and increased risk for corruption.** The RS uses a system of reference prices based on a generic drug level to define sales prices for HIF reimbursable drugs. Pharmacies sell drugs at a price about three times above the MoH

<sup>24</sup> See: Andreas Seiter, 2005, *The Pharmaceutical Sector in Bosnia and Herzegovina*, The World Bank.

suggested prices.<sup>25</sup> In the FBH, drug prices are not regulated, but are set in a non-transparent way with preferred manufacturers and wholesalers in the cantons. The costs related to inefficient pricing and procurement are shifted to the patients, with co-payments for the same drugs varying between 25 and 100 percent of drug prices across the cantons and the entities. In 2004, out of pocket co-payments for drugs financed at least one-third of total pharmaceutical expenditures (Table 6.18).

## Health Outcomes

**6.66 Substantial improvements have been achieved since the war but some health indicators still raise concerns.** Infant mortality is higher than in Croatia, SaM and most CEE countries (Table 6.19). The incidence of tuberculosis is above the levels reported in neighboring countries and four times higher than the EU average. Disability, posttraumatic stress, depression and chronic diseases including high blood pressure, arthritis and diabetes rank highly on the burden of diseases. Diseases of the heart and circulatory system, stroke and cancer have increased above European averages. Cancer is one of the leading causes of death and lung cancer the leading cause of cancer deaths, with BH reporting the highest mortality rates from lung cancer among the countries in ECA.<sup>26</sup> Accidents and injuries are at a high level and appear to be rising.

**6.67 Population ageing is exerting new demands on the healthcare system.** About 11 percent of the population is estimated to be older than 65 years of age, up from 6.4 percent in 1991. Together with ageing, the incidence of chronic diseases has risen, including high blood pressure, arthritis and diabetes.<sup>27</sup> Diseases of the heart and the circulatory system, stroke and cancer have increased sharply to levels above the European average.<sup>28</sup> These diseases are the leading causes of death.

Table 6.19. Health Indicators for Selected Countries, 2002

	BH	Croatia	Bulgaria	Estonia	Low middle income
Population growth (In percent)	1.3	0.1	-0.5	-0.4	1.3
Fertility rate (Births per woman)	1.3	1.5	1.2	1.4	2.1
Life expectancy at birth, male (In years)	71.0	69.0	68.0	65.0	69.2
Maternal deaths (Per 100,000 live births)	31.0	10.0	5.8	7.7	
Infant mortality (Per 1,000 live births)	14.0	6.0	14.0	9.0	31.4
Immunization, measles (In percent)	89.0	95.0	92.0	95.0	75.0
Tuberculosis incidence (Per 100,000)	56.1	44.4	44.2	56.0	161.3

Sources: World Bank: HNP statistics; and the WHO.

**6.68 A lot remains to be done to improve the population's health.** Policy measures must focus on facilitating access to quality care for low-income groups, implementing effective preventive care

<sup>25</sup> This is due to accumulated wholesale margins as wholesalers sell drugs among themselves charging the margin at each transaction.

<sup>26</sup> BH is also the leading cigarette consumer in Europe, with survey data suggesting that 48 percent of the population smokes. Estimates from higher-income countries suggest that smoking accounts for 6-15 percent of the overall cost of healthcare and estimates for BH are probably at the higher end.

<sup>27</sup> LSMS Wave 4, 2004.

<sup>28</sup> See WHO: Atlas of Health in Europe 2003; IPHs (FBH and RS): Annual Health Statistics 2003.

measures to curb the incidence of high-cost diseases (cancer and heart diseases), and the rational use of secondary and tertiary care.

## **Health: Recommendations**

**6.69 The current organization, financing and functioning of the health sector does not contribute to achieving the governments' overall health policy goals.** Relative to countries with similar income levels, BH spends more on healthcare, reports lower utilization and productivity levels and poorer health outcomes. The following recommendations are based on this chapter's analysis.

### *Reform Health Insurance*

- **Review the rationale for making available free health insurance to internally displaced persons (IDP) and refugees and limit free health insurance only to veterans with high levels of disability.**
- **Consider shifting the collection and control of health contributions to at least an entity level authority to help improve collection.**
- **Pool the insurance risk related to hospital and pharmaceutical care at least on an entity level.** Subsequently, in the FBH, centralize major insurance functions including collection, contracting and purchasing to the entity level and harmonize operation of cantonal funds.
- **Ensure insurance portability and a common benefit package at least at the entity level.**

### *Improve Governance*

- **Work towards reducing fragmentation and doubling of functions. Consider consolidating at the entity level health functions** including policy and strategy, planning, financing, and regulation of the public and private sector. Reduce staff levels in the administration of health care, including in the MoHs and IPHs.
- **Institutionalize the National Health Accounts (NHA) to ensure provision of standardized and timely information needed for policy development and monitoring.**
- **Enact and enforce clear rules governing the private sector including the use of public resources for private practice and referrals from public to private practices.**
- **Validate and resolve the arrears situation and tighten policies to prevent new accumulation of arrears.**

### *Advance Hospital Rationalization*

- **Restructure and rationalize hospital care and build networks of care with referral patterns to ensure an equal access to cost-effective and high-quality services.** Reduce the number of beds and implement standards to help reduce the average length of stay in hospitals. Plan the number of hospitals

based on an entity level, and for tertiary care on a state-level for efficient population catchment area of 2.5–3 million.<sup>29</sup>

- **Limit high-cost procedures to few hospitals and reorganize care towards ambulatory and/or day care.**
- **Strengthen the PHC providers as gatekeepers to hospital care and ensure efficient referrals.**
- **Advance hospital rationalization and reduce staff more in line with the degree of utilization of health facilities.**

### *Rationalize Pharmaceutical Procurement*

- **Support creating a central drug agency in charge of quality control, positive list and pricing.**
- **Limit reimbursement for non-innovative drugs to the lowest generic equivalent.**
- **For new drugs, consider limiting reimbursement to the lowest cost therapeutic equivalent to keep expenditures for new drugs at market-entry under control.**
- **Centralize procurement of drugs to at least the entity level and purchase all generic and hospital drugs through competitive tenders.**
- **Enact transparent regulations of pharmacies.**

### *Improve the Efficiency and Equity of Access to Healthcare*

- **Increase emphasis on preventive medicine** (e.g. cancer screening, hypertension screening, diabetes prevention, tobacco cessation, mental health care) **to reduce high-cost diseases.** Smoking prevention is among the most cost-effective health interventions.<sup>30</sup>
- **Charge progressive co-payments for treatment abroad based on patients' socio-economic background.**
- **Target low-income groups with services such as immunization, prevention of tuberculosis and respiratory infection, and reproductive health care.**
- **Take an aggressive stance against staff who take informal payments (bribes) from patients.**

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<sup>29</sup> Howard Lyons and Robert Tinston, 2003, London International Healthcare Ltd.: Preparation for a Masterplan.

<sup>30</sup> Gallus et al, 2003, *Price and consumption of tobacco in Italy over the last three decades*, European Journal of Cancer Prevention, 12(4):333-337.

## E. SOCIAL PROGRAMS FINANCED FROM GENERAL REVENUES

**6.70. Non-insurance social transfers in BH are high by international standards and have had only a modest impact on poverty alleviation.** Social transfers financed via general revenues amount to 4 percent of GDP in BH, with veterans' benefits accounting for about two-thirds of the total (Table 6.20 and Figure 6.9). In contrast to other countries, only a small fraction of general revenue financed transfers are means-tested with the aim of providing a safety net for the most vulnerable groups. Cash transfers to individuals are budgeted to increase further in 2006, notably in the FBH, due to a continued proliferation and expansion of benefits.

Table 6.20. BH: General Revenue Funded Cash Transfer Spending, 2002-2005  
(In millions of KM and in percent of GDP)

	2002		2003		2004		2005	
	In millions of KM	In % of GDP	In millions of KM	In % of GDP	In millions of KM	In % of GDP	In millions of KM	In % of GDP
FBH	472	4.5	480	4.3	474	4.0	481	4.3
Child protection	31	0.3	47	0.4	48	0.4	38	0.3
Social welfare 1/	61	0.6	66	0.6	68	0.6	71	0.6
Veterans' benefits	331	3.2	316	2.8	318	2.7	334	3.0
Refugees benefits	48	0.5	51	0.5	40	0.3	38	0.3
RS	137	2.9	164	3.4	180	3.7	170	3.5
Child protection	21	0.4	16	0.3	21	0.4	25	0.5
Social welfare 1/	9	0.2	12	0.3	14	0.3	10	0.2
Veterans' benefits	85	1.8	112	2.3	117	2.4	114	2.4
Refugees benefits	22	0.5	24	0.5	28	0.6	20	0.4
<b>Total BH</b>	<b>608</b>	<b>4.0</b>	<b>644</b>	<b>4.0</b>	<b>655</b>	<b>3.7</b>	<b>651</b>	<b>3.5</b>

Sources: BH governments and World Bank staff estimates.

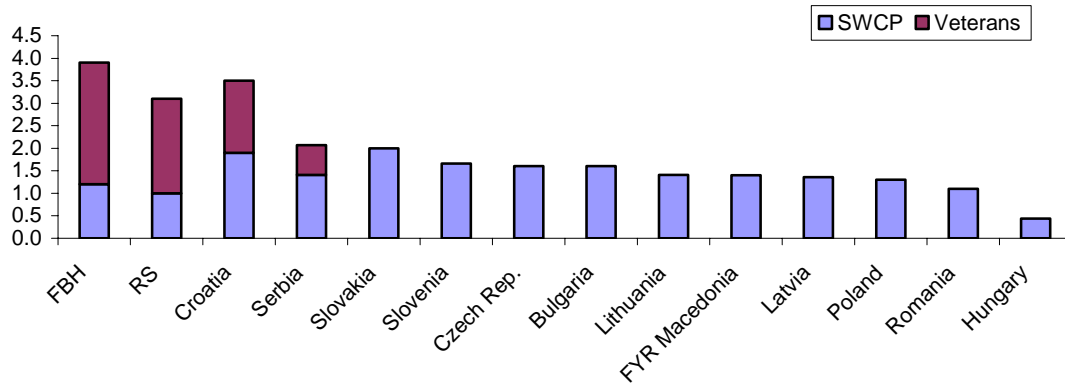
### E.1 VETERANS' BENEFITS

**6.71. Veterans' entitlements are similar in both entities, covering disability benefits for military war invalids and survivor benefits for members of families of killed soldiers.** Disabled veterans' can also qualify for a carer's allowance and orthopedic aid. The bulk of these benefits are financed from the Ministry of Veterans' Protection in the FBH and the Ministry of Labor and Veteran-Invalid Protection in the RS. The cantons and municipalities in the FBH and the municipalities in the RS finance additional entitlements. The entity ministries are organizationally separate from the social welfare ministries and their administrative structures at the entity and sub-entity level, such as the Centers for Social Work (CSW) that administer most other social benefits.

**6.72. With more than one-half of the beneficiaries under the veterans' programs members of families of killed soldiers, these programs are more appropriately defined as survivor family schemes and disability programs.** In the RS, 41,000 family members and 39,000 military war invalids received benefits in 2005. In the FBH, the ratio is even starker, with more than 51,000 family

beneficiaries and 44,000 military war invalids. Family beneficiaries include the immediate family (spouse and children) and the wider family (parents, siblings and grandparents).

Figure 6.9. Spending on Social Welfare in Selected Countries 1/  
(In percent of GDP)



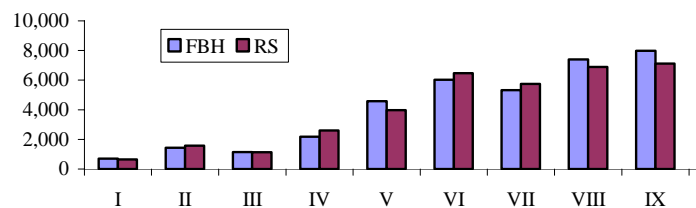
Source: BH governments and World Bank staff estimates.

1/ Data for BH and Croatia is for 2004 and for Romania from 2002. The calculations for BH are relative to adjusted GDP. The RS figures include outlays for child protection, also financed via social security contributions.

**6.73. Despite some recent tightening of benefit eligibility, veterans’ benefits are not based on need.** Recent reforms have resulted in some reallocation of spending to the more disabled veterans, but unlike other disability benefit systems in BH or elsewhere, veterans’ disability benefits are not limited to those who are 50 percent or more disabled. Benefits are awarded on functional disability rather than on inability to work, and the system remains dominated by beneficiaries with relatively low levels of disability, disability categories VII-X (Figure 6.10). Furthermore, the FBH recently introduced an additional system that awards benefits to war medal holders, irrespective of disability status. In the FBH, the new veterans’ protection law stipulates that the benefit levels for parents of killed soldiers who are married depends on income, but the eligibility for this benefit does not. Under the new RS legislation, benefit levels can be reduced by 50 percent for those beneficiaries whose annual net income is more than twice the average net annual wage in the RS. However, there is considerable scope for better alignment of veterans’ benefit eligibility with receipt of other social protection benefits and wage income.

**6.74. There is considerable scope for “double dipping.”** Veterans’ disability beneficiaries can also qualify for a disability pension under the social insurance system or for an old age pension, provided they meet the social insurance eligibility requirements. Similarly, survivor families can qualify for veterans’ survivor benefits and social insurance financed pensions. The authorities will be well advised to limit scope for double dipping by making it difficult

Figure 6.10. BH: Veterans Beneficiaries by Category, 2004



Sources: Entity Ministries of Veterans’ Protection.

to receive more than one social benefit. For example, disabled war veterans' and survivor family beneficiaries who currently qualify for veterans' benefits, old-age or survivor pensions could be given the choice of either a social insurance funded pension or a veterans' benefit. Likewise, recipients of disability benefits (veterans', CVW and non-war disabled) who also qualify for a disability pension could be required to choose between the two benefits. Initial estimates show that limiting veterans' benefits to those parents and grandparents of deceased soldiers who do not qualify for old age pensions could save roughly KM30 million a year in the FBH and KM10 million a year in the RS.

**6.75. Veterans' benefits are high relative to other disability benefits, pensions and average wages.**

The average size of veterans' benefits is five times the average payment to civilian victims of war (CVW) or the average disability benefit in the FBH, and 60 percent in the RS. Benefits for the first five categories of disability are higher than the average wages in both entities. For example, payments to category I disabled are about three times the average wage in both entities. By contrast, benefits at the other end of the disability spectrum are low, suggesting that such benefits play more of a role of recognition of veteran status rather than of substantial income support. Due to the high number of low level disability beneficiaries, even these low benefits result in substantial outlays.

### **Veterans' Benefits: Recommendations**

- **Further focus veterans' programs on the most vulnerable, while achieving savings to bring down the overall high general revenue financed social transfer expenditures and to reallocate resources to the basic social safety net. Measures to that end could include:**
  - **Limit veterans' disability benefits to disability categories I-VI. Remove benefit eligibility for veterans' in disability categories VII-X to bring eligibility for categorical disability in line with that of CVW, other disability benefits and international practice.** The savings from such a measure could amount to KM20 million a year in the FBH and KM10 million a year in the RS.
  - **Refrain from implementing the FBH system for holders of military decorations. Introduction of this benefit is estimated to cost KM 18-20 million, an expense that is hard to defend in the face of underfunded benefits for those most in need.**
  - **Adjust veterans' and family benefit levels downward to align them more with benefit levels for CVW and disability benefits.** There are two options: either legislate lower benefit levels or utilize the benefit rationing mechanism available in veterans' legislation in both entities.
  - **Prevent "double dipping" for all beneficiaries by making benefits exclusive of one another.**
  - **Review disability assessment rulebooks to allow for more consideration to work ability and create a single assessment and administration system for all disability benefits.** Tighten eligibility for benefits, especially at the lower end of the categorical disability distribution. Introducing joint disability assessment rulebooks for veterans' and non-veterans' alike may be an opportunity to introduce a limit of disability benefit eligibility to those persons with a disability status above 50 percent (currently disabled veterans' are entitled to benefits if they have a disability status above 20 percent).
  - **Discontinue additional cantonal and municipal veterans' benefits programs that are usually not targeted to need, such as such as free transport, employment stimulation and housing programs.** At present, cantons and municipalities continue to provide heavily subsidized housing to war veterans without verifying employment status or need.

## E.2. SOCIAL WELFARE AND CHILD PROTECTION BENEFITS

**6.76. The social welfare and child protection (SWCP) system in BH remains underdeveloped, with spending relative to GDP lower than in almost all countries in the broader region.** BH has substantially higher poverty incidence than the NMS on average, but outlays on SWCP amounted to 0.9 percent of adjusted GDP in 2005, almost half the average level among the NMS. Moreover, most of the expenditures reflected outlays for child protection in the RS and in the Sarajevo canton, and for social welfare in the Sarajevo canton.

**6.77. Decentralized financing mechanisms result in substantial inter-regional disparities in coverage, with the poorer localities providing the least amount of services** (Table 6.21). In the face of resource constraints, eligibility criteria for most benefits are *ad hoc*, as local welfare offices use discretion when rationing available resources. The only notable exception to this pattern is the child benefits system in the RS. This system is financed centrally via a payroll tax and administered by a semi-autonomous institution, the Child Protection Fund, although at local level benefit eligibility is assessed by the CSW.

**6.78. The SWCP system is underfunded, but there are multiple poorly coordinated programs with substantial scope for “double dipping.”** In the RS, the social protection system foresees a child allowances contingent on an income test and the number of children. Additional benefits in the RS include: a child birth grant; maternity benefits and assistance to unemployed mothers of young children; material assistance for newborns and nutritional supplements for newborns and their mothers; cash social assistance payments conditional on income and inability to work; a carer’s allowance for disabled in need of home care, one-time social assistance; accommodation in social care institutions or foster families; health insurance for social assistance beneficiaries; and disability benefits for civilian victims of war with disability of more than 50 percent. In the FBH, entity level legislation foresees the same benefits, though the financing and definition of implementation is left to the cantons, with the outcome that many of these benefits are only sporadically or not at all available in the poorer cantons and municipalities. The Sarajevo canton, on the other hand, has a broad benefit system, which comprises price compensations and utility allowances in addition to the above named benefits. The FBH recently also adopted legislation to provide entity level financed disability benefits to non-war disabled, though the system to administer these benefits has not yet been established.

**6.79. The separation between policy development and implementation engenders mismatches between legislative mandates set at the entity level and what can be afforded and implemented at the sub-entity level.** In the FBH, the

Table 6.21. BH: Beneficiaries of Social Welfare and Child Protection Programs, 2004

Benefit Type	FBH	RS
<b>A. Social Welfare</b>		
Permanent Social Assistance	12,967	6,177
Recipients		4,170
Eligible but not receiving		2,007
Carer's Allowance	13,649	5,540
Recipients		2,904
Eligible but not receiving		2,636
One-Time Assistance	10,318	12,023
Transfer for Family Care	n/a	762
Transfer for Residential Care	n/a	984
RS		794
FBH		190
Health insurance	n/a	6,568
Other benefits	n/a	5,601
Total	36,934	37,655
<b>B. Child Protection</b>		
Maternity Benefit	11,226	4,414
For employed mothers	2,980	1,266
For unemployed mothers	8,246	3,148
Breast-feeding allowance	n/a	11,290
Child allowance	39,933	24,504
Child development programs	n/a	1,634
Preschool	n/a	3,141
<b>C. Civilian Victims of War</b>		
	6,789	3,483

Sources: RS and FBH governments; RS Child Protection Fund; cantonal ministries; and the EPPU.

Ministry of Labor and Social Policy has been in charge of overall policy but has not been responsible for benefit financing. Each canton has the jurisdiction to define specific benefits and allocate funding either completely to the municipal or cantonal level, or as a shared responsibility between the canton and the municipalities. This has resulted in a system where each canton essentially defines its own parameters for eligibility, benefit amount and benefit types. In practice, only the wealthier cantons, such as Sarajevo, actually provide a full range of benefits, including child and maternity benefits, social assistance and disability for civilian victims of war. The FBH government has expressed its intention to shift the responsibility for financing and administering child protection and CVW benefits to the entity level to ensure greater uniformity and equity in the system. When this will become reality is unclear at present, however.

**6.80. The centralization of social welfare and child protection financing in the RS is well advanced.** In a marked contrast to the FBH, the entity-level Child Protection Fund in the RS finances benefits uniformly across the entity.<sup>31</sup> Disability benefits for civilian victims of war are financed at the entity level and administered by the Ministry of Labor and Veteran Invalid Protection. Social assistance and allowance for care of another person, by contrast, are financed at the municipal level.

**6.81. Coverage of the social protection system in both entities is limited and varies considerably across the cantons and the municipalities.** The number of social welfare beneficiaries registered at the CSW is large, but only a fraction receive cash benefits. In the FBH, more than 188,000 beneficiaries are registered at the CSWs and in RS almost 90,000, or altogether more than 7 percent of BH's population. Despite low income thresholds, there is a substantial number of people who are registered to receive social assistance benefits in principle, but receive nothing or little due to shortage of funds. As a result, only 1 percent of those below the poverty line in the RS and 4 percent in the FBH receive social assistance. Coverage is much more substantial for child and maternity benefits in the RS, but is available in only four of the ten cantons in the FBH. Similarly, disability benefits for civilian victims of war are provided in eight of the ten cantons, with substantial variation in coverage and benefit levels.

**6.82. Variations in coverage are accompanied by variations of the actual level of benefits received.** For example, in 2004 the average monthly social welfare spending per registered recipient ranges from KM2 in East Stari Grad to KM69 in Milici, both in the RS. These figures compare with an average monthly wage in the formal sector of KM422 and a monthly poverty line of KM185. Similar variation is found across the municipalities and cantons in the FBH (Figure 6.11).

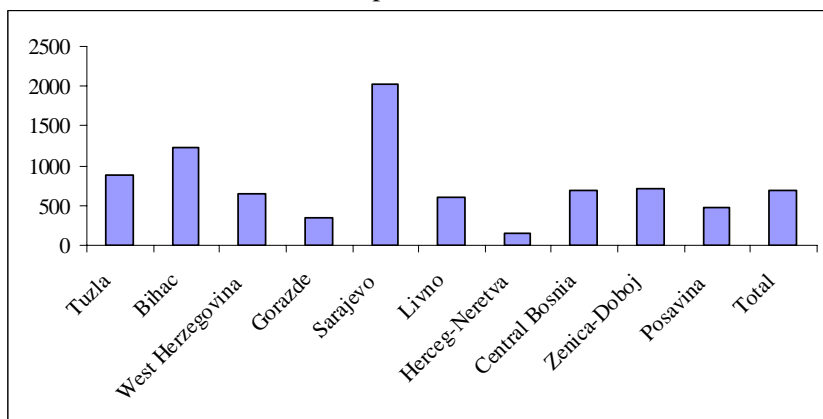
**6.83. The targeting mechanisms currently legislated and employed for social assistance and child benefits are underdeveloped.** Targets are based on income, a variable that is hard to measure with confidence given the large and growing informalization of the economy. As an example, the monthly income threshold to qualify for child benefits in the RS is KM53 per capita and for social assistance is KM47 per capita. This is well below both the poverty and the extreme poverty lines, defined as consumption levels of KM185 per month per capita and KM64 per month per capita, respectively.<sup>32</sup> However, EPPU's recent poverty analysis found that there is no absolute poverty in BH. This suggests that there should be no recipients of child benefits and social assistance, yet almost 22,000 families qualify for child benefits and over 6,000 people qualify for social assistance. The same considerations apply to the child benefits and social assistance systems in the FBH. With income clearly a poor choice for targeting social protection, the authorities would be well advised to explore alternative options, such as using proxy-means indicators to target these benefits to the most vulnerable groups.

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<sup>31</sup> Law on Child Protection, June 1996, amended in 1998 and 2001.

<sup>32</sup> See: EPPU, 2005, *Poverty Update*.

Figure 6.11. FBH Cantons: Social Assistance Spending Per Recipient, 2004



Source: Ministry of Labor and Social Policy and staff estimates.

**6.84. Expenditure pressures, inefficiencies and inequities in the current system of multiple social benefits call for action to further streamline and better target these expenditures to the most vulnerable groups.** The governments indicated recently their intentions to embark on a medium-term reform of social protection aimed at reorienting expenditure from veterans' programs to SWCP, while reducing overall social protection expenditure as share of total spending. First steps in this process included some tightening of veterans' benefit eligibility and

limiting expenditures, which have led to a nominal freeze in veterans' benefit expenditure in RS. In the FBH, by contrast, expenditures on veterans' programs are on the rise, and the proliferation of new benefits is ongoing. This report endorses the fundamental logic of the initially formulated reform agenda. However, it suggests the need for more far-reaching adjustments if the goal of creating a well-targeted and fiscally sustainable basic social safety net is to be achieved. Recommendations in line with the analysis above are summarized in the following section.

## Social Welfare and Child Protection: Policy Recommendations

- **Centralize further financing for the core SWCP benefits to help narrow the gaps in coverage of basic social assistance in the RS and social welfare and child protection in the FBH.** While some additional financing is required in both entities, the primary focus needs to be on a more even and targeted provision of benefits rather than on securing additional budgetary resources.
- **In both entities, make financing of basic social welfare and child protection (already done in the RS) an entity level responsibility.** Consider merging child allowance, social assistance and benefits for the refugees and the IDPs into a single benefit.
- **Introduce and utilize a coefficient rationing provision for social welfare and child protection benefits.** Such a rationing mechanism is in place in veterans' benefit legislation in both entities and disability benefit legislation in the FBH, as well as in draft FBH legislation on child allowances and CVW benefits.
- **Develop a more rigid method for targeting benefits, including greater reliance on means- and proxy means-testing.** The latter have performed well elsewhere in conditions of low administrative and staffing capacity.
- **Review financing arrangements for social protection between general revenue and payroll taxation financing.** In the RS, move financing for child allowance to general revenue, but retain payroll contribution financing for maternity benefits. This would entail a transfer from general revenue to the RS Children's Fund, possibly through the Ministry of Health and Social Welfare.