Final Consultancy Report
on Design of the
Affordable Quality Healthcare Project
of Kosovo

on behalf of Swiss Development Corporation

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Table of Contents

1. Acknowledgements 5
2. Acronyms 5
3. Executive summary 6
   3.1. Suggested Vision/Goals 6
   3.2. Suggested Objectives 7
      Component A: Provider Focus- Providers enabled to meet the needs of Patients 7
      Component B: Management Focus- Managers enabled to support the Providers 7
      Component C: Population Focus- Population know/make known their needs 7
4. Background 8
   4.1. Historical Context 8
   4.2. Socio-Economic context 8
   4.3. Health System 9
      Historical Overview 9
      Structure 9
   4.4. Health System Strategy 10
   4.5. International Support 10
   4.6. Population Health Status and Utilization of Health Services 11
5. Purpose of the consultancy and methodology 13
6. Current Situation 13
   6.1. Health Service Organization 13
   6.2. Health Financing and Spending 15
   6.3. Human Resources 16
   6.4. Medical Equipment, Medicines and Supplies 17
   6.5. Utilization of services 18
   6.6. Management of Health Facilities 19
   6.7. Special Issues 20
7. Swiss Government Role in Health Development 23
   7.1. Rationale 23
   7.2. Relevance and Coherence with Strategic Framework 23
   7.3. Involvement of Switzerland in Kosovo Health Sector 24
8. Options for Interventions 25
   8.1. Strategy for Change 25
   8.2. Suggested Project Vision 27
   8.3. Suggested Project Objectives and Intervention Strategies 27
      Component A: Provider Focus - Providers enabled to meet the needs of Patients 28
      Component B: Management Focus - Managers enabled to support the Providers 37
      Component C: Population Focus: Population know/make known their needs 43
9. Stakeholders and Potential Partnerships 47
   9.1. Key Stakeholders (see also Annex 3) 47
   9.1.1. Ministry of Health 47
   9.1.2. MoH-Related Agencies 49
   9.1.2.1. Health Funding Agency (HFA) 49
   9.1.2.2. Health Inspectorate 49
   9.1.2.3. National Institute of Public Health of Kosovo 50
   9.1.2.4. Kosovo Agency for Medical Products and Equipment (KMA) 50
   9.1.2.5. Hospital and University Clinical Service in Kosovo (HUCSK) 51
   9.1.2.6. Chambers/Professional Bodies 52

9.2. Local Governments, Municipalities ... 54
9.2.1. Kosovo Health Project (KPH)- using loan funds from the World Bank ... 55
9.2.2. Health Support Programme (LuxDev) ... 56
9.3. SDC-Supported Organisations ... 57
9.3.1. Association of Kosovo Municipalities (AKM) ... 57
9.3.2. Private Sector Development Programme ... 58
9.3.3. DEMOS -Local Governance Project ... 59
9.3.4. Kosana NGO ... 60
9.3.5. Community Psychiatry/Clinical Psychology project ... 60
9.3.6. P4H ... 61
9.4. UN Agencies ... 61
9.4.1. WHO, UNFPA, UNICEF ... 61
10. Organisation, Management & Administration ... 63
10.1. Overall Approach ... 63
10.2. Pilot Sites (PHC level and Hospitals) ... 63
10.3. Selection of Pilot Regions/Municipalities ... 65
10.4. AQH Project Management ... 68
11. Resources ... 69
11.1. Staffing/Technical Skills ... 69
11.2. Preliminary Estimation of AQH Project Costs over 4 Years ... 70
12. Risk Assessment ... 71
12.1. Government Elections ... 71
12.2. Budgetary funding ... 71
12.3. Capitation-Related PHC Budget Allocations ... 71
12.4. Municipal-Level Transparency ... 72
12.5. Private Sector ... 72
12.6. Performance Based Capitation implementation ... 72
13. Open Issues ... 73
13.1. Establishment of HUCSK and reorganization of SHC and THC ... 73
13.2. Private Health Sector Conflict with the Public Sector ... 73
13.3. Accuracy of Capitation Calculations ... 74
13.4. Management/Epidemiology Training for Long-Term Planning ... 74
13.5. Development of Professional Chambers ... 74
13.6. Support Secondary/Tertiary health facilities managed by Serbian Minority ... 74
13.7. Optional Implementation Activities/Procurement Items/Contingencies ... 74
14. Annex 1: Mission Agenda: February 14 – March 23, 2014 ... 76
15. Annex 2: Trainings Delivered to PHC Staff ... 80
16. Annex 3: Stakeholder Analysis Summary ... 81
17. Annex 4: ToR of the Consultant Team ... 84
18. Annex 5: References ... 93

Table of Figures

Figure 1: Linking Quality and Affordability 25
Figure 2: Producing Quality 26
Figure 3: AQH Approach to Improve Quality/Affordability 27
Figure 4: Tobacco use - comparison of the Kosovo to the EU and the Region (WHO 2013) 29
Figure 5: All-cause mortality rates in countries in the European Region, last reported data, 2006–2010 in comparison to Kosovo (2011). 30
Figure 6: Comparison of Kosovo to the EU and European Region, by the first five leading causes of deaths in Kosovo (Source: NIPHK 2013, HFA-DB of WHO). 30
Figure 7: Causes of Morbidity for women according to age groups and diseases 31
Figure 8: Causes of Morbidity for men according to age groups and diseases 32
Figure 9: Prevalence of some types of NCD's in Kosovo in comparison to Europe 32
Figure 10: Current PHC Budgeting Process 37
Figure 11: Potential future PHC Budgeting Process 37
Figure 12: Summary of PHC Management structure 41
Figure 13: Existing Network of Health Promotion/Education 45
Figure 14: Overview of Project Implementation Strategy 63

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2. Acronyms

AQH Project	Affordable Quality Healthcare Project of Kosovo
CPG	Clinical Practice Guideline
FM	Family Medicine
FMC	Family Medicine Center
HFA	Health Financing Authority
HI	Health Insurance
HIF	Health Insurance Fund
HIS	Health Information System
HUCSK	Hospital University Clinical Service of Kosovo
KHP	Kosovo Health Project
Lux Dev	Luxembourg Development Cooperation
MCH	Maternal and Child Health
MFMC	Main Family Medicine Center
MHI	Mandatory Health Insurance
MRI	Magnetic Resonance Imaging scanner
MoF	Ministry of Finance
MoH	Ministry of Health
NIPH	National Institute of Public Health
P4H	Providing for Health
PDSA	Plan-Do-Study-Act
PHC	Primary Health Care
PPP	Public Private Partnership
RAE	Roma, Ashkali, Egyptian
SDC	Swiss Development Cooperation
SHC	Secondary Health Care
SWOT	Strength, Weakness, Opportunity, Threat
THC	Tertiary Health Care
ToR	Terms of Reference
UCDCK	University Clinical Dentistry Centre of Kosovo
UCCK	University Clinical Centre of Kosovo
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WB	World Bank
WHO	World Health Organization

3. Executive summary

In line with the Swiss Cooperation Strategy 2013 to 2016, a team of 5 consultants carried out a review of the situation of healthcare in Kosovo from 14 February through to 23 March 2014 with a view to help suggest plans for a 4 year CHF 7.5 million "Affordable Quality Healthcare Project".

The main findings suggest that patients are not receiving high quality of care, particularly at the Primary Health Care Level, for a number of reasons, causing them to find health services elsewhere, either at higher levels of the public system, or in the private sector in-country or abroad, or abstain from modern medical treatment altogether (for the RAE community, staying at home eg for home deliveries).

A number of factors are contributing to this, a key one being the lack of government budgetary funding of the public healthcare system. However, there are also fundamental weaknesses in the coordination and management of the health system, with little opportunity for feedback from the providers or patients that could allow the system to respond better to the needs of both these important groups.

This SDC-funded Affordable Quality Healthcare (AQH) project is likely to commence almost simultaneously with two other major projects seeking to address these same issues. First, the Kosovo Health Project which is to be funded from a loan by the World Bank, will (among other things) aim to increase funding of health care through a new mandatory health insurance system. Second, funded by a grant from LuxDev, there will be the development of a new Health Information System and roll out in all Municipalities.

This leaves room for the AQH Project to focus on issues surrounding the delivery of care and health promotion/prevention services, and the key issues that will improve the quality of this, described below in the suggested vision and main objectives of the Project.

3.1. Suggested Vision/Goals

Overall (ideal) vision:

The health of the population of Kosovo has improved, with the PHC services delivered by health providers - supported by strengthened managers - able to meet the needs of the patients (especially vulnerable groups), who are more aware of their rights and needs.

Stated in more practical terms, the goals to be achieved by the end of the AQH Project:

Patients in selected Municipalities will receive health care from clinical providers who are well trained and adequately equipped in selected clinical areas such as Circulatory and Respiratory Diseases, and Maternal and Child Health Care (MCH).

These clinical staff will be supported by managers who are listening to them and aware of their facility situation and needs, ensuring maximal long term efficiency of the available health budgets.

The patients' educational needs in relation to selected health prevention and promotion issues will be met as conveniently for them as possible, and transparent processes of feedback to the health authorities will be in place that result in appropriate responses.

3.2. Suggested Objectives

Component A: Provider Focus- Providers enabled to meet the needs of Patients

The objectives for this component are as follows:

1. Facilities at PHC and referral levels supported to improve clinical care practices in "selected" thematic areas in order to ensure patients receive appropriate, timely and cost-effective care.
2. Facility management standards, at least at the PHC level, are reviewed and refined, in order to allow a system of effective supportive supervision and monitoring processes and to promote consistency of best practices across the levels of the health care system.
3. Health care professionals (especially at PHC level) have increased access to relevant educational training information in order to improve their health-related knowledge and understanding in selected thematic areas for the benefit of their patients
4. The Chamber of Healthcare Professionals of Kosovo is supported to develop and function, in particular, to promote sufficient, relevant and regular Continuous Professional Development programmes for the PHC (and hospital) health care staff.

Component B: Management Focus- Managers enabled to support the Providers

The objectives for this component are as follows:

1. Facility heads of PHC will be better able to carry out basic planning and budgeting functions for their facilities in order to argue for allocated and, if possible, appropriate funds.
2. Health service managers (at Municipal and MoH levels) are enabled to understand, evaluate and respond effectively in order to meet the needs of the facility staff at the PHC level.
3. Issues are identified that should result in greater efficiency and implemented through pilots to promote long term cost savings and rationalization.
4. Policy-level analysis and evaluation of data (evidence-based) is improved at the relevant managerial level(s) for relevant, efficient, "provider-oriented", long term decision-making.

Component C: Population Focus- Population know/make known their needs

The objectives for this component are as follows:

1. The health education needs of the population are assessed in relation to available IEC materials in order to address the information gaps (including those of the vulnerable groups).
2. Appropriate IEC materials are developed (created/adapted), produced and distributed to the relevant population at selected sites on issues of selected thematic areas, while simultaneously strengthening mechanisms of delivery (PHC facility staff, schools, home visits, media etc) and monitoring.
3. The patient/population feedback mechanisms to the health providers and managers are improved (systems developed, transparency achieved, responsiveness assured) in order to ensure that ideas for improvements (including those arising from complaints) are identified and appropriately addressed.

4. Background

4.1. Historical Context

Prior to the war period in 1999, Kosovo was part of Yugoslavia, and all its structures, including the health system, operated according to Soviet-style principles and structures. The health system apparently functioned well especially at the Primary Care level. The population paid health insurance premiums and the quality of care they received met their expectations, with good access and availability of services for no extra costs.

During the 1990s, health system started to show severe failures and collapsed, due to multiple socio-economic, political problems that culminated by the war in Kosovo. From 1990 to 1999 all Albanian Kosovars were sacked from their public posts (including health professionals), and this led to a gap in both skills maintenance and new knowledge.

During the war a lot of infrastructure and systems were lost, and these have been rebuilt Municipality by Municipality with support from different donor agencies and using strategies that vary from the ex-Soviet models, for example tax based health financing model, introduction and the development of Family Medicine (General Practitioners) as a model, changed management of Regional Hospitals and UCCK etc.

4.2. Socio-Economic context

Kosovo's economic growth has been steady, generally at rates above those in neighbouring countries. The GDP average growth rate of 4% during 2009–2012 has largely been attributable to public investments in post-conflict reconstruction, donor assistance, and remittances (Table 1). The particular structure of Kosovo's economy—with limited financial linkages and a small export base—has implied that, similar to the aftermath of the global crisis in 2008–09, spillovers from the worsening Eurozone crisis have been less severe than in neighbouring countries. In particular, remittances recorded as "transfers" in the balance of payments, foreign direct investment (FDI), and other non-debt creating flows from Kosovars living in Germany and Switzerland are expected to remain relatively stable. FDI inflows, covering close to 60% of the current account deficit, are expected to surge over the medium-term horizon, reflecting considerable investor interest in the telecommunications and energy sectors[1].

Despite large investments from the international community in recent years, the needs and challenges in Kosovo remain numerous almost thirteen years after the conflict. Kosovo continues to face a vicious cycle of low growth, significant trade imbalance and fiscal constraints. The industrial sector of the economy remains weak and the electric power supply remains unreliable, acting as a key constraint.

Table 1: Main Socio-economic Indicators

	2003	2008	2009	2010	2011	2012
Population, total (million)	1.7	1.75	1.76	1.78	1.79	1.8
GDP (current US$, million)	3 355	5 642	5 449	5 594	6 453	6 238
GDP growth (annual %)	5	7	3	4	5	4
Life expectancy at birth, total (years)	68	69	70	70	70	…
Poverty headcount ratio at national poverty line (% of population)	34.8*	45.1**	34.5	29.2	29.7	…
GNI per capita (US$)	2 550***	3 080	3 250	3 350	3 530	3 640

Source: World Bank Indicators, 2012

*2005, **2006, *** 2006

[1] Kosovo Country Snap-shot, World Bank, 2013

Unemployment and poverty are the main factors that could derail Kosovo's stability. Almost 40,000 people have no regular income and require government social assistance. The government aid totals 45€ to 80€ a month, much less than what a family needs to make a normal living in the country.

4.3. Health System

Historical Overview

Following the war, the health system was rebuilt and reactivated under UN administration and new governance structures were established and centralised, vesting most of the policy, decision making and financial power at the level of the Ministry of Health. Post conflict health reforms introduced a new health financing model – a tax based model, abandoning the pre-war health insurance model due to collapse of Health Insurance (HI) structures and the conclusion that it was not feasible to establish and maintain the HI system due to scarce human resources and administrative capacities.

Kosovo has been struggling with an under-performing health system since the war, and a financial situation that precluded substantial investments in a post-war system. Donor activities have been extensive, but not transformative due to the rigid and ineffective health system.

The health system continues to operate under a direct provision model, where the financing, risk pooling and provision of health care is integrated and managed by the Ministry of Health (MoH), financed from the general state budget rather than from a system of health insurance. While the level of government spending in Kosovo is among the lowest in the region, with about 3% of GDP[2], a large proportion of total health expenditures, about 50%[3] are "out of pocket" contributions from patients.

Corruption and nepotism in healthcare is a concern, as is the health status of Roma, Ashkali and Egyptian communities, whose access to health facilities is limited due to financial constraints and, in some cases, subjected to poor treatment and discrimination. The Serb minority benefits from services offered in parallel health care structures, funded by the Serbian Government. The EU-led process of normalization of relations between Serbia and Kosovo is expected to enable an incremental integration of such structures into Kosovo's mainstream system.

An important reform in primary health care has been the introduction of the Family Medicine concept, aiming to provide personal, comprehensive and continuing care for individuals in the context of the family and the community. The primary responsibility over primary health care stands with the Municipalities, a devolution that needs further improvement considering the Municipalities started with little professional nor managerial capacity for the task.

Structure

Health services in Kosovo are provided at public, private and public-private health institutions. The public network of Primary Health Care (PHC) in Kosovo consists of a total of 429 institutions, of which there are 29 Main Family Medicine Centers (MFMC), 166 Family Health Centers (FHC) and 234 Family Medicine Clinics (or Punkta).

The network of Secondary Health Care (SHC) level public hospitals is composed of 6 general hospitals in the regions, 5 general hospitals in cities, including hospitals in municipalities with a Serbian majority community (Gracanica, Mitrovica North and Sterpce). Hospitals provide specialist health care services to both inpatients and out-patients.

[2] World Bank Indicators, 2012
[3] BIRN, Informal Payments in Kosovo Health System, 2010

At the SHC level there are also professional mental health services through the institutions of Mental Health Centers, Integrated Houses in the Community, and the Center for Integration and Rehabilitation of Chronic Psychiatric Patients in the municipality of Shtime.

Tertiary Health Care (THC) is offered by the University Clinical Center of Kosova (UCCK) which comprises 31 institutes and clinics including medical education of undergraduate, postgraduate and relevant scientific research departments in collaboration with the Faculty of Medicine. It also includes the Dental University Clinical Center of Kosova (DCK). For the Pristina region, the UCCK is accessible as if it were secondary level. Other THC institutions include the National Center for Blood Transfusion, the National Institute of Labour Medicine; and the National Institute of Public Health (NIPH).

Based on the new Law on Health 04/L-125 , secondary and tertiary level institutions will be organized in the framework of the new institution called Clinical Health Service Hospital University of Kosovo (CHSHUK) as a unique integrated health service for secondary and tertiary health care.

Continuing postgraduate Family Medicine education is organized by the Center for Development of Family Medicine (CDFM) while Continuing Nursing Education for all 3 levels of health care is organized by the Center for Continuing Nursing Education (CCNE).

Private sector health care in Kosovo is provided by 1,421 licenced private health institutions, of which 905 are providing specialized outpatient care at the PHC level, mostly in urban settings.

4.4. Health System Strategy

Kosovo's actual reform agenda has the potential to transform the current centralized health system towards a contemporary system that offers comprehensive preventive, diagnostic and treatment services and increasingly meets the heath concerns of the population as a core aspect of human development. The initiated reforms are ambitious and comprehensive and require extensive support for successful implementation.

Performance improvement in health facilities will require a modern organizational role for managers, featuring professional responsibility and autonomy as well as related management information systems. Therefore, management and leadership must become central themes of human resource development in the future.

In order to change this situation, Kosovo is now embarking on an ambitious reform agenda that intends to improve the quality and efficiency of services as well as the financial protection, thereby improving access for vulnerable groups. The new Heath Law of May 2013 envisages many new tools for improving the quality of care. Notably, a separation of purchaser and provider functions is aimed with the establishment of the Health Financing Agency (HFA), as the authority for purchasing care from health facilities through the use of contracts between the HFA and accredited public or private providers.

4.5. International Support

The extensive post-conflict donor support to the health system in Kosovo has shrunk considerably. The Luxembourg government, through LuxDev, is an important donor, supporting the MoH mainly in the enhancement of MOH stewardship capabilities, establishment of a Health Information System, as well as in improving maternal and child health, in a partnership with WHO, UNICEF & UNFPA. Other donors are also present with limited interventions, Italy supporting specialized treatments in cardio-surgery, Global Fund for HIV/AIDS and TB, and USA, Japan, France, Sweden and Turkey with small-scale interventions.

The World Bank is now considering supporting the health sector reforms with a highly subsidized loan (IDA funds) in the range of 25 Mio USD. Anticipated areas of support are the implementation of the mandatory health insurance and enhancing the inclusion of primary

health care in reforms, through performance incentives. The scope and modalities of this intervention shall be defined in early 2014, with the support becoming effective in autumn 2014.

The Health Sector Working Donor Coordination group is led by Lux Development and serves as a platform for policy dialogue and coordination.

The Swiss AQH project will offer a valuable contribution in the implementation of these systemic reforms, particularly in promoting the consideration and inclusion of socially vulnerable communities.

4.6. Population Health Status and Utilization of Health Services

The country has some of the worst health indicators in South Eastern Europe and ranks below neighbouring countries.

Life expectancy in Kosovo was 67 years for males, and 71 years for females in 2008, whereas in 2011 the overall life expectancy was 70.0 years (see Table 1 above). Currently, life expectancy in post-war Kosovo is considerably lower than in the EU member states for both males and females[4].

Table 2 below shows that there is a relatively high infant mortality rate of 17.1 per 1000 live births in 2011, and a high maternal mortality rate of 7.2 per 100000 in 2011, with the excess mortality in Kosovo due to the higher death rates from injuries and other external causes of death and, to a lesser degree, from cardiovascular diseases and cancer.

Death rates from stroke in Kosovo are considerably higher than in the EU member states – a situation which is similar to many countries in the Western Balkans.

Table 2: Selected socioeconomic and health indicators in Kosovo

Indicator	Estimate	Year	Source
Infant mortality rate (per 1000 live births)	17.1	2011	Ministry of Health, Kosovo, 2012
Maternal mortality rate (per 100000)	7.2	2011	Ministry of Health, Kosovo, 2012
CVD mortality rate (per 100000 population)	157.0	2011	Agency of Statistics, Kosovo, 2012
Cancer mortality rate (per 100000 population)	34.2	2011	Agency of Statistics, Kosovo, 2012
Infectious diseases mortality rate (per 100000 population)	1.36	2011	Agency of Statistics, Kosovo, 2012
External causes of death (per 100000 population)	7.7	2011	Agency of Statistics, Kosovo, 2012
Proportional mortality from CVD	59.3%	2011	Agency of Statistics, Kosovo, 2012
Proportional mortality from cancer	15%	2011	Agency of Statistics, Kosovo, 2012
Proportional mortality from infectious diseases	0.55%	2011	Agency of Statistics, Kosovo, 2012
Percentage of smokers in the population 15-64 years	28.4%	2011	NIPH Survey, Kosovo, 2011
Alcohol consumption	25%	2011	ESPAD, Kosovo, 2011
No. Physicians per 100000 population	146	2011	Institute of Public Health, Kosovo, 2011
No. Nurses per 100000 population	412	2011	Institute of Public Health, Kosovo, 2011
No. Health visits per person per year	2.8	2010	World Bank, 2010
Public spending on health (in % of GDP)	2.3%	2009	Ministry of Health, Kosovo, 2010.
Public spending on health (in % of total government expenditure)	7.6%	2009	Ministry of Health, Kosovo, 2010.

[4] World Health Organization, Regional Office for Europe. European health for all database. Copenhagen, Denmark, 2013

In a recent study involving a population-representative sample of older individuals in Kosovo (N=1890), 83% of the elderly people reported at least one chronic condition (63% cardiovascular diseases), and 45% had at least two chronic diseases[5] . In multivariable-adjusted analyses, factors associated with the presence of chronic conditions and/or multi-morbidity were female sex, older age, self-perceived poverty and the inability to access medical care. This limited access to medical care was a significant and consistent predictor of chronic morbidity and chronic multi-morbidity among older people in Kosovo. The overwhelming majority of older Kosovo individuals who couldn't access medical care (almost 90%) indicated the economic barriers as the main reason for this.

Utilization of services at all levels of care is low, with financial barriers to access, as well as low confidence in the capacities and quality of health services. Among all Kosovo residents, the Roma, Ashkali and Egyptian communities and rural households are most disadvantaged. Preliminary results from an ongoing MIC Survey have shown evidences of unattended home deliveries and low immunisation rates among the members of those communities.

Despite the low number of beds (220 per 100,000 inhabitants as opposed to an EU average of 570 per 100,000 inhabitants), the average daily bed occupancy rate in 2012 was 54% in regional hospitals ranging from 30% in Mitrovice to 61 % in Vushtrri (49% in Gjakove, 50% in Gjilan, 59% in Prizren, 61% in Ferizaj, 61% in Peje) and 65% in tertiary care[6] . This could be due to a number of reasons including transport issues, poorly perceived quality of services by the population, lack of medicines, consumables and diagnostic tests, out of pocket costs, private sector and the possibility that the referral system is not functioning properly, which requires patients to either purchase required health services in the rapidly growing private sector, or seek care outside of the country. The implications of this are that patients are not getting the treatment they need, for any of the reasons described. Furthermore, the combination of low number of beds with low occupancy rates may indicate excessive number of beds for certain underutilised services (like maternities) combined with shortage of beds for specialised care (e.g. intensive care, cancer treatment etc.).

A poorly served population also presents a hazard wherever they go to work and live, including those who seeks employment outside the country in Europe.

As the country develops and as the past high levels of donor support begin to be reduced, the public health system has to become more effective and efficient.

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[5] Jerliu N, Toçi E, Burazeri G, Ramadani N, Brand H. Prevalence and socioeconomic correlates of chronic morbidity among elderly people in Kosovo: a population-based survey. BMC Geriatr 2013;13:22

[6] Source: Performance Study of the Health Sector 2012 Marusic D., Ceglar J. Lux Development (2013)

5. Purpose of the consultancy and methodology

The SDC has commissioned consultancy services for identification of the AQH Project design with the main purpose to look at ways to improve the existing health care system with the main focus on institutional strengthening and autonomy, management and skills of health professionals.

A team of five experienced consultants carried out the consultancy. This consisted of three international consultants, with Peter Campbell as Team Leader, supported by Tamar Gotsadze and Joao Costa. The national consultants comprised Merita Berisha and Lulzim Cela.

The consultancy took place from 14 Feb -23 March 2014. The ToR of the consultants is found in Annex 4.

The consultants carried out numerous interviews with stakeholders (including donors, healthcare leaders and staff, and patients), and visited a cross section of health facilities and institutions, from Primary Health Care level to Tertiary and University level, and geographically from rural to urban areas. The agenda and key informants of the trips is found in Annex 1.

Regular briefing sessions were held during this timeframe with SCO Kosovo staff, and a presentation was arranged for Dr Campbell with the SDC in Bern on 6 March 2014 to discuss the findings and options for the way forward.

6. Current Situation

The findings of the consultants are listed under the main thematic areas below. No attempt will be made here to describe the detailed functioning of the current system. This can be found explained in detail in the Master Plan (WB), The Transition in Health and Health Care in Kosovo (Kosovo School of Public Health 2010), in the WB Report (2008), in the report by UNICEF report on Maternal And Child Health In Kosovo (2013), LuxDev's Review of the Current Status of Health Care in Kosovo, Performance Study of the Health Sector (2012) and Analysis of the Health Status of the Population (2012) and in the recent reports carried out on behalf of SDC.

6.1. Health Service Organization

The health care system in Kosovo is organized in three levels: primary, secondary and tertiary and delivered through public and private health institutions.

Primary Health Care (PHC)

Municipalities ensure provision of Primary Health Care in Kosovo by prioritizing preventive measures through implementation of the family medicine concept. Kosovo is divided into 38 Municipalities, where the PHC facilities are located. PHC system is organized through Main Family Medicine Centres (MFMC), with limited diagnostic capabilities. Under MFMC operate the Family Medicine Centres (FMC) and Family Medicine Punkta (FMP). Where there are no hospitals easily accessible, MFMCs also have outpatient maternities (in 15 Municipalities) and also Women Wellness Centres (WWC). The majority of the (>400) PHC level facilities appear to be in reasonable condition, although there are reports of old, poorly maintained and poor construction quality, which will lead to problems over time. Some PHC level facilities have been located without concern for population needs at difficult-to-reach sites far from the center of the community.

Observation visits and data studied show that many patients choose to bypass the PHC facilities and go straight to the higher-level facilities (referred by the PHC staff or self-referred), including the hospitals (contributing to their overflow) and the private clinics (contributing to

their growth, and possibly encouraged by payments to the referring doctor). A simple explanation for this is that if patients find that the PHC level is not able to provide for their needs, they are wasting their resources, time and effort to visit, and will soon seek an alternative facility (public and/or private) that provides them with what they require. Lack of medicines at the FMCs and Punktas were mentioned as the main reasons for patients to avoid those facilities and go directly to facilities (public or private) located close to private pharmacies where they can buy the prescribed medicines.

Secondary and Tertiary Health Care

Secondary level hospital care is provided through six large hospitals located in the regional administrative centers of Kosovo[7] and three in larger cities [8]. All hospitals are working but the diagnostic (laboratories and X-ray) capacity of some hospitals is limited. Hospitals provide inpatient care and specialist services. Assessment of bed capacity from January 2012 showed that there were 3823 hospital beds, of which there were 1907 in SHC level and 1916 in the UCCK, with an average of 220 public beds per 100,000 inhabitants [9].

Tertiary Health Care comprises specialized clinical medical services provided through health institutions that are also linked to the University teaching of medical undergraduates and post-graduates and to related scientific research. Consequently the tertiary level is covered by the University Clinic Centre of Kosovo (UCCK), and the University Dentistry Centre of Kosovo (UDCK), with 24 Clinics and Institutes. These health institutions at the tertiary health care level also serve as secondary level institutions for the Region of Pristina.

Paradoxically, there is high capacity in the hospital laboratories (also at the Main FM Centers of the main regional centers) to do large numbers of tests, but machines capable of 200 tests per hour only carry out 60-100 tests per day. Thus, at the hospital level alone they are operating at less than 5% capacity - which means the cost per test is high. This reflects inefficiency of planning mechanisms in the hospitals: the current processes of the central procurement mechanisms mean that staff have no idea about the real costs, and are not encouraged to look for cost/efficiency savings (and similarly at the Main FM Centers).

Also reflecting planning inefficiencies, it was noted that lung ventilator machines at one site were being used to maximum capacity due to the demand, and none were available to be removed in order to undergo full maintenance procedures, thus shortening their life span.

The hospitals are being formed into a single conglomerate (the Hospital University Clinical Services of Kosovo (HUCSK), which will allow direct contracting with the new Health Financing Agency and potential funding through up to 22 Professional Service Lines (e.g. Maternity Care, Internal Medicine, Surgery etc.). However, even with such initiatives, there are major concerns about how the quality of care will be improved - the major goal of the reforms - at these facilities which are in high demand by the population, with the current management capacities and structures in place. Staffing levels are not directly linked to activities, budgetary underfunding is chronic (forcing out-of-pocket payments from the patients and promoting corruption) and there is little ability to move funds between budget lines or build-up funds from one year to the next and, last but not least, modern hospital management and planning methods are poorly understood or implemented. None of the current large-scale donor-supported projects will directly deal with any of these issues.

Private health sector – The private health sector is rapidly growing in Kosovo. The private healthcare network consists of 1421 private health licensed institutions, out of which 905 are small size diagnostic health care institutions providing specialised care. In private hospitals there are 235 beds or 5,8 % of all beds in hospitals in Kosovo or 13,5 per 100,000 inhabitants.

[7] Mitrovica South, Mitrovica North, Peja, Gjakova, Prizren, Gjilan,
[8] Vushtrri, Ferizaj and Gracanica)
[9] Performance Study of the Health Sector 2012 Marusic D., Ceglar J. Lux Development (2013)

6.2. Health Financing and Spending

The health sector is mainly financed from the consolidated budget of Kosovo and revenues from official co-payments. Despite receiving over 10 % of the government's budget (3 % of GDP), public expenditure for health in 2012 amounts only 71 Euro per capita[10] (of this, 45% goes for wages and salaries) which is one of the lowest in Europe and the health sector faces serious imbalances with regard to its fund allocation.

The Ministry of Economics and Finance (MEF) transfers health funds from the central budget to hospitals (51 %) that are owned by the MOH, to Municipalities in the form of an earmarked health grant for the provision of PHC services (26 %), and to the Ministry of Health (MOH) for other services (22 %)[11]. This Budget is planned through main budget lines – wages and allowances, goods and services and also capital investments. A small percent of the financing is through patient co-payments for health services they receive, a step to rationalize the unnecessary use of services.

Public funding manages to cover only half of total health expenditure and largely relies on out of pocket payments. The current level of government spending manages to cover about half of total health expenditures while patients co-finance care out-of-pocket at the point of service use. By far the largest amount of public health expenditure, 30 %, is used for drugs, followed by expenditures on salaries. In the absence of recent household survey data and accounting systems in health facilities, the level of private spending is extrapolated based on estimates from the 2002 Living Standards Measurement Survey (LSMS) and more recent Household Budget Surveys (HBS).[12]

The MOH lacks clear basis for allocating hospital budgets. Budget allocations to hospitals are historical and made in relation to the size of the population in the catchment areas and adjusted to the number of beds for hospitals. The budget planning is mostly based on historical budgets, rather on actual case load, resulting in some hospitals providing more services being funded at a lower level than hospitals providing less services. Furthermore, facility heads have limited role in budgeting as well as on spending decisions.

Frequent budget cuts by the Government and the MoF are common. Budgets being cut by the MOF and passed though the MOH to hospitals without discussions on options and ways to reduce spending is a common practice. According to the key informant from the MOH budget cuts mainly apply to capital investment and goods and services category of the budget. The latest 25% increase in health staff salaries (2014) will change the internal structure of health facility budgets and grants and critically decrease allocations for goods and services and capital investments.

The provision of **PHC in Kosovo is financed by an earmarked health grant,** transferred from central general revenues to Municipalities and calculated based on simple capitation formula. The grant is calculated annually based on a simple capitation formula taking into account the total population in a Municipality, the geographical area covered, and minority communities based on the 2011 Census data. However, the data from this census does not always correlate to the numbers of patients seeking healthcare at a facility. Thus, patients travel from outlying regions to live and work in the urban areas (especially in Pristina and regional centers) where they were not registered as living in the census, and seek healthcare at these often better equipped and staffed facilities which lack funds to cope.

None of the PHC facilities, neither the Main FM Centers nor the FM Centers and Punkta, appears separately as budgetary entities in the Municipality PHC budget. They all simply submit their requests upward to MFMC management and receive what they receive. This is also true

[10] Kosovo Medium Term Expenditure Framework 2013 - 2015
[11] MEF 2007
[12] Kosovo Health Financing Reform Study, World Bank, 2008

for any particular needs they have with regards to building maintenance or equipment repairs/replacement and supplies (drugs/ consumables).

Only the Director of the MFMC and his direct team (the accountant and deputy) have knowledge and some discretion over the execution of the Municipal PHC budget If the Director of the MFMC works well with the Health Director of the Municipality and the Mayor, they can make good use of the small budget they have and likely lobby hardest for what their own Main FM Center needs. The authorization of expenses has to go through the formal process and approval by the Major, who is in legally in charge of the execution.

This means that the rest of the PHC facility staff (FM Centers and Punkta) is disempowered to plead their case for what they may have a right to receive. Not only do they lack power, but this also leads to demotivation, frustration and, eventually, a level of patient care that does not meet the patient needs. For them, annual planning has become a bureaucratic exercise unlinked to any expectations by the staff of meeting their needs.

The most serious issue in management performance relates to the limited scope of autonomy of health facility heads. Unlike facility heads elsewhere in Europe and in North America, heads in Kosovo are not given autonomy to perform the usual range of management functions such as planning, organizing, leading and controlling resource utilization. Hiring, firing, and salary setting is governed by civil service law, budget rigidities, as well as other laws and policies. Accountability for the facility head is also essentially non-existent since specific goals are not explicit or written, the ownership of the results not clear, nor are there any recognition incentives (other than the negative possibility of reassignment). The facility head is viewed by the organization as a passive supervisor or overseer of a rigid production process for which he is given resources to supervise.

Performance improvement in health facilities requires a more modern organizational role for managers, featuring professional responsibility and increased autonomy. *"The absence of point-of-service manager autonomy means that conventional policy instruments like incentive payment to improve facility performance will not be effective in this environment. Managers have insufficient flexibility over resource allocation to be able to respond to payment incentives".* [13] This is a very real threat to the success of the KHP plans to provide incentive payments for performance.

The hospital sector in Kosovo is funded based on line-item budgets determined prospectively, at the beginning of the budget year, and are based on projected input use, including the number and type of staff employed in the hospital and controls on non-salary expenditures. This budget formulation creates relatively low administration costs, and there is limited need for accurate information systems. It is also a central planning and budgeting tool for rigid control of government expenditures, and linked to "use it or lose" annual budget lines this method of payment sets only weak incentives for hospitals to adopt innovative management and improve efficiency.

6.3. Human Resources

In 2010, there were 13210 total employed workers in public health care institutions. In 2013 the total number of employees was 10568: 5479 (51.8 %) in PHC ; 2077 (19.7 %) in SHC; and 3012 (28.5 %) in THC.

In 2010, there were 2003 physicians (19.0 %), 6043 nurses (57.2%), 321 dentists (3,0 %) and 1996 (18.9 %) ancillary staff. Thus the nurse to physician ratio is higher than in EU27. Kosovo's nurse to physician ration is 3:1 while EU average is 2.5 per one physician.

[13] Gaumer G, June 28, 2007. The World Bank Health Management and Accountability Study; KOSOVO Report on Management Accountability in the Health Sector.

For every 1000 population, there are 1.15 physicians, 3.48 nurses, 0.19 dentists, and 0.15 non-medical workers. The ratio between clinical and ancillary staff is 4:1.

In the private health institutions there were in total 3472 employees, of whom 1806 (52%) are physicians and 1666 (48%) nurses[14], but it is unclear how many of these are also counted in the public sector, since staff are allowed to work in both public and private sectors in parallel.

Compared with the EU or the European region , Kosovo has a relatively low proportion of doctors and nurses in comparison to the population served[15], and this is exacerbated by the falling numbers in the country. There is no clear information available as to the causes of this decline.

The country has the youngest educated workforce in Europe with over 50 % fewer than 21 years old and a median age of 26.[16]

Human resource management and development in the health service can be improved. For example, there can be staff shortages often due to a mismatch between staff hired and skills required. Half day working hours at some sites (eg at the maternity units that are located at some Main FM Centers) also contributes to reduced patient accessibility. A major concern of medical education specialists was poor clinical training, as access to patients in hospitals by the students was very difficult to achieve. After the cessation of the conflict more than a decade ago, significant efforts to improve “hands-on” training have been made, since it has been recognized that new hospitals and modern equipment alone do raise the quality of care, but this also requires well trained people.

As a result, many healthcare staff have received **update professional development trainings** over the past few years both at hospital and PHC level. A new cadre of Family Doctors has been developed, but nurses appear to function mainly as assistants to the doctors, despite a proportion of the PHC level having upgraded their skills through a Finnish project. A system of Continuous Professional Development (CPD) ensured that most family doctors achieved 100 credits, but this seems to have lapsed since the project that supported it stopped around 2011. The main hospitals continue to provide Medical Education lectures to which PHC staff is invited, but the focus is mostly on hospital care level issues, and there is no extrinsic motivation for staff outside the hospital to attend.

There is an almost complete lack of **modern textbooks** at the facilities. Clinical Practice Guidelines are available for a few important topics, but can never substitute for the breadth and depth of information provided in basic textbooks. The Kosovo Telemedicine Center system provide the opportunity to ensure access to modern medical diagnostic and treatment information, but this needs to be clearly defined, promoted, and made available in the local (e.g. Albanian, Serbian) language.

Low salaries undermine health professionals’ motivation. The Report on Kosovo’s Healthcare System highlights that low salaries ‘undoubtedly undermine health professionals’ motivation. While this is difficult to prove, one can understand the logic behind the argument. Certainly, it seems that low salaries increase the chances of public-private conflict arising, and the incidence of informal out-of-pocket payments as well as **affect quality of services.** Health inspections may have the unintended effects of adding to their passivity and low morale, since the staff can be punished for doing their job (e.g. absent from clinic to do a home visit).

6.4. Medical Equipment, Medicines and Supplies

Shortages of essential drugs and other supplies are reported to be widespread in public health institutions at all levels of the system. Theoretically, essential drugs are provided to

[14] Taken from the final draft of the Health Sector Strategy (HSS) 2014-2020 document, which is in the phase of approval by the MoH
[15] OECD Health Data 2011
[16] MOH Kosovo

patients free of charge. But, public funding is insufficient to provide access to essential drugs for the entire population. For instance, the health budget for 2014 allocated Eur 4.3 million for drugs for PHC level, or approximately Eur 2.4 per inhabitant/year, low funding provision that does not guarantee most of the public access to free of charge medicines. As a result, at least 80 percent of Kosovo's pharmaceutical market is financed by patients' out-of-pocket payments, contributing to the impoverishing effect of illness.

Clinical health care staff **at the hospital level** complains of the lack of essential drugs and supplies, and say that this is a constant cause of friction with the patients. The low salaries they receive also induces them to seek funds from other sources (e.g. private sector, recommending patients to go correctly - or incorrectly - to specific clinics/ pharmacies). Furthermore, allocation of drugs and medical supply is not linked to the activity of the facility.

At the PHC level, staff are also affected by lack of supplies and medicines, including laboratory test, which means they have a low reputation with patients who do not wish to be treated by them and go elsewhere if possible. They also feel a lack of power/responsibility, since patients (e.g. antenatal cases) are free to bypass Family Medicine Physicians and go straight to other specialists (e.g. to the Obstetrician).

The problems, including equipment and building maintenance issues, seem to be worse moving downwards through the system from urban to rural settings. Staff at these sites explains that they have no power to advocate for what they need to run their facility, other than sending in requests up the system that often meet with no response.

Hospital-provided supplies are not always of high quality, due to the procurement processes that promote purchases of the cheapest items. This is leading to poor quality of surgical supplies such as hip prostheses and ocular lenses, and poor diagnostic quality if equipment is cheap (e.g. blood pressure cuffs, stethoscopes etc.).

Although logistical supply systems are in place, at facility level (both hospitals and FM clinics) appear to be ill-defined and poorly managed resulting in inefficient identification of needs, delayed ordering and procurement, poor feedback on the results of procurement, with consequent stock-outs and loss due to exceeded expiry dates. Storage rooms are extremely cramped, often with insufficient air conditioning, leading to reduced shelf life of supplies, and incomplete monitoring likely to cause existing supplies run out of date. The management of the MoH Central Pristina Warehouse for Medicines and Supplies for the storage and distribution of supplies is no longer outsourced privately and is disorganised and in poor condition with insufficient and poorly managed storage shelving capacity.

There are anecdotal stories of inefficient distribution of supplies from central levels with some sites receiving too much, some too little. Also, complaints were made by staff about poor quality of supplies received through the centralised procurement system (e.g. cataract lenses, hip replacements, drugs, disposable items, sutures etc.), and it appears that there is a lack of feedback to/from the procurement departments, which could help to reduce this.

One of the major - but less publicised - successes of the Kosovo health system, is the **EPI program**. It appears that, with some exceptions among the RAE community, vaccination and immunity levels are generally high, with the main PHC partners adequately supported and supplied and monitored. However, much of the originally provided cold-chain equipment and transport means equipment is now ageing, and in order to ensure it remains functional a review of the equipment is overdue. An option to use the Project Funds could be support renewal of those items that now need replacement.

6.5. Utilization of services

From the perspective of the **patients, access to high quality care** is limited primarily by lack of essential drugs, and also by stock-outs of reagents and deficiencies in diagnostic testing due to

delays in repairs to diagnostic (e.g. lab) equipment. This results in patients having to pay out of pocket for what they need, either to private pharmacies or to the private clinics.

For those seeking care at the **rural PHC level**, this is a double loss, due to the time and effort made to go to their local facility, and then duplicated as they have to pay the expense of travel and the significant extra time it takes to get to a more urban setting where either better functioning public facilities can be accessed, or directly to the private facilities where full care is more likely to be guaranteed (especially for the few who have private health insurance).

As a result the population are placing a high demand on the hospitals.

Hospital staff complain of excessive numbers of patients being admitted many of whom could be managed at the PHC level. Patients complain of being referred to specific pharmacies to purchase medicines, or to private clinics where the referring doctor has an interest. There is also a lack of clear information for the patients about what medicines/supplies/(lab) diagnostics are available in the hospital.

Patients are often managed in **hospital settings** of generally low hygienic standards due to lack of effective air filtration/air conditioning systems and insufficient antiseptic hand wash solutions, and overcrowding with relatives and visitors pressuring to be with the patients. Linked to this, and exacerbated by the lack of staff and the large numbers of patients, is a lack of sensitivity to patient/family needs including an absence of suitable waiting areas and seating for visitors, limited patient/family information materials, and response to patient complaints or suggestions for improvement.

Care pathways are not established to ensure the best and most efficient care is provided from the patients' perspective so that, for example, antenatal care is not shared with the secondary/hospital level in any way, nor is the needed equipment of tests (e.g. urinary glucose or protein or leucocyte test strips) available to the FM staff. This needs to be reviewed in more detail, since it appears that patients are therefore forced to bypass the FM clinics, and the staff there, who may wish to do more, but are not empowered to do so.

Also at the PHC level, there is no means (transport) or expectations for the clinical staff to do any **home visits** to patients who need this - such as those who are unable to get to the facility - as part of the public health service provision. It was even heard that the Family Doctors can be punished and fined if they are found to be away from their facility for any reason - including carrying out a home visit to a patient - during their assigned working hours. There used to be a system of Patronage (home visiting) Nurses in place before the war, but this has not been continued. UNICEF is looking at a pilot to try to begin to address this issue.

One option would be to consider providing facilities with appropriate transport to facilitate and encourage home visits (eg a bicycle- possibly electric; or a moped).

6.6. Management of Health Facilities

There is significant on-going change in the **management structure** of the health system, with the PHC level now receiving its operational funding (including payments of salaries) from the Municipalities (managed by staff in the Department of Health and Social Welfare who may be replaced as a result of the election of new political parties). If the new Health Statute receives final parliamentary approval, a new Health Insurance system will come into force - supported by a loan from the World Bank - planned to provide a little additional funding for the PHC facilities linked in some way to performance targets.

Hospital Managers are replaced fairly frequently, often linked to changes in the political system, and there was some acknowledgment of the lack and need for clear, relevant and focused management training. The National Institute of Public Health (NIPH) run a Masters-level course on Health Management, but it lasts 2 years and would be impractical to meet the current managerial felt needs. Interest was expressed in receiving management training in the form of short modules linked directly to work activities.

Quality Officers are in place at each major health facility (hospitals and Main FM Centers), but their work is not currently well coordinated or supported from the highest levels, and their overall goal and roles are not clearly defined in any systematic way throughout the health system. Nor is there any comprehensive system of indicator monitoring, analysis/ evaluation and suitable management response mechanisms/ funding. The current and future role of the Division for Quality and Safety of Healthcare Services at the MoH is also not clearly defined.

The National Institute of Public Health (NIPH) carries out some **monitoring of indicators and standards of the healthcare facilities** - mostly focused on ensuring hygiene standards and infectious disease control - but lacks funding and capacity to do much in the way of ongoing monitoring of other aspects of facility functioning or to provide any pro-active supportive supervision to the facilities. While the NIPH collects and analyses routine healthcare statistical and epidemiological data, this is not done in a comprehensive way that allows for effective healthcare planning and decision-making. This year (2014) the NIPH working with the Statistical Agency of Kosovo (SAK) started to collect data on household health care spending to find out health care seeking behavior, out of pocket costs and the extent to which such costs impoverish the population. The results will help to understand the impact of the previous policy decisions and are expected to provide useful practical information to future health care policymakers.

While some **management/ facility quality standards** were in place (e.g. twice daily checking of vaccine refrigerator temperatures) there are few other standards written up and in the hands of the clinical staff. And there is no system for supervisors (e.g. managers, MoH Health Inspectors/ Commissions, Quality Managers) to make a transparent and predictable assessment of the facilities and what is expected of them. Management/facility standards for all three levels of the healthcare system were developed and piloted back in 2005-2006 as part of a previous LuxDev project, but have never been scaled up or evaluated.

A new integrated Health Information System is being piloted and covers two main regions – Pristina and Prizren - covering almost 50% of the entire health structure. This new **Health Information System** (HIS) - supported by LuxDev - is designed to ensure improved flow of information within and between health facilities and the overseeing institutions. Computer hardware is already in place at nearly all the clinical sites (not at the Punkta level), awaiting the system to be finalised and made operational.

6.7. Special Issues

Private Facilities

It is often cited that the continued parallel functioning of the laboratories, pharmacies and **private clinics** next to the public ones, with clinical staff able to work freely at both, is creating **conflict of interest**; health staff are inclined to dedicate more time and efforts to private facilities, which offer better remuneration prospects. Also, doctors in the public system may find ways to unnecessarily promote private facilities who reward them to the detriment of the activities in the public system. There has been no systematic assessment of the impact of the private facilities in the public system yet, but there are plenty of anecdotal cases.

One patient interviewee explained how, when a certain injectable medication was required, they were instructed by the duty doctor to go to a specific pharmacy and pay €35 for a single dose. The next day, when asked about this same medication, a different duty doctor stated it was - and had always been - readily available in the hospital.

One point that this illustrates: not all doctors are behaving in a corrupt way, and even those who are doing so are aided by the lack of any standards to define transparent mechanisms of demonstrating availability of medications.

Low funding and supplies, and the **failure to define and maintain high standards of management of the public system** allows the private system to thrive. If Kosovo intends to

keep its public system, improvement of its functioning will reduce, though at current funding levels is unlikely to eliminate patient demand for private services.

Those who suffer most from a failing public system (especially at PHC level) are the vulnerable: the poor and those limited in their ability to travel. The Consultancy Team found many examples of doctors and nurses dedicated to their tasks and their facilities, but frustrated at the conditions and limitations they are working under.

Patient feedback mechanisms

Patient feedback mechanisms that allow them to voice their concerns and ideas to improve the health system are in the early stages of development. A recently introduced anonymous telephone line has become operational, but there is limited capacity to respond due to the staffing levels, and the response to complaints has so far been mainly linked to punitive actions by the Health Inspectors, which is a mechanism for control, but not for improvement and the ultimate aim to reduce the (seriousness of the) complaints.

Neither hospitals nor PHC level clinics have formalised or systemised processes in place to monitor or respond to feedback questionnaires or complaints. Patients are not always clear about their rights and the possible mechanisms to give feedback or voice complaints. This also includes the access by patients to know the availability of hospital supplies, to prevent unnecessary (or fraudulent) referral to make purchases from the private sector.

Vulnerable/Minority Groups

There are a number of **vulnerable communities** in Kosovo, here defined as those who have financial and social and security constraints to access appropriate healthcare services. These include any who fall below the poverty line (estimated to be up to 30% of the population) who cannot afford to pay for the medications and consumables that the public system is unable to supply; the RAE communities; the handicapped (mentally and physically); single mothers or victims of domestic violence; and those whose treatment is unavailable (e.g. cancer cases due to lack of available funds/supplies).

The preliminary results of recent MICS survey that focuses on the **RAE community**, carried out with UNICEF support, highlights reduced health seeking behaviour low levels of health knowledge, relatively high levels of home births, and poor immunisation rates. There is anecdotal evidence that RAE patients are treated less well by staff in the health system, but it is not clear how much this is due purely to cultural and ethnicity issues, and how much poverty plays a part (e.g. are Albanian Kosovars also poorly treated when they have no funds to (co-) pay for the supplies or treatments needed).

These are issues that could be addressed by home visiting strategies using the PHC system, which are not now in place in the Kosovo governed health system. UNICEF will start some trials to develop this aspect.

Healthcare services to women appear to be readily available, but there is evidence that they are increasingly seeking obstetric and gynaecological care outside of the PHC level, at the hospitals (or at private clinics). This situation is not helped by the lack of supplies available at the PHC level, and the lack of a gate-keeping function to empower the PHC staff.

While several Maternity Units have been set up attached to the Main FM Centers, it is becoming clear that women are travelling further in order to deliver at hospital level facilities. The reasons for this are not clear, but lack of full time staff (they clock off at 14.00) at the maternity units at the Main FM Centers is likely to be a reason.

The picture with regard to gender issues is mixed. According to the NIPH Annual Report on public health institutions, at the end of December 2013, there were 80% female nurses compared to 20% male nurse technicians. Regarding doctors, the ratio was much more equal, with 42% female compared to 58% male.

The vast majority of nursing management positions are held by female staff while almost all high managerial positions in clinics, hospitals and MFMC are held by male staff.

For those with **mental health** issues, a good system has been set up with Mental Health Centers established in the main 7 regions of the country, with trained staff and transport vehicles. This, combined with reasonable levels of salary and operating (including maintenance) costs, has provided enormous relief to those in need. However, the vehicles are now getting old and unreliable, and more is needed to be done to coordinate regular support between these Centers and the PHC level facilities, which have no such support to do home visits. A new, readily identified group, who require support are those being forcibly repatriated from abroad, sometimes children who have grown up entirely abroad and must now adapt to their new home and situation.

It was noted that those classified with **physical handicaps** are sometimes housed in institutions for the mentally ill, since there is no specific institution that can provide support to this group. This group, who may need intensive and regular physiotherapy/ occupational therapy support have no access to it due to lack of appropriately trained staff or availability of training aids.

The minority **Serbian communities**, in contrast, are reasonably well served since their local health facilities continue to be supported by the Serbian government. However, their preference for medicines imported from Serbia is leading to supply issues and stock-outs, which may worsen when the border with Serbia is more strictly controlled.

The Serbian-run hospital in Gracanica is stated to provide a point of first contact for Serbs living throughout the south of Kosovo, who may then require referral to the more comprehensive Mitrovica (North) facilities. This hospital (the surgical wing) which was set up as a temporary solution – was old, cramped and crowded (including managing cases from the local RAS community), working at full capacity with surgical operations managed with full general anaesthesia. However, supply shortages have meant that the surgeon only performs what he considers to be emergency cases, with other planned operations having to go elsewhere, or wait. An old military-type X-Ray machine was installed but not operational, with a request to find a modern replacement. A small new hospital building had started to be constructed on the outskirts of the town, but this was halted apparently due to concerns that the foundation underneath was not stable. It was said that there are Euro 3 million pledged by the Serbian authorities to develop facilities for the Serb minority in Kosovo, and that Euro 2 million was pledged by the Kosovo authorities also for this purpose. However, with the cessation of the new hospital construction, no-one is working to move this forward.

Mitrovica (North) was also visited, where the original health system is functioning, with all staff saying it is working well. There is concern that, when the border to Serbia is controlled more strictly, delivery of medical supplies will be interrupted. A policlinic provided a list of needs, including equipment for the gynaecology unit (ultrasound, colposcopy and a gynaecological examination chair), the laboratory (biochemical analyser), and for physiotherapy and ophthalmology units (split lamp, tonometer, auto-refraction machine).

The picture for the Serbian community is extremely complicated, with financial support coming from both the Serbian and Kosovo sides (apparently this can mean that no-one supports them in the end, both sides thinking the other will do so), staff paid their salaries by the Serbian government, the lack of a coherent/coordinated management process, and the ongoing process of arbitration in Brussels led by Mr Ahtisaari. Apparently, this latter process should help to clarify how things can work in the future, with health and education being allowed to continue to be supported directly from Serbia.

7. Swiss Government Role in Health Development

7.1. Rationale

Swiss foreign policy considers the Western Balkans region among one of its top regional priorities. Swiss cooperation with Kosovo, Albania, Bosnia and Herzegovina, Macedonia and Serbia is founded on the countries' mutual interest in stability and security as well as European integration. Kosovo, while in the centre of the region, is the least advanced in regards to the transition process. A failure in transition for Kosovo would create circumstances that could risk destabilizing the region as a whole. Switzerland has been providing support to Kosovo since 1998 and was an early recognizer of Kosovo's independence.

Between 150,000 and 170,000 Kosovars live in Switzerland, which equals about 8% of the population of Kosovo. They make up the biggest Diaspora group of all countries in which SDC and SECO are active.

The group generates an intense social and economic network between the two states. These strong links represent a potential for increased economic cooperation and provide interesting perspectives to tap deeper into the still unexploited potential of boosting transition through migration. As part of its foreign trade strategy, Switzerland is focusing on integrating partner countries like Kosovo into the global economy and promoting socially and environmentally responsible economic growth.

Between 2009 and 2012, the Swiss Cooperation committed 68 million Swiss francs in three important areas of cooperation: Economy and Employment, Rule of Law and Democracy, Public Infrastructure and in the special programme on Migration. The general orientation and approaches applied so far appear to be appropriate to the context and effective in the given circumstances.

Overall lessons learned lead to the conclusion that Swiss cooperation has to 1) ensure even more that activities are in line with the goals of the Government of Kosovo, in order to be able to count on its programme ownership, 2) implement less but more extensive programmes, and 3) facilitate the active participation of civil society in decentralized decision-making.

Switzerland has played a very important role in the reconstruction and rehabilitation of the psychiatric care system in Kosovo since 2001, through several projects at all institutional levels, including infrastructure building, staff-trainings and sensitization of the population. In 2012, Switzerland initiated a project supporting the MoH to diversify the range and scope of psychiatric care offered, through establishing a post-graduate training in clinical psychology. There are important synergies to be pursued with other Swiss interventions in Kosovo, notably those that aim at enhancing skills and employability, improving local governance, rural and urban infrastructure and promotion of hygiene.

The long-term Swiss support has been decisive in embedding the concept of community-based mental health care as well as the introduction of specialized tertiary treatments in psychiatric care. Swiss presence to the sector has been continued in the frame of the Migration Partnership Strategy with Kosovo.

7.2. Relevance and Coherence with Strategic Framework

Kosovo aims at improving the quality of and access to its healthcare services by undertaking substantial reforms, with particular emphasis on healthcare management and financing. In the first two steps, the new Health Law adopted in May, 2013, will enable the establishment of a HUCSK (a public enterprise including all care services) and a Health Financing Agency (executive agency for contract services with health providers, both public and private; a predecessor to a Health Insurance Fund). Furthermore adoption of the Health Insurance Law (expected to be

approved by June 2014) will enable mobilization of additional resources to the health care system for years to come.

Switzerland intends to support these reforms focusing on guaranteeing better quality healthcare provision for vulnerable segments of the population.

7.3. Involvement of Switzerland in Kosovo Health Sector

A comprehensive Health Sector Assessment conducted in the beginning of 2012 recommended the following areas as entry points for a potential Swiss intervention, and based on these recommendations, SDC has decided to include health as a new domain of cooperation for the period 2013-2016 focusing on:

- Support the implementation of reforms, particularly in establishing a sustainable health insurance scheme;
- Improve service delivery at the primary and secondary level, with a special focus on vulnerable groups, such as Roma, Ashkali and Egyptians (RAE);
- Health promotion and literacy, with a focus in schools.

As set in the Country Cooperation Strategy 2013-2016, the goal of SDC's interventions in health is to contribute to the development of a sustainable health care system that offers good quality services to its population, including socially vulnerable communities. This is a new direction for Swiss development aid, which until now had focused on other aspects of development.

The SDC Health portfolio consists of two main interventions:

Contribution to World Bank's Improving Quality of Health Care in Kosovo - In September 2013, SDC initiated a cooperation with the World Bank (WB), offering technical assistance to the Ministry of Health (MoH) in further developing the health insurance, piloting the service line in Maternal and Child Health and analysing gaps and deficiencies in current pharmaceutical procurement policies. Continuation of this support beyond June 2014 through a Trust Fund is under consideration.

Affordable Quality Health Care Project - The bilateral Affordable Quality Health Care in Kosovo (AQH) Project is planned to commence in January 2015. It will have a budget of approximately CHF 7.5 million, for a duration of 4 years, and will be subject to an international tender following WTO rules and procedures.

The goal is to contribute to the development of a sustainable health care system in Kosovo that offers quality services to its population, including socially vulnerable communities.

Outcomes are expected to:

1. Significantly contribute to a successful implementation of the envisaged health reforms, leading to an increased financing for health and an improved management of health services;
2. Enhance access to better quality of health care for all Kosovo citizens, with particular attention to the needs and inclusion of socially vulnerable communities.

Beneficiaries of the project include:

- The citizens in the target geographic region, in particular the socially vulnerable groups who shall benefit from easier access and better quality services;
- Health professionals shall benefit from targeted trainings and professional development; while Heads of health facilities shall benefit from leadership and management capacity development.

8. Options for Interventions

8.1. Strategy for Change

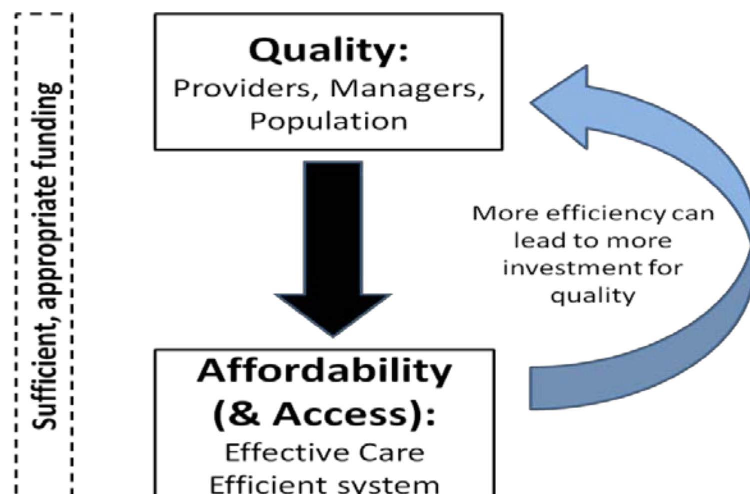
The overall key findings have shown that while the public health system is functioning, it is not providing the **quality** and/or **affordability** of care that patients are hoping for, leading increasing numbers of patients to **access** services at higher levels without referral or seeking healthcare outside the public system.

The two other major health projects planned for the country over the coming 4 years will mainly focus at a high policy level on developing the health financing system (Health Insurance- supported by the WB), and the Health Information System and policy/governance issues (supported by LuxDev).

This leaves room for the new AQH project to focus on supporting improvements in service delivery and health promotion from the perspective of the health providers (clinical staff and facility heads) and recipients (patients). This is also in keeping with the third of the key objectives of the latest HSS, to improve health prevention and promotion among the population.

Figure 1 below describes how a focus on improving the **quality** of care, over the long term, will increase **affordability** and, with it, **access**, which can in turn lead to further investments and improvements in quality and patient satisfaction. Ensuring sufficient and appropriate funding of the system is required throughout, a key goal of the new Health Insurance system.

Figure 1: Linking Quality and Affordability



In this context, **quality is defined** *not* as a level of perfect and expensive healthcare (eg according to European standards) but as a process in which, according to modern theory, the workers have what they require to meet the needs of their clients (patients). This theory assumes that, in general, the health care staff knows what they need to do their job (and being sensitive to the concerns of the patients), with the majority of shortcomings related to systemic issues and not directly under the responsibility of the staff. When the health staff needs are met and the shortcomings are addressed, the outcomes can begin to be predicted. This is the ultimate goal of quality improvement (as opposed to relying on monitoring and evaluating *after* the care has already been provided, perhaps inadequately). Eventually, over the longer term, this will lead to reduced costs (and **affordability**) for the overall health care system.

To give a simple example, prompt action taken with the support of managers to repair/replace a vaccine refrigerator reported by the staff to be malfunctioning, although in the short-term requiring investment of funds, will in the long-term lead to fewer cases of preventable disease and the enormous associated costs of treatment and support of those cases.

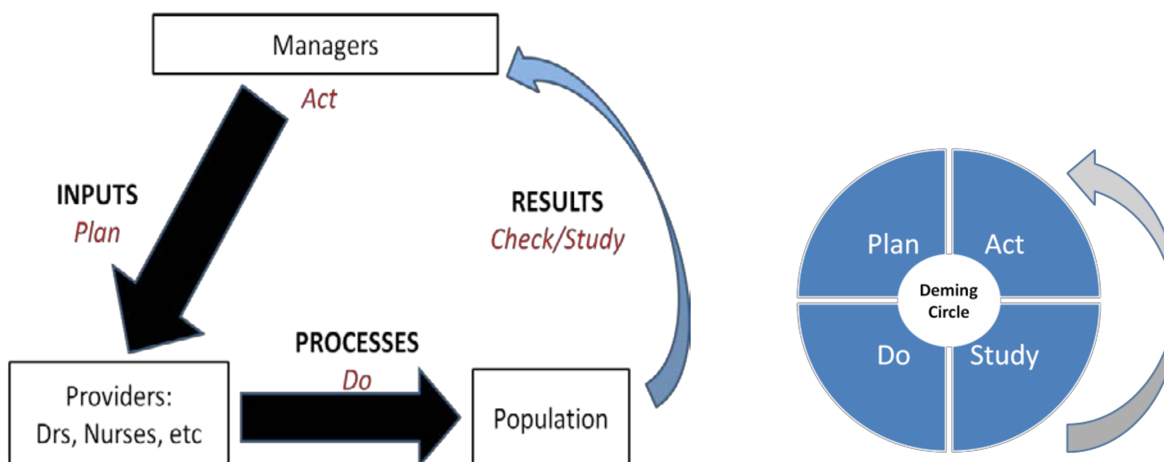
Another example, actually noted during a site visit, was the procurement of the wrong type of cataract lens for an ophthalmology department. This was noted, too late, by the clinical staff and the entire shipment had to be destroyed, wasting valuable health system resources and consuming yet more when replacement lenses are ordered. A quality process would, by contrast, learn from this experience and involve the right clinical specialists in the procurement process to ensure the correct type of lens was ordered and delivered, resulting in no wastage of funds, even if the right type of lenses are more expensive in the short-term and fewer are able to be procured for the given funds.

Thus, in this theory, emphasis is put on making improvements to the functioning of the entire system, rather than on making the individual health care workers responsible. If these workers are supported and understood by the managers - who are the ones who can influence the functioning of the system - then it can be predicted that hoped-for results (improved patient outcomes) will be achieved.

Sufficient, appropriate funding of the system will allow for the best results, but almost no health system in the world is ideally funded and all function within certain constraints, Kosovo included. The theory explained above (based on feedback loops centered around the health care staff - and also the patients concerns) is valid no matter what the funding level and, as has been seen during this consultancy, even low levels of budget funding do not prevent inefficiencies and wastage of extremely precious and limited resources.

This becomes a cycle of improvement with the inputs, processes and outputs mirroring the basic Plan-Do-Study-Act (PDSA) cycle, which many view as the foundation of all efforts to improve quality. This is shown diagrammatically in Figure 2 below.

Figure 2: Producing Quality



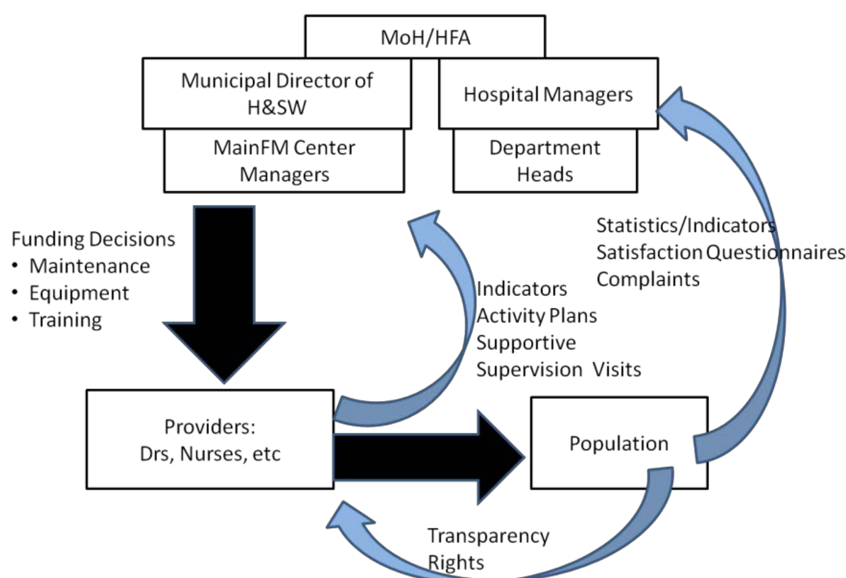
So, in this model, **Quality** is achieved when healthcare providers have what they need, when their managers give them what they need, and when the views and needs of patients (and health care staff) guide decisions on interventions.

As this Quality is developed, it will lead to increased **Affordability** of (and access to) health care as the care that is provided is as effective as possible (leading to reduced 2nd/3rd opinions and travel by patients and therefore, by default, an enhanced gate-keeping role for the PHC providers), as the health system functions as efficiently as possible over the long term (with most efficient use made of scarce resources), and health seeking behaviour and health promotion is improved (leading to less costs for treatment).

8.2. Suggested Project Vision

The health of the population of Kosovo has improved, with the PHC services delivered by health providers - supported by strengthened managers - able to meet the needs of the patients (especially vulnerable groups), who are more aware of their rights and needs.

Figure 3: AQH Approach to Improve Quality/Affordability



Stated in more practical terms, the goals to be achieved by the end of the AQH Project:

Patients in selected regions will receive health care from clinical providers who are well trained and sufficiently equipped in selected clinical areas such as Circulatory Diseases and Maternal and Child Health Care (MCH).

These clinical staff will be supported by managers who are listening to them and aware of their facility situation and needs, ensuring maximal long term efficiency of the available health budgets.

The patients' educational needs in relation to selected health prevention and promotion issues will be met as conveniently for them as possible, and transparent processes of feedback to the health authorities will be in place that result in appropriate responses.

8.3. Suggested Project Objectives and Intervention Strategies

In order to meet stated vision, the proposed AQH Project will have three main objectives, focusing on the three main "players" of the healthcare delivery system (providers, managers and population), and building the feedback loops between them. In order to achieve this, the Project will need a team of experienced and competent staff (including 1-2 full time international experts) who will have the capacity and respect to work closely with health care staff and facilities at all levels, and with the health system managers, also at all levels.

After an initial **inception phase** of sufficient time (eg 6 months), concrete plans will be drawn up - including the selection (perhaps in phases) of pilot sites/municipalities, and the choice of thematic clinical areas - and agreed with the authorities. Activities will focus on **3 main components** (described below), with an initial focus on working with, and understanding, the **health facilities** in the selected areas, agreeing standards of care for each of the chosen thematic priorities, and following through with the facilities to what extent they are able or unable to carry out their expected responsibilities. Activities will be carried out to improve standards of care and clinical skills in the thematic priorities.

Knowledge of the key health issues of the pilot sites should be used by the Project staff to support the development of facility plans, and using these - and other means - to begin to inform the higher level management authorities of what is happening, and how they can support resolution of any issues that are not able to be resolved at the level of the health facility alone. This might include issues of procurement, available petty cash, supply logistics, efficient use of resources, referral mechanisms etc.

This will then lead to activities to support the **managers**, including mentoring, discussions, workshops, training sessions, mentoring and coaching. Inputs should be based on actual known on-the-ground issues clearly related - at least in the initial phases of the Project - with the selected thematic areas, always keeping in mind the ultimate goal of the health system to be aligned to meet the needs of the patients/population.

Similarly, working with the **population**, the Project will ensure that the needs of the population are met (including those identified through complaints/rating systems) with regard to the selected thematic areas at the level of PHC and based on population surveys. The Project will develop activities with the population to increase the awareness about health issues and rights.

Throughout this work, there should be open discussions between the Project staff, the MoH and the SDC (and other relevant stakeholders) on how to move forward, allowing **flexibility** to the Project whenever possible to review and perhaps adjust the thematic areas, or the scale and depth of the interaction with the health system, and interactions with the units/ departments of the authorities which influence the quality of health care provided (eg Health Inspectors, procurement departments, training institutions, statistics departments, Ministry of Finance etc).

Component A: Provider Focus - Providers enabled to meet the needs of Patients

The objectives for this component are as follows:

1) Facilities at PHC and referral levels will be supported to improve clinical care practices in "selected" thematic areas in order to ensure patients receive appropriate, timely and cost-effective care.

Understanding of how to achieve improved Quality and Affordability of care will grow as reforms to actual care practices begin to be implemented. The AQH project would be ideally placed to become involved in supporting and monitoring specific areas of patient care, working from the point of view of the carers (and patients) to understand the issues they face at PHC level and between PHC and SHC and THC stages, and bringing these to the attention of managers, along with highlighting areas for support from higher levels of management.

From the findings of the Consultancy, it is evident that there are weaknesses in most areas of public healthcare provision. Immunisation appears to be one of the few unequivocal successes. The **prioritization for choice** of areas/topics of health care to focus on will be a complicated process that will depend on a multitude of factors (e.g. burden of disease, pressure based on agendas held by political/MoH leaders, the media, the donors, NGOs etc.).

The AQH project can be influenced by each of these, but its main task, no matter which topics are selected, is to develop **improved feedback processes** to allow obstacles to performance to be identified, evaluated and appropriately addressed.

Since such obstacles are likely to run upwards through the system, it would be advisable that the **AQH Project, while starting from the PHC level initially, should also follow the patient pathway from this PHC level up to secondary and tertiary levels**. However, the focus of the project will remain on PHC issues; the attention given to the pathways at secondary and tertiary levels will inform and ensure coordination of improvements to the continuity of care that need to take place at PHC level. This will result in improvements to the development of standards (e.g. job descriptions/responsibilities), referral criteria and communication care

pathways (including strategies to enhance the gate-keeping function) and, ultimately, flow of funds to and within the PHC level.

All this work should be carried out in very close cooperation with the MoH, and especially the department responsible for Quality. The work on clinical thematic areas could also be tied to the development of acceptable and appropriate health facility management standards, such as those used for Accreditation purposes, and linked to measurable indicators that can be used by the managers to identify issues and provide support to address them.

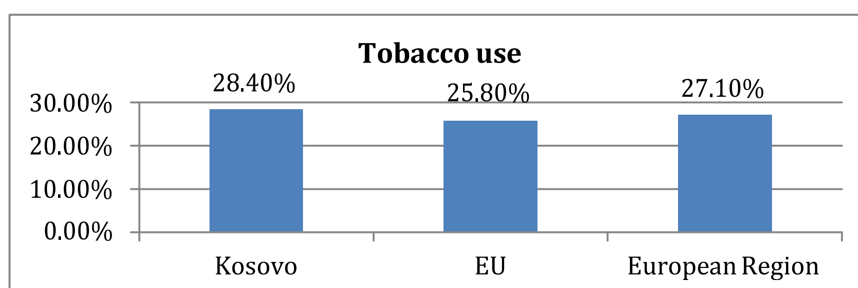
At the PHC level, choices of topic will have to be made that are based not only on feasibility and epidemiological data and preference for target populations (e.g. the vulnerable), but also to ensure alignment and synergies with the KHP and the Performance Indicators envisaged (see Sections 8.2 & 8.3) and the development of the HIS.

Choices of health topics

According to a detailed report, "**Analysis of the Health Status of the Population 2012"** produced by consultants on behalf of the company ConseilSanté in April 2012[17] and quoted from extensively below, there are issues concerning arising from analysis of health determinants (behavioural risk factors) and of also from analysis of morbidity and mortality statistics.

With regard to behavioural factors, it is clear that tobacco use is at the high end of the spectrum (see Figure 4 below); drug taking (7% lifetime use among students) is a relatively minor problem compared to EU countries (20%); the current HIV prevalence is low in the Republic of Kosovo, with an infection rate of less than 1% in the general population and less than 5 % in all groups at risk of acquiring HIV (although the report is critical of the accuracy of this data); fruit in the diet is rated as 55%, just below the EU average of 63%; physical activity levels are relatively high compared to the EU, but obesity is present in 19.2% of the respondents.

Figure 4: Tobacco use - comparison of the Kosovo to the EU and the Region (WHO 2013)



The average number of deaths reported by the Statistical Agency of Kosovo in 2011 was 7510. Linked to the population this amounts to 421.9 deaths per 100 000 population in 2011 which, in comparison to the European Region, is extremely low (see Figure 5 below).

[17] NIPHK & Rupel VP, Marušič D, Ceglar J, on behalf of ConseilSanté, "Analysis of the Health Status of the Population 2012", April 2012

Figure 5: All-cause mortality rates in countries in the European Region, last reported data, 2006–2010 in comparison to Kosovo (2011).

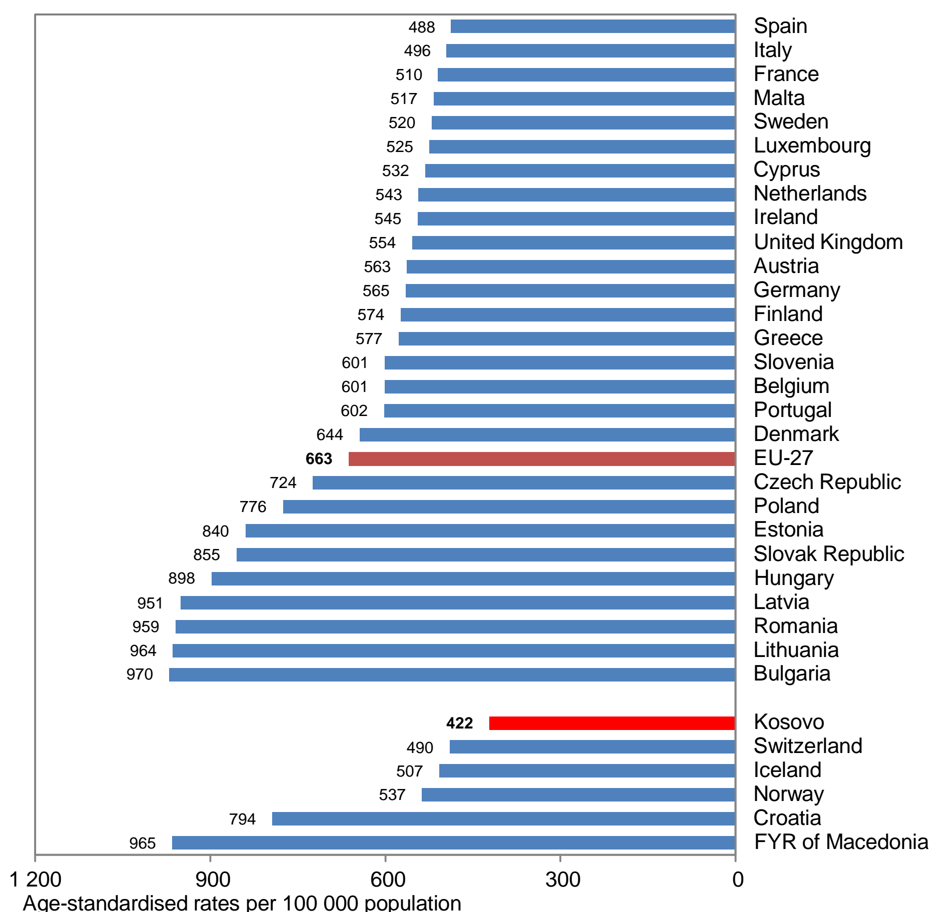
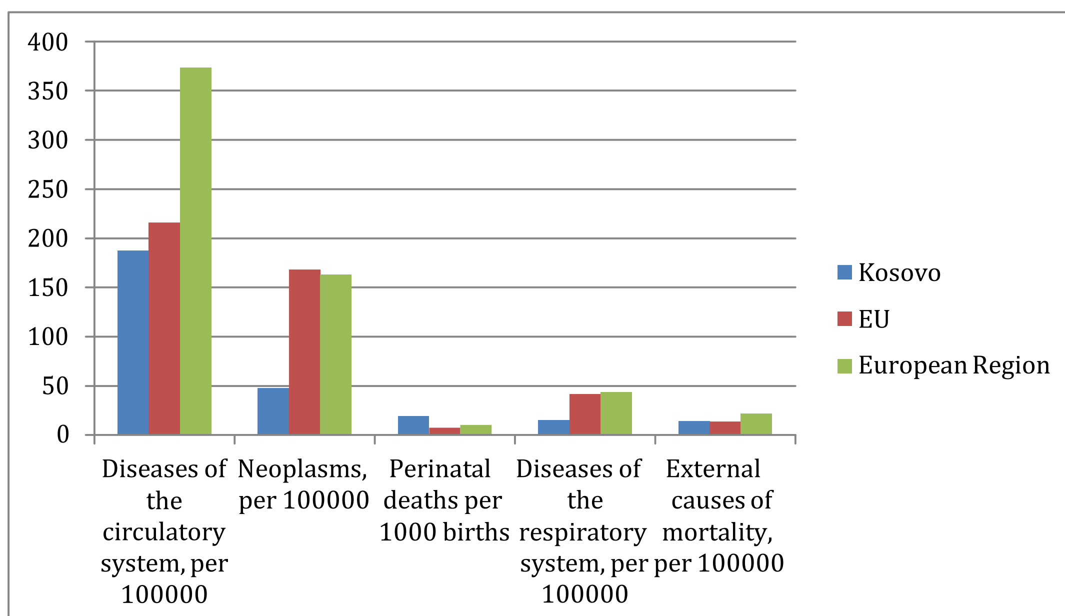


Figure 6 below compares Kosovo, the EU and the European Region as regards to the main five leading causes of mortality in Kosovo, shown above. This is taken mostly from data of 2011 (but perinatal mortality data is from 2009).

Figure 6: Comparison of Kosovo to the EU and European Region, by the first five leading causes of deaths in Kosovo (Source: NIPHK 2013, HFA-DB of WHO).

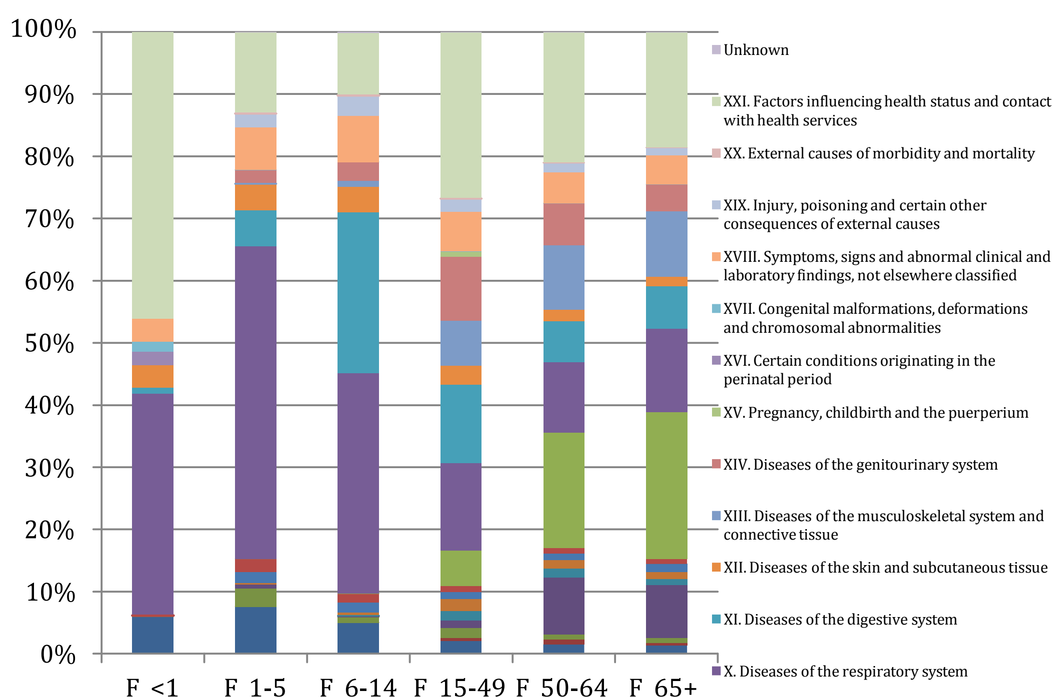


Analysis of this reported data for causes of death in Kosovo during 2006 - 2011 showed that the causes of death from most frequent to least were:

- diseases of the **circulatory system** (upward trend from 137.1 in 2006 to 187.5 in 2011 - per 100000. But still low in comparison to the EU.)
- **neoplasms** (which show an upward trend over time: 26 in 2006 rising to 47.6 in 2011 - per 100000)
- conditions originating in the **perinatal** period (with a downward trend 29.1/1000 lives in 2000 to 19.3/1000 lives in 2009: perhaps due to numerous post-conflict trainings and projects focused on infant mortality rate reduction -NIPHK 2013).
- diseases of the **respiratory system** (upward trend from 9.7 in 2006 to 15.2 in 2011 - NIPHK 2013)
- extrinsic causes of morbidity and mortality - mainly accidents, transport accidents, intentional self-harm and assault - have shown an upward trend from 3.5 in 2006 to 14.2 in 2011 - per 100000 -NIPHK 2013. This is slightly higher than in the EU).

Morbidity data for men and women registered in Primary and Secondary Healthcare in Kosovo, between January and December 2012 is shown in the figures below[18]:

Figure 7: Causes of Morbidity for women according to age groups and diseases

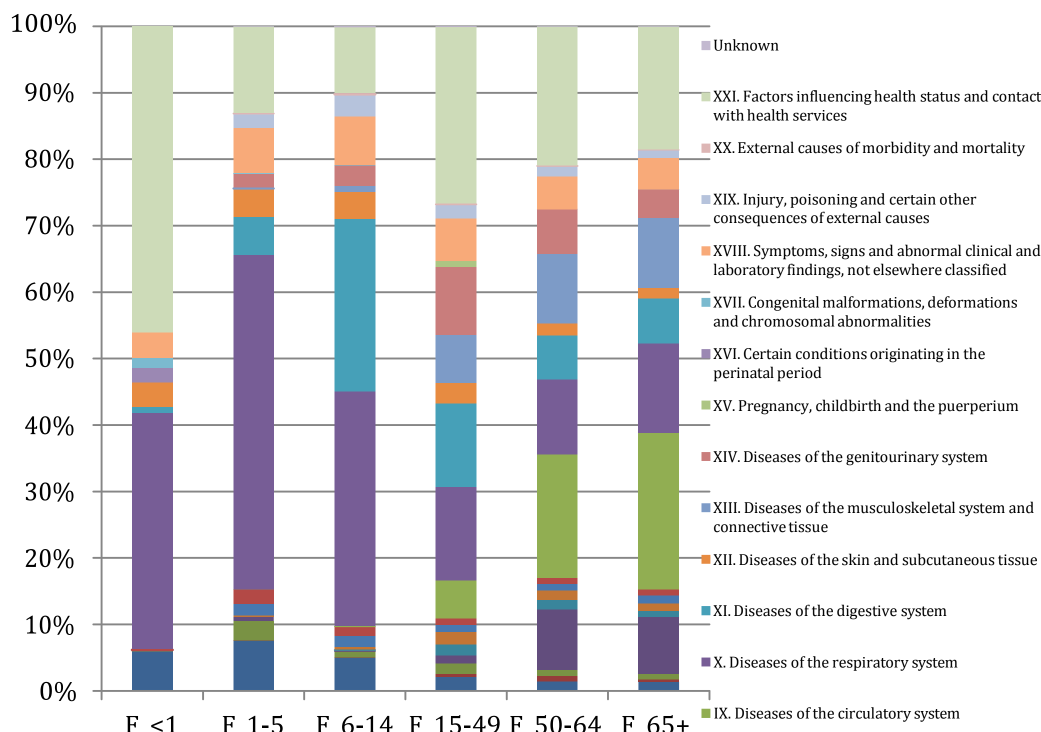


At the PHC level the main causes of morbidity **among females** of the first four age groups are the diseases of the **respiratory system**: 35.5 % of morbidity in a group F<1, 50.3 % in age group from 1 to 5 years, 35.4 % in a group from 6 to 14 years and 14 % in age group from 15 to 49.

In women of 50+ the main reason for morbidity are the diseases of the **circulatory system**, 18.6 % of morbidity in age group 50 - 64, and 23.6 % of morbidity in women aged 65+.

[18] Primary Healthcare Female and Male Databases, NIPHK

Figure 8: Causes of Morbidity for men according to age groups and diseases



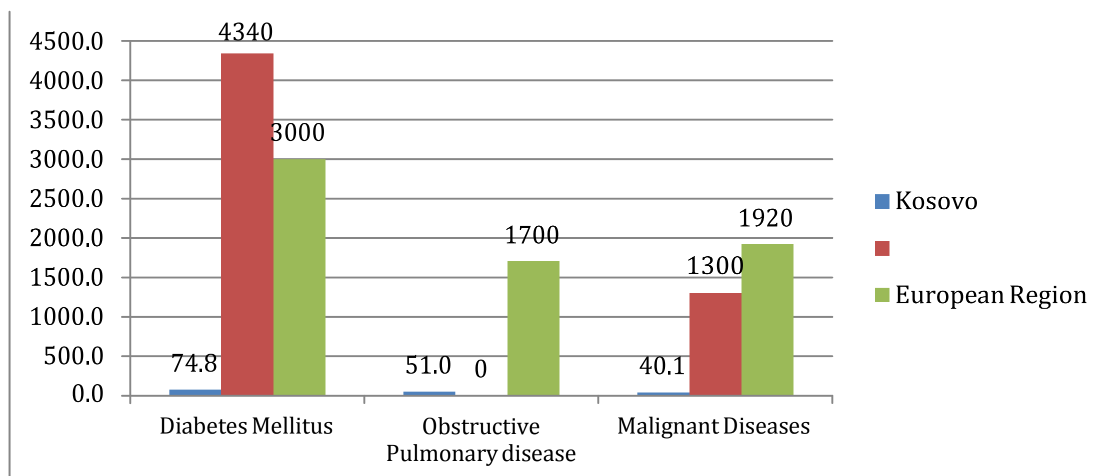
The picture is similar **for males**, with the main morbidity cause in the first four age groups are the diseases of the **respiratory system**: (37.3 % of morbidity in a group F<1, 52.9 % in age group from 1 to 5 years, 36.8 % in a group from 6 to 14 years and 18.8 % in age group from 15 to 49).

The main reason for morbidity In ages 50+ are the diseases of the **circulatory system** (16.6 % of morbidity in age group from 50 to 64 and 24.3 % of morbidity in group of men 65+).

Other leading causes of morbidity include diseases of the **digestive system, circulatory systems, musculoskeletal system and connective system.**

However, Figure 9 below highlights how the prevalence of some chronic diseases is still far below the levels recorded in Europe, although with these huge variations questions must be raised about the availability and accuracy of diagnostic and monitoring systems in Kosovo.

Figure 9: Prevalence of some types of NCD's in Kosovo in comparison to Europe



In conclusion, it appears from the available data that (7) major causes of mortality and morbidity in Kosovo are due to respiratory diseases, circulatory diseases, perinatal conditions

in women, neoplasms, digestive diseases, accidents and trauma, and diseases of the musculoskeletal system and connective system.

It would therefore make sense for the AQH Project to include these conditions as potential selected thematic areas for intervention, bearing in mind questions that have been raised regarding the reliability of the data. Final decisions on which topics to cover should include factors such as how such areas could be leveraged to bring about changes to the functioning of the entire health system structures and processes from planning and budgeting to referral patterns and development of care pathways and monitoring systems.

Based on the available morbidity and mortality data, preliminary ideas for choices on topics based on these criteria could therefore include:

- Linked to the morbidity causes of circulatory disease: **Hypertension care** (rationale: potential for PHC to be involved and improve both quality and efficiency of care delivery, necessity for communication between levels, inclusion in KHP selected "chronic care" theme)
- Also linked to the morbidity causes of circulatory disease: **Diabetic care** (rationale: potential for PHC to be involved and improve both quality and efficiency of care delivery, necessity for communication between levels, inclusion in KHP selected "chronic care" theme and potential Outpatient Drug initiative)
- Linked to the morbidity causes of Perinatal problems in women: **Antenatal/postnatal care**, including **Family Planning** where 98% of ANC and FP services are carried out by ObGyn specialists, with more than 70% of this in the private sector (rationale: potential for PHC to be involved and improve both quality and efficiency of care delivery, necessity for communication between levels, inclusion in KHP selected themes, relevance for the RAE communities).
- Linked to the morbidity causes of respiratory disease: **Pneumonia** (rationale: potential for PHC to be involved and improve both quality and efficiency of care delivery, necessity for communication between levels)
- Linked to the causes of malignant disease: **Oncology care**, **screening programs** for cancer cases eg cervical cancer, breast cancer, prostate (rationale: potential for PHC to be involved in palliative care and screening programmes, especially for vulnerable categories who cannot afford this care for their family members due to social or other circumstances, pain relief, end of life)
- Linked to the extrinsic causes of morbidity and mortality: **Emergency Health Care** at the PHC level to build capacity of staff in Emergency Care - providing CPD modules such are "first man on scene", resuscitation & stabilization etc. (rationale: this would target Municipalities that do not have mobile "Urgency" medical capabilities).
- **Population educational activities** could include all the above to complement the clinical activities, and could also focus on the key risk areas of **smoking** and **drug taking**.

Associated with the identification of some of these cases is the need for good diagnostic equipment, and provision of this **may be considered** by the Project (in the context of strengthening PHC service provision, sustainability, and keeping within the Project budget limits), in order to help ensure that the capacity of the system to manage these conditions is maximised eg:

- **Child growth with development monitoring and care**: WHO & UNICEF invested in this in bigger Municipalities and it could be scaled up all over Kosovo. The Project can help to expand this by implementing these activities in the selected municipalities. Activities could include systemic medical check-ups for school children; and home visiting for pregnant women, new mothers, newborns and infants; in particular for most vulnerable communities e.g. RAE.
- for diabetes management at PHC level the availability of **blood glucose and protein tests.**

- for circulatory conditions the need for **CT Scanners with Angiographic capacity**;
- for cancer screening the need for **breast screening equipment**, **cervical screening equipment** and processes/training, for prostate screening availability of **marker tests**;
- for oncology cases and musculo-skeletal diseases the provision of an **MRI scanner**: it has been stated from within the MoH that the existing MRI scanner at the UCCK in Pristina is old and often undergoing repairs/maintenance and that there is a need for another public MRI scanner for the country;

Another selected thematic area could be:

- **Mental health care** especially forcible repatriations initially focusing on selected Project Municipalities (rationale: potential for PHC to be involved and improve both quality and efficiency of care delivery, necessity for communication between levels, inclusion in KHP selected themes, to build on previous Swiss-funded projects to develop capacity in this area of mental health)

Implementation would focus on ensuring that cases are managed appropriately at the PHC level, with efforts made to compare guidelines of care, the capacities of providers to implement these including provision of basic essential medicines, systems of communication and care pathways between levels, and feedback to the authorities for improvement (needs for equipment, supplies, processes including strengthening the gate-keeping function as possible, funding, training etc).

In those regions where the Project will choose to work, it will be important for the Project staff to follow patients through to the secondary/tertiary referral facilities and to ensure that the channels of communication and transfer are effective, and that the use of guidelines/treatment protocols is consistent between the levels, providing any support that is necessary to ensure it for the future.

Such detailed work, starting with the PHC level and moving up the chain of referral, will teach many lessons which, when successfully addressed, can be used to teach facility staff and managers in other facilities/municipalities.

In addition, other thematic options of more localised importance could be considered, including region-prevalent topics depending on the pilot regions chosen (eg haemorrhagic fever, brucellosis, dental caries in children, vehicle accidents, kidney nephropathy).

There is no burden of disease information available on **effective neonatal screening procedures** (eg for neonatal hypothyroidism, phenylketonuria) since such procedures are not in place. This might still be considered an option to be supported by the Project and would require more research. It could be considered an important area for the Project particularly if (a) it can be used to strengthen the links between PHC and the hospital level and (b) it is clear that there are sustainable budget funds for continuing the tests. Thus, postnatal mothers could be discharged home without delay, and the PHC center would be made responsible for the collection of the screening blood samples and for reporting the results to the patients. This could be linked to the development of an automatic system to send data to PHC level to inform mothers of results.

2) Facility management standards, at least at the PHC level, are reviewed and refined, in order to allow a system of effective supportive supervision and monitoring processes and to promote consistency of best practices across the levels of the health care system.

The AQH Project should enable the Main FM Centers to be involved in the **supportive supervision** of the FM Centers and Punktas under their responsibility.

This could involve the AQH Project helping develop and agree with clinical staff some distinct, **realistic facility standards** for the facilities (e.g. linked to the selected thematic areas but also including function and process standards of expected leadership, financial management, patient safety and hygiene, injection safety and waste management, supply storage and ordering, patient feedback etc.).

The AQH Project should help establish mechanisms by which facilities are monitored regularly and supported to achieve, maintain and even, surpass them, with information fed upwards for analysis, comparisons and decision/policy making.

First-hand knowledge of the situation of these FM Centers and Punkta will also enable better advocacy to support them at the Municipal level. Travel to the facilities should be encouraged, and ways found to promote this (e.g. sharing a vehicle that makes visits to the sites e.g. if laboratory testing is centralised and regular sample collections are made).

The head of the Division of Quality at the MoH should be involved in coordinating and overseeing such activities, and this could be done in cooperation with the system of Health Inspectors if there is freedom for them to operate in a supportive supervision role, rather than simply a punitive one.

Once the work at the PHC level is moving forward, and depending on the implementer's capacity and synergy with its activities, selected hospitals could also be supported by the AQH Project in the development and implementation of equivalent standards, and links made to the appropriate authority to oversee and monitor their usage.

The LuxDev project has stated that it plans to assist the MoH in elaboration of standards of care at all levels of the health care system, so close coordination with AQH in developing these will be important to promote a "single approach" and to maximise the strengths of each project.

3) Health care professionals (especially at PHC level) have increased access to relevant educational training information in order to improve their health-related knowledge and understanding at least in selected thematic areas for the benefit of their patients

Access of the providers to educational materials is an ongoing need. Few if any PHC facilities visited had any up to date textbooks in the local language(s) and the AQH Project should carry out a survey of what is available and appropriate with a view to procurement. This would be highly appreciated by the PHC facility staff at the sites visited by the Team. The primary focus on the PHC level is because most of these sites do not have any internet or library access, and the materials needed are more basic and valid for longer. At the hospital level, internet access is planned to be good, there is more access to libraries and training programs, and printed literature on specialist topics goes out of date sooner. However, materials provided to the PHC staff should also be provided to the hospital staff to update their libraries/literature.

Development of Clinical Protocols/Algorithms is also a possibility, particularly where textbooks are unavailable or provide insufficient detail with regards to, for example, the performance indicators selected by the KHP. Such guidelines, developed with support from the AQH Project and built on existing materials whenever available, should be provided between the levels (PHC up to tertiary level) in order to ensure consistency of service provision.

In addition, making use of the established Telemedicine facilities will allow clinicians and facility heads at the Main FM Centers to participate in and benefit from presentations given in Pristina, where teachers and researchers are more readily available and also access electronic library. The AQH Project could provide funds to expand this system (into Phase 3 of the expansion plans of the Telemedicine Centre) to encompass more Main FM Centers where the Telemedicine is not readily accessible. In parallel, AQH can support and facilitate all the related processes to maximise their use.

LuxDev have shown interest in working on aspects of CPD, and this could be aligned well if LuxDev provide their input more at the central level, while AQH supports building the capacity of the providers in the development of the needs based CPD programs through application of needs-assessment methodology. This will need to be clarified during the Inception Phase of the AQH Project, but could be clarified even during the planning phases of both projects through discussions between relevant SDC and LuxDev experts.

4) The Chamber of Healthcare Professionals of Kosovo is supported to develop and function, in particular, to promote sufficient, relevant and regular Continuous Professional Development programmes for the PHC (and hospital) health care staff

While LuxDev are planning in their forthcoming project to support the general development of the evolving Medical/Nursing Chambers, the AQH project could provide specific input for the development of functions directly related to Continuous Professional Development (CPD) activities based on detailed observations and feedback from the clinical staff with whom the project is cooperating.

This could include technical assistance for design of logistical plans for overseeing CPD activities, establishing an integrated CPD database (learning lessons from ideas from SDC-supported CPD project in Albania, eg design individual portfolios) and training in its use to monitor and certify achievements of individuals, pilot activities in certain regions/levels, conference/workshop support (using Telemedicine). In the end, this could lead on to regular licensing of health care professionals, which may ultimately be linked with the new payment mechanisms.

The Chambers could be involved in developing suitable standards for the facilities (which might later evolve into some form of Accreditation process).

Component B: Management Focus - Managers enabled to support the Providers

The objectives for this component are as follows:

1) Facility heads of PHC will be better able to carry out basic planning and budgeting functions for their facilities in order to argue for allocated and, if possible, appropriate funds.

As stated in previous sections, currently facility heads play a meagre role in budgeting and spending decisions. Therefore, empowerment of facility heads will be given priority in AQH project enabling them to participate in budgetary spending and to provide useful feedback to higher level (funding) authorities.

Figure 10: Current PHC Budgeting Process

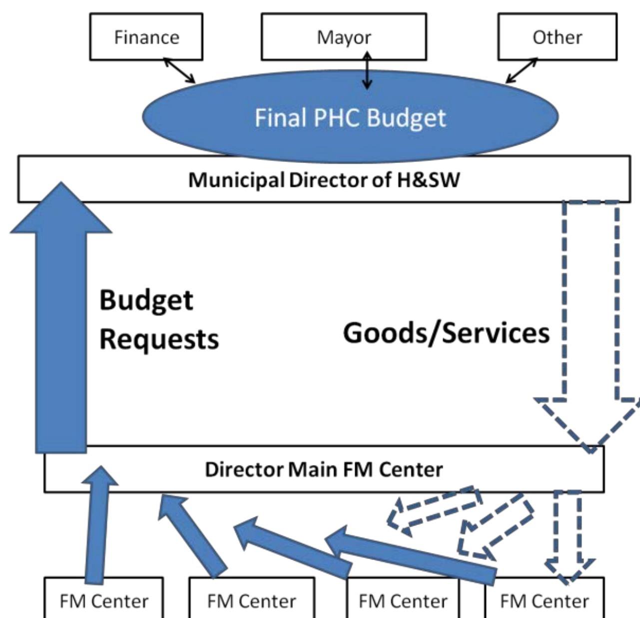


Figure 5 above describes how, currently, the PHC facility facilities provide inputs for the development of the annual budget based on their needs for goods and services. The information on needs (goods and services) is sent upwards from FM Centers to the Director of the Main FM Center and amalgamated into a single PHC budget for the entire Municipality. Thus there is no breakdown of the PHC budget between the individual facilities (MainFMC, FMCs or Punkta), and instead one overall budget is allocated and managed by the Municipality manager/s.

During the year, each of the PHC facilities receives goods and services paid and organised by the Municipality. The Finance/Procurement Department carries out the procurement functions with inputs from the Director of the MFMC and the Municipal Director of the H&SW, and the Mayor approves the processes.

However, this means that the PHC facility leaders (with the exception of the leaders of the Main FM Centers) have no idea how the allocated Municipal PHC budget is being used, and whether the budget is fully spent or not. All they see are the goods/services/capital investments that they receive.

This means there is the possibility for the Municipalities to withhold funds, or allocate them in a way that meets what they consider priority needs, leaving what is left to filter down to the Main/FM Centers and Punkta. There can also be a disconnect between what the Main FM Center receives and what is allowed to filter further down to the FM Centers and Punkta.

Figure 11: Potential future PHC Budgeting Process

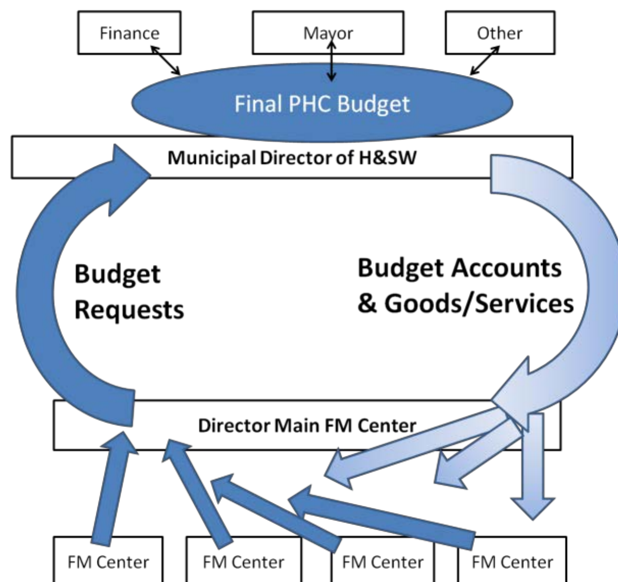


Figure 6 above shows how PHC facility heads, by developing understanding/knowledge of their budgets and expenditures, will be enabled to advocate better for what may originally have been allocated to them in the final PHC Budget, if it was divided up between each individual facility.

It should be noted that this is not an argument for additional autonomy for the facilities, but more for the development of improved feedback within the existing managerial structures and processes. Also, most of the ideas described below have been developed in the context of the currently low funding levels, seeking ways to maximise efficiency through making more transparent the real needs of the PHC level (particularly the FMCs) and revealing how this affects also the demands for care at the higher levels.

The mechanisms for this could be as follows: initially the AQH Project should advocate and agree with a limited number of selected Municipal authorities and MFMC management to introduce/ implement annual planning and budgeting at the FMC level. When this is agreed, new planning and budgeting procedures can be formalised/standardised (i.e. become a part of the MFMC internal management processes). This will involve training in basic budgeting and accounting procedures, using simple spreadsheets in a way that is understandable to the facility staff. Such an exercise may require that AQH develops the spreadsheet in partnership with a few initial pilot facilities to ensure its appropriateness, and usefulness (simplicity).

Experts from the AQH Project could then work with the Director of the **Main FM Center** to prepare the following year's plan of action and respective budget for all the PHC facilities in the Municipality, with the added dimension that the allocation for each FMC is defined. The Punctas are affiliated to certain FMCs both for reporting and budgeting purposes.

The FMC heads should be sufficiently skilled to be aware of the budget that is allocated to each of them, and to be kept informed as it is used to procure goods and services. This would enable them to become involved in discussions on the full and appropriate use of their allocations, and to have a say in prioritisation of spending and in advocating to utilise anything unspent. It would also allow them to fully appreciate any increases in funding allocations e.g. through the planned performance-based capitation to be introduced with the HIF (initially with funds from the KHP) and supported by the reports generated from the HIS.

Most of the above activities remain internal to the PHC system, and do not require any changes to the way in which the Municipality manages the PHC budget. The main implication for the Municipal authorities will be the additional knowledge gained when it is clear what is being apportioned to each individual PHC facility, and the development of a mechanism by which the spending of Municipal PHC funds can be quantified and made known. In the early stages, the AQH Project should only work with those Municipalities where their agreement to such reforms is agreed.

Later, if these principles are successful and it is agreed that the ideas should be extended to other regions, it could be that other Municipalities may not agree to participate. Hopefully, through convincing arguments and discussion within coordination forums such as the Association of Municipalities' PHC Health Collegium they might be persuaded. But, even if not, work by the AQH Project to improve the internal PHC budgeting mechanisms and feedback loops could still be valuable to bring to the forefront the needs of the PHC FMC facilities.

An additional approach, with minimal involvement in (and unpredictability of) attempting to change regulations, would be for a couple of members of staff at each FMC to be responsible for an amount of petty cash, a proportion disbursed on a monthly basis (or, if not possible, annually) to the facility to carry out minor services and acquisition of goods for the maintenance and daily running of the facility. Initial seed funds to establish this could be provided by the AQH Project. Upon submission of the receipts of the purchases made, the petty cash can be replenished. This can already raise the level of autonomy of the facilities. The AQH Project would need to do a comprehensive assessment of the situation and feasibility of this as the project commences, keeping in mind the overarching goal to make this a sustainable process integrated into the system.

Activities of the AQH Project to build the capacities of the heads of the facilities will involve training in basic budgeting and accounting, prioritization and planning, and developing and enhancing the communication interfaces between the heads of the FM Centers with the Main FM Centers, and between the heads of the Main FM Centers and the Municipality authorities.

To accomplish much of this, the AQH project should work in close cooperation with the KHP project (see explanation below), and also with the Swiss-funded DEMOS project which has its focus on local governance issues centering around the decentralised **roles of the Municipalities**.

It will be important to work in some Municipalities where Demos is also working, since they can provide substantial inputs and lessons from experience on how to work with the Municipal authorities and systems/processes and planning, especially for this Component, should be done hand-in-hand with them. More details of potential cooperation can be explored during the inception phase.

Hospital level managers in the regions where PHC heads and administrators are trained can also be invited and involved in the training modules.

Finally, lessons learned by the AQH Project from the budgeting processes at Municipal levels should encompass a vertical dimension in order to highlight **funding issues at central level** (lobbying function through AKM, FM Associations, and possibly also supported by the newly forming Medical Chambers). A study on the potential for more autonomy at Municipal level (for example, proposed as a new component of the Swiss Trust Fund), might serve to strengthen the case for additional health care funding and for more backing to maximise efficient and sustainable use of health care funds.

AQH Project and the KHP

The KHP will be implementing similar budgeting mechanisms in its pilot municipalities, mainly in Prizren, and Pristina. While the AQH Project will focus on other municipalities, there should be some deliberate overlap in these regions - perhaps in a later phase of the AQH Project to allow the KHP time to institute its own processes and mechanisms and to avoid any duplication/contradictions.

The aim of such overlap in Prizren/Pristina should be complementary to the KHP, to bring additional benefit to the facilities on top of what can be provided through the KHP. In particular, the KHP would be strengthened through the availability of AQH expertise and time to work in a day-to-day way to achieve the expected standards of care (in its key thematic clinical areas) with facility staff - and following through from the patient's perspective as they

may be referred upwards from the PHC level through the system. Lessons learned by the AQH staff from implementation of the Health Insurance mechanisms can also be used to adapt trainings and processes in other municipalities in order to prepare them to be involved in Health Insurance-related activities in the future.

To highlight the complementarities between the projects, it is understood that (at the time of writing) the KHP will work to develop and monitor achievement at PHC facilities of certain numerical targets using quantitative indicators which are easy to measure and set for performance-based capitation payment. In contrast, the AQH Project will focus more on process/qualitative performance indicators to ensure improvement of the service quality (not focused so much on "How many"? but on "How well"?). Linked to the support on thematic areas, the AQH project will also work to define competencies and standards for the facilities and across levels of care, and learn lessons from supporting the facilities to begin to achieve them.

AQH Project and LuxDev

The current LuxDev Health Support Programme is due to end in mid-2014, with a follow-on 3-project currently in the planning stage.

Most of the activities will focus around implementation of the new HIS system, but LuxDev are also planning to be involved in supporting the restructuring of the MoH and in developing evidence-based health policy making (see Objective B-6), in developing a road map for Accreditation (see Objective A-2), and in supporting the system of Continuous Professional Development (see Objective A-3).

Final clarifications of roles and responsibilities for these activities will need to be worked out during the Inception Phase, if not earlier as both projects are at similar stages of planning.

2) Health service managers (at Municipal and MoH levels) are enabled to understand, evaluate and respond effectively in order to meet the needs of the facility staff at PHC level.

This can be supported by ensuring regular communication mechanisms between the Municipal Directorate for Health & Social Welfare, the Main FM Centers and FM Center staff linked to the Budgeting/Activity Plans, and by providing "as-needed" training modules for the managers to assist them in carrying out their responsibilities to achieve the highest performance possible for the patients

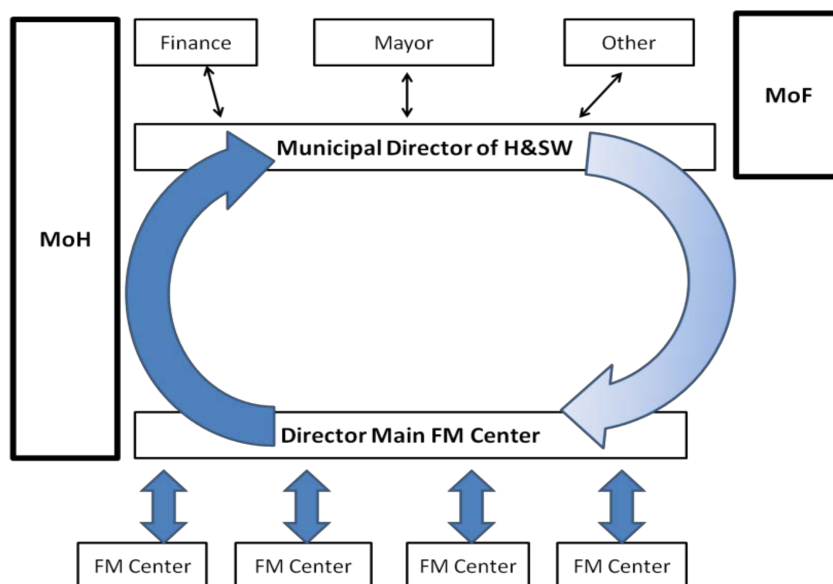
This objective lies at the heart of the weaknesses of the current system: decisions are taken in a top-down manner, with those closest to the decision makers getting mostly what they need, while those further down the chain receiving only what is left over. And in the current climate of underfunding, this often means nothing at all, so that the PHC system is performing mainly on what it has been given historically.

The consequence of this is the gradual failure of the PHC system where currently little in the way of diagnostic/ laboratory tests, supplies, drugs, is available - especially at the FM Centers/Punkta - and the staff are demoralised and unwilling to perform better. This leads patients to bypass the PHC level in favour of private (sometimes out-of-country) care and to seek help higher up the chain, often at the hospital level leading to excessive demand there.

However, the managers face challenges in reversing this decline. Mechanisms need to be put in place to allow regular and relevant feedback from the providers that can be used to evaluate the functioning and progress (or not) towards achieving better quality patient care. A standardised system of recording this information and responding to the needs should also be developed and monitored. Procurement departments in particular should be involved in this feedback process. Procuring poor quality equipment or supplies can be counted as a mistake, but to repeat this should be treated as incompetence and not to be tolerated.

Figure 6 below highlights this, and shows how the mechanisms of feedback are essential to guide the procurement of goods and services at the Municipal level

Figure 12: Summary of PHC Management structure



The majority of **FM Center leaders** require skills and training to do basic budgeting and accounting, in order to empower them to begin to argue for their needs and budget allocations.

The **Main FM Center Director**, including staff involved in the finances and budgets, administration, and "quality", also need support to develop and monitor plans and budgets, and to listen and respond to the needs of the FM Center leaders working and thinking in terms of a PHC team. This dialogue and transparency, if established as a normal managerial process, could help foster innovations in the delivery and efficiency of care services across the levels (e.g. through piloting centralised laboratory services) to improve the quality and access to healthcare provision across the entire PHC level.

Municipal H&SW Managers including, if possible, the relevant staff in the departments of finance and procurement, should be supported to develop standardised management processes, linked to useful management training modules particularly financial management and procurement (technical specs) and the support role to PHC.

There should also be a special focus on the **procurement department at the Municipal level**, promoting best practices and open and transparent mechanisms of procurement that are sensitive to learn lessons from the beneficiaries (i.e. the PHC clinical staff) in order to maximise efficiency and limited budgets. Lessons could also be learned from one Municipality to the next, and the involvement of the Association of Municipalities will be key to this.

The **MoH Division of PHC** might also be given support to present and promote the national policy/guidelines etc. to the Providers (e.g. periodic quarterly/biannual meetings of PHC stakeholder leaders).

All effective changes should be documented and developed into managerial guidelines/ standards coordinated by the MoH and the Municipal leaders.

Hospital level managers in the regions where PHC leaders are trained may also be invited and involved in the training modules.

Small Grants

As an option, as the AQH project develops and the needs become more apparent, it could also begin to make available some **small grant funds** to PHC facilities, which would be available to support this process in ways that enhance sustainability of system improvements.

Consideration could be given to making such grants available (a) in the early phases of the project simply to enable improved performance of indicators linked to the developing KHP project and before Health Insurance funds become sufficiently available due to the lag phase in collection and allocation of the funds. This might support implementation of expected selected thematic areas such as management of maternal and child care (e.g. urine protein/leucocyte/haemocyte strip tests) or diabetes (e.g. blood strip tests), or strengthen links to secondary/tertiary levels of care (e.g. tests for haemorrhagic fever, set in place mechanisms for centralised laboratory services).

They could also continually be made available for (b) enhancing management capacities of the system such as for communication, travel for site visits (e.g. travel costs, vehicles), conferences/ meetings/ workshops (e.g. advertising, transport costs) etc.

These would be applied for by facility leaders, and would be linked to Budget/Activity (Annual) Plans.

3) Issues are identified that should result in greater efficiency and implemented through pilots to promote long term cost savings and rationalization

In view of the acute lack of funding being allocated to PHC, there is a pressing need to make maximum use of current budgets. The system of health care delivery at the PHC level needs a thorough and ongoing analysis with participation of all stakeholders to find ways to bring efficiencies.

Maximisation of **laboratory efficiency** is also an option for consideration, as well as the system for maintenance of equipment. For example, laboratory testing is one area identified by the Team that could be considered. Currently there is excess capacity at the hospitals, and simultaneously at many of the Main FM Centers. How could these be aligned to benefit not only PHC but secondary care as well?

Are there opportunities to develop agreements/ contracts between the Municipalities and hospitals e.g. for (co-)payment of reagents to allow many facilities to send their samples to larger centers? Is any seed investment needed to establish and pilot this eg transport vehicles, which could also be used to deliver other services/goods, and sustain supportive supervision/monitoring visits?

At the hospital level, specific issues could be addressed by the project. Early ideas for this include improving the **management of logistical systems** for ordering, storage, distribution and procurement of supplies of drugs and consumables and medical equipment.

One option that could be considered at later stage would be for the Project to fund the reorganisation of the **MoH Central Storage Warehouse in Pristina**. With the newly introduced health system budgeting procedures, budget for drugs from the essential drug list for PHC will be managed by the MoH based on the requests received from the PHC facilities and stored at the Central Storage Warehouse. Therefore, if the AQH Project aims to improve access to free drugs it is essential not only to support the PHC management to forecast, request, store and disperse drugs so that they reach the people in need but also to support the MoH to improve management of this central warehouse.

4) Policy-level analysis and evaluation of data (evidence-based) is improved at the relevant managerial level(s) for relevant, efficient, "provider-oriented", long term decision-making and Partnerships coordination

The Project will support the exchange of experiences gathered at PHC level with other municipalities and the Central level institutions. The Project can bring the evidences from the PHC field into policy making and support all policy initiatives that are of interest of the Municipalities for strengthening PHC services. For that the project can promote and support policy dialog between municipal health authorities and the Ministerial bodies like the NIPH and the HFA, and other Ministries that may have influence over the structure and functioning of the PHC network. This may include carrying out specific surveys, organizing conferences and workshops, support high level meetings with diverse range of partners, including other Ministries, Institutions that may carry out activities with health impacts, Donors, etc.

With the development of the new HIS supported by LuxDev there is the opportunity to substantially increase the capacity for analysis and evaluation of data for long term planning decisions and identification of areas for improvements.

For example, during the course of this consultancy, the Team began to develop a database of financing, social and health indicators to enable comparisons between the various Municipalities (see Sections 8.2 & 8.3). This information was not readily available, and some may need additional confirmation, but is something that can form the basis for further development.

However, just as important as the information, is the ability to analyse and interpret it accurately. This will require in-depth assessment of the needs of relevant health-related managers, of the national capacities to provide such training, and the development of suitable modules that can be institutionalised.

Long-term, politically-sensitive decisions will have to be taken by the MoH to identify who should be involved in this. The major likely actors include the HFA (who will soon take over significant responsibility for managing the payments to the providers linked in some way to quality of services), the NIPH (who currently collate similar data and provide some analytical feedback), the managers of the HIS who will be intricately involved in the input of data, Municipal Health and Social Welfare Officers and the MoH who must use the data for advocating the priority of healthcare and make the final policy decisions..

LuxDev are interested to support evidence-based policy/ decision making so this final decisions on fulfilling this objective will need to be clarified during the Inception Phase.

Component C: Population Focus: Population know/make known their needs

The objectives for this component are as follows:

1) The health education needs of the population are assessed. Information gaps are identified and available IEC materials are evaluated in relation to the gaps

A study of the health seeking behaviour of the general population (with a special focus on the poor categories of the general population and in particular RAE community) poor and disadvantaged minorities) is required in order to highlight reasons why they may or may not seek health care such as any issues of distrust or corruption, (in addition to Quality of Care issues), and how. Particular attention (but not to the exclusion of other topics) should be paid to issues surrounding emerging thematic areas such as Circulatory and Respiratory Diseases and MCH issues.

This is needed to inform the AQH Project of how to address these needs, and how to focus any educational materials. This could be carried out as part of the Inception Phase activities in order to assist in the final design of the Project.

Over the last few years numerous agencies and organisations have provided inputs to develop health education and promotion activities using printed materials and audio-visual productions (see Annex 2). As the years have passed and projects come and gone, the materials have been distributed and print-runs discontinued so that few facilities visited have any materials to use to inform their patients.

Many of the materials may be re-used, some with minimal adaptation, which will speed up the process and keep costs and effort to a minimum. This situation needs to be comprehensively reviewed, in particular with regard to topics that could form the focus of this project. A formal database should be established which highlights the nature of each item, and whether or not it needs review, and how often.

An electronic repository of education material can be supported by the project, which can keep in an organized archive all education materials as well as all studies and reports produced with focus on health aspects of Kosovo. This repository may be set up as a website available for consultation and download of materials on line.

2) Appropriate IEC materials are developed (created/adapted), produced and distributed to the relevant population at selected sites on issues of selected thematic areas, while simultaneously strengthening mechanisms of delivery (PHC facility staff, schools, home visits, community groups, associations, media etc) and monitoring.

Once it is decided (with the respective departments of the NIPH) what materials can be made available through the project, a database should indicate those ready to publish/produce, and those needing adaptation or development from scratch. From this, a first step could be to develop a CD/DVD of those that are ready or can be easily adapted for public use. Such media should be accessible using a simple search function giving potential for each health facility to access them at least in soft format, and perhaps also in printable form depending on the capacity of each facility.

Hard copies could be printed through the project, but mechanisms to ensure better sustainability should be developed if at all possible. This might involve developing mini-libraries of these materials in the facilities, ensuring that a high proportion of the materials are returned to be reused.

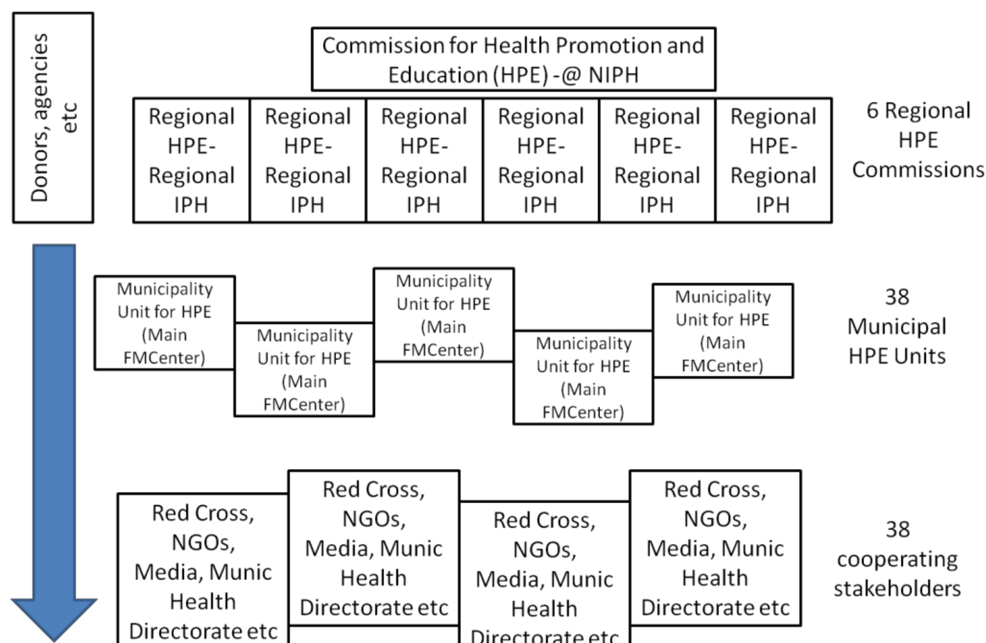
The functioning of the Woman's Wellness Centers attached to the hospitals and Main FM Centers has demonstrated that health promotion and prevention activities can be sustained if there is commitment and support. Some of the ideas, such as video presentations in the waiting areas, can be adapted for use in the waiting areas of PHC facilities and even the hospitals: this would need procurement and installation of appropriate equipment, and establishment of suitable systems including procedures, responsibilities and ongoing monitoring and maintenance as needed.

Materials focusing on the needs of the vulnerable groups such as the RAE could also be developed and tested, including materials targeting any prejudices held by the clinical staff towards such groups.

Figure 7 below describes the existing Network of Health Promotion/Education (HPE) and how information, education and communication (IEC) materials are developed and then transferred down through the network to the Municipality Units for HPE and then on to NGOs, the Red Cross, the media and the Municipalities. It is not clear exactly how well this system is functioning currently, nor how effectively and to what extent it reaches the general population.

Further assessment of this network is needed, in order to decide whether to commence immediate cooperation, or if further support is needed - and wanted- to strengthen it. Monitoring mechanisms also need to be assessed to be able to show the activities carried out, and if possible, their outputs and outcomes.

Figure 13: Existing Network of Health Promotion/Education



3) The patient/population feedback mechanisms to the health providers and managers are improved (systems developed, transparency achieved, responsiveness assured) in order to ensure that ideas for improvements (including those arising from complaints) are identified and appropriately addressed.

The MoH Hotline for receiving and responding to **patient complaints** is functional, but its capacity could be strengthened and broadened. Currently serious complaints are sent to the Health Inspectors who may investigate and penalise health care staff found to be responsible. It is not clear how many complaints are being received, nor the percentage that are responded to.

The scope of this service could be strengthened with the development of a comprehensive **"trends and patterns" database** for areas-for-improvement that could be used to analyse not only individual cases, but to identify overall trends of weaknesses and patterns such as issues related to geographical areas or levels of the healthcare system. This could lead to new initiatives to strengthen the health system. Examples might include focusing on mechanisms of procurement if complaints revolve around poor quality supplies; or on operating procedures if common surgical errors become apparent).

Cooperating with other partners and stakeholders on this database could broaden the service. These could include the Department of the Health Services Division of Quality and Safety of Healthcare Services of the MoH, the Association of Municipalities, the newly developing HFA, interested medical malpractice insurance companies (not yet operating in Kosovo), or even NGOs with an interest to educate medical staff so that patient care can improve.

The aim of such partner activities should be kept very focused: to learn from patient feedback in order to bring about improvements to the system of care, and not primarily to identify individual culprits. Such information should be kept confidentially and not released

Neither PHC facilities nor hospitals routinely request or analyse **patient feedback questionnaires** (e.g. as questionnaires/complaints forms) in order to improve their services. Setting up processes, mechanisms and responsibilities to carry this out could be linked to the "trends and patterns" database to strengthen its reliability, sensitivity and validity. Participation in this could be linked to the quality monitoring of facilities and the standards they are expected to adhere to.

Patient's rights are the basis for patient/population feedback. Legal instruments defining patients' rights should be collected and disseminated among civil society, community organisations and associations with health interests. Among those rights, are certainly rights to information on services that must be provided and access to health resources that should be guaranteed by the health system. For example, currently they have no way of knowing the **availability of medical supplies** in the hospitals, which makes it easy for medical staff to push them towards private pharmacies with whom they have a personal interest. Hospitals have functional supply systems in place, and there may be ways in which this can be more easily accessed by the patients or their families in order to reduce this type of malpractice (e.g. setting up an LCD screen linked to daily update of hospital drugs/supplies). Partners who might be willing to support such an initiative could include patient rights groups (NGOs), the HFA, and even the private pharmaceutical sector.

Educating patients of their rights (including rights to complain and procedures for this, official payment/co-payment policies and detailed explicit costs) is another aspect that should be standardised across the hospitals and PHC services with systems developed to promote this. General statistics of the complaints database should also be made available, possibly with a patient representative(s) on the managerial committee.

An interesting development in patient focused care is being introduced by a private company called Kerkomjekun.com who are creating an App for smart phones that can be used as a search engine for doctors and health care treatments (the Better Health Care Initiative). In addition, it will integrate a transparent rating system for carers and services, which should allow more understanding of what quality of services are on offer, at least from the simple perspective of what is received by the patients

They identified three major issues:

- **Lack of information and transparency:** They see that there is a general lack of information and data on and about health care in Kosovo, and that patients have to spend time and effort to discover information on available treatments and pharmaceuticals
- **Lack of competition**: which they view as being due to lack of choice of healthcare facility
- **Lack of Patient Feedback (Loop):** They describe the lack of a functioning "external" patient feedback mechanism which is not fully resolved by the one recently established through the Ministry of Health as an "internal" complaint hotline to report shortfalls in the health care system. They believe that unless there is a more diversified and external mechanism patients have practically no say in the Kosovo Health Care System.

The company proposes three main solutions to address these issues:

- An **Information System** which will map out health care institutions and healthcare services and make this information available for patients on kerkomjekun.com and the mobile app. This information will inform patients where to find health care services and doctors by location, working hours and contacts. Part of these information will be used as a reference data for the report system. For example information on patients' rights and pharmaceuticals provision will be provided and thus patients can report shortfalls.

- A **Rating System** so that patients will be able to rate received health care services on webpage, mobile app (online and offline). Rating is done on a 5-star rating system with preset categories. These categories could include (but don't have to be limited to): cleanliness, waiting time, bedside manners, nurse manners etc. Patients won't be able to give feedback on professional criteria because most of them won't have the necessary professional background.
- A **Reporting System** will be set up as a complimentary feedback tool to enable patients to report shortcomings via mobile app and/or website. Reporting is done anonymously in preset categories which will be provided with detailed definitions to avoid ambiguity during reporting.

Also, a **Bar Code Scanner** for pharmaceutical identification will be included which will give additional information about the drug scanned. It will for example inform its user if this drug is to be paid for or can be acquired for free from given social categories. Users will immediately know if they are paying wrongfully for drugs and if that's the case they could report this

This appears to be a serious initiative and one which would obviously complement the work of the AQH Project since it identifies many of the same issues in the health system, and tries to deal with them by enhancing feedback loops.

However, there are a couple of risks. The first is that this is a private initiative which markets private providers. At the time of writing, although its icon appears there, the link for public institutions is inactive. Similar pages can be found attached to apps of daily e-newspapers. Depending on its findings, the AQH Project could alternatively consider supporting the MoH/ Medical Chambers to do a similar web page/ app which includes all licensed doctors and public institutions.

Another risk is that a rating system, in the context of healthcare, could lead to false interpretations and responses by the public perhaps unnecessarily penalising staff/facilities for individual problems or for issues that are beyond their control. Those being rated may try to find "unofficial" ways to boost their scores, creating a whole new scoring industry.

However, despite these risks and concerns, more openness that leads to positive and supportive outcomes is something that the AQH Project should consider supporting/cooperating with.

9. Stakeholders and Potential Partnerships

9.1. Key Stakeholders (see also Annex 3)

9.1.1. Ministry of Health

The Ministry of Health is responsible for the health of the citizens of Kosovo and is interested in improving access and affordability to quality health care. The Kosovo Ministry of Health (MoH), established February 2002, is the major funder and provider of health care services. The Ministry continues to assume the lead role in most areas of health care. It "owns" most health services, with the partial exception of primary care facilities and private providers.

The MoH is responsible for monitoring, supervising and supporting the health care system in general. More specifically, MoH is responsible for:

- **Evidence based policy development and strategic planning -** Predominantly with respect to policy development, the MoH is responsible for the National Health Sector Strategy, and thematic area strategy development including Maternal and Child Health (MCH), Primary Health Care and Quality of Care Strategies etc., and implementation plans.

- **Financing –** within the frames of multiple year budgetary plan (Midterm Expenditure Framework (MTEF)) MoH develops annual health budgets based on annual budgetary estimates prepared by subordinated Health Institutions and secondary and tertiary level health providers, and submits for approval to the Ministry of Finance.
- **Procurement and Delivery -** A third area of MOH responsibility relates to procurement and delivery of medicines. The procurement was organized as a centralized function through which MoH delivered drugs, on preapproved essential drug list, in kind and against budget transfer to public pharmacies, PHC institutions, and hospitals. Recently decentralization of this function to the providers has been introduced on the pilot basis.
- **Service Delivery** – The MOH is responsible for managing the service delivery to the population through public secondary and tertiary hospitals. MOH plans budget allocation for staff, capital investment and recurrent expenditures centrally. Clear lines of reporting between municipalities/hospitals/the private sector and the MOH are still to be established. The MOH has no direct role in the delivery of PHC services, although it assumes important responsibilities through a number of key functions.
- **Regulation of Health Sector –** The Ministry is also responsible for development and implementation of sector regulations. There are a number of designated institutions and departments responsible for this function.

Whereas the MoH with its policy development and regulation functions is instrumental in mobilization of adequate resources (human and financial) in support of the affordable quality care delivery to the population of Kosovo, it has a number of **resister**s to change. Specifically:

- Deficiency in linking planning (Health Strategy) to budgeting (medium term expenditure framework and annual budget), MoH strategic and operational plans, annual plans for hospitals and others, reporting and monitoring appears to be an obvious weaknesses of MoH.
- The stewardship role is not functioning well in terms of accountability for different levels and in terms of implementing what is planned. There is nobody in charge to systematically assess the strategy implementation. There are no monitoring or review and there is difficulty in accessing monitoring information. The draft Health Sector Strategy proposes that Department for Strategic Health Development carry out monitoring and evaluation functions through its Monitoring and evaluation Division.
- Weak capacity, unclear roles and responsibilities of MoH staff, pared with ongoing and planned reforms further undermine MoH stewardship function;
- The MOH devotes most of its efforts to health care administration, rather than policy and planning and is heavily dependent on partner technical assistance in Policy development;
- Poor administrative capacity of MoH to monitor and supervise regulatory compliance in the sector hampers effectiveness and efficiency of service provision;
- Weak health care quality regulation and implementation shortcomings alongside with its punitive nature undermines quality objectives of the MoH;

Functional reform of the MoH, particularly splitting provider purchaser functions, followed by recent organizational restructuring of the MoH, alongside with on-going and planned LuxDev technical assistance in building MoH capacity particularly in the area of policy development, reform implementation, monitoring and evaluation, as well as introduction of the Health Information System will potentially enhance evidence based policy development, planning and monitoring functions of the MoH. Further technical support to be rendered from WB financed KHP project and DSA AQH projects, will supplement aid planned by LuxDev and enhance MoH capacity to effectively implement its mandate.

Drivers of change with regard to the potential AQH Project inputs include the desire for development and institutionalization of the quality of care strategy, introduction of the health insurance system and strengthening of the HFA/HIF capacity in strategic purchasing of services, delegation of CPD function to the Professional Chamber, integration of fragmented health

system through introduction of Line services, institutionalization of HIS system will positively influence AQH project implementation and contribute to its objectives.

9.1.2. MoH-Related Agencies

9.1.2.1. Health Funding Agency (HFA)

Kosovo has introduced a purchaser/provider split to heighten accountability in the system and build the foundation for a future health-insurance system. The HFA was established within the MoH with the purpose to split the purchaser and provider functions and was conceived as a forerunner to an insurance fund. This structure is designed to sign performance contracts with municipalities for primary care, and with hospitals for secondary and tertiary care and essentially buy the services that these institutions provided, stipulating the type and quality of service.

However, progress in establishing the HFA was hampered by the absence of key inputs such as adequate number of staff, accurate data, information and management systems, and reward systems alongside with political decision for postponement of performance based contracting. With the introduction of the new Health Law in 2012 and the Health Insurance Law adopted in 2013, the role of the HFA or its successor agency (Health Insurance Fund) will be strengthened to administer pooling of insurance premiums and performance-based contracting of health service providers.

As in most countries, **resisters** to change of the introduction of the Health Insurance Fund (HIF) are the initially weak and ineffective governance system. Most countries have taken several years to implement Social Health Insurance (SHI) after introducing the concept. The reasons for this delay are closely related to governance structure and capacity, poor financial management, lack of guidelines for the investment of insurance funds, weak banking systems, and incidents of fraud and the misappropriation of funds. In addition, excessive levels of administrative bureaucracy have hampered performance, especially where the percentage of the enrolled population was low.

The administrative costs of SHI funds varied throughout Central and South Eastern Europe. Estonia, Lithuania, and Poland, which operate single HIFs with regional branches and almost universal coverage, reported administrative costs of 1−2 percent of revenue. Albania, in contrast, spent 7 percent on administration of its health insurance scheme in 1998 while achieving a coverage rate of only 68 percent of its population (Preker, Langenbrunner 2005).

Drivers of change include the inputs of the WB financed KHP project to attempt to minimize potential weakness of HFI through managerial and operational capacity building of the fund and development of performance based contracts, and the AQH project can be seen to be instrumental in assisting the health service providers in improving performance through provision of on-job training and mentoring/coaching in planning quality improvement activities, building provider capacity in regular monitoring of performance.

9.1.2.2. Health Inspectorate

Health Inspectorate under the MoH is tasked with Quality Assurance of medical services and care. The Inspectorate carries out external monitoring of the professional activities of health care institutions regardless of their forms of financing and ownership in order to achieve respective standards approved by the MOH and stipulated in various primary and secondary legislation.

At present, **resisters** of change include the lack of human, procedural and financial capacity for effective operations. Although it manages to inspect hundreds of health institutions per year, the quality and effectiveness of such inspections is disputable due to the limitations of human and financial resources alongside with underdeveloped quality standards and inspection tools.

Drivers to overcome these challenges include the new organizational structure and staffing of the Ministry, being recently approved as well as by on-going work on new Administrative Instruction to refine and improve quality standards.

Development and institutionalization of the quality of care strategy, introduction of the health insurance system and strengthening of the HFA/HIF capacity in strategic performance based purchasing of services will contribute to effectiveness of AQH project. More specifically support provided for institutionalization of supportive supervision function at all levels of health care system will enable operationalization of the quality of care strategy and achievement of the health care quality objective.

9.1.2.3. National Institute of Public Health of Kosovo

This is a public institution, with key responsibilities for: i) planning and management of public health programs; ii) collection, processing, analysis and publication of health analytical reports on general health system, specific population groups and diseases; iii) epidemiological surveillance of communicable and non-communicable diseases, environmental health and sanitary conditions; iv) referral center for HIV/AIDS, TB and STI; v) Center for public health education; vi) quality monitoring of public laboratories.

NIPHK has a network of six public health institutes in selected municipalities (former Regional Centers) and provides support to local and national authorities in health monitoring and performs public health interventions. There are approximately 200 staff in 6 areas (environmental chemistry, epidemiology, microbiology, environmental health, sanitary health, health information). The NIPHK also coordinates the activities of the network of public health institutes (IPH) in Kosovo. Strengthening of the IPH network in the area of environmental health would be assisted by a move from the current mainly short term project funding to longer term program funding, based on a regular budget. Greater financial support for the "prevention" agenda is recommended.

NIPH **drivers** for change include their interest and committment to the improved quality of public health services, enhanced health knowledge of population and capacity of health workforce. NIPH activities in the area of delivery of Master level training courses in health management; monitoring indicators and standards of health facilities; collection and analysis of health data will contribute to the evidence based policy and planning for improvement of access to affordable and quality health care. AQH possible support for strengthening NIPH capacity in data collection, analysis and development of policy recommendations, utilization and revision of health management training curricula for short term modular training of MOH, Municipal and health facility heads will be a value added.

Resisters of change may include the desire of other institutions to hold/take over some of the current functions of the NIPHK, and the capacity and willingness of the staff to take on more/different responsibilities in relation to the Project activities.

9.1.2.4. Kosovo Agency for Medical Products and Equipment (KMA)

The Kosovo Medicines Agency (KMA), in combination with Kosovo Customs, controls the importation of pharmaceutical products and medical devices. A valid import license is required for the importation of these products. The Law on Medical products and Equipment, NO. 03/L-188, Article 14, and other legal norms regulates the importation of pharmaceutical products and medical devices.

The KMA is responsible for protecting people's health by providing quality and guaranteed medical products and equipment, and services related to medical products and devices through the licensing of professional companies and individuals. Under the Law, the KMA regulates the production, import and distribution of medicinal products, active substances, herbal products, dietary supplements, therapeutic dosage vitamins, and medical equipment

(medical imaging machines, medical lasers, life support equipment, in vitro diagnostic, etc.).

Drivers of change for this organization could be the potential of the Project to provide support to improve its processes and give useful feedback; but **resisters** could include an unwillingness to accept such support, linked to implicit criticism when defining the issues, and also the lack of desire to change any staff benefits that may be reduced due to highlighting the issues.

9.1.2.5. Hospital and University Clinical Service in Kosovo (HUCSK)

HUCSK is a newly formed unique, integrated, healthcare institution which is a legal entity of public law composed of secondary and tertiary healthcare institutions as its organizational units, as well as of Professional Services as its administrative and functional units, in accordance with the Health Law. Healthcare institutions that constitute HUCSK are autonomous units that organize and manage their common and regular administrative and professional affairs in order to fulfil their duties and legal responsibilities, except for duties and responsibilities, which have been assigned to HUCSK by the Health Law and the Statute.

Healthcare institutions, which constitute HUCSK, are required to enable and facilitate the establishment, operationalization and integration of Professional Services within one specialised healthcare field, and have decision-making powers for clinical, professional as well as scientific and academic standards, and advice-giving authorizations to the Steering Board of HUCSK. Professional services aim at providing integrated and continuous care in specific clinic areas across entire health service provision (the three levels of health care), in order to fulfil their duties and legal responsibilities. Particularly, Professional Services aim at and ensure in particular the continuous upgrading of quality and performance of health care services. Professional services integrate and coordinate health services provided by organizational units of HUCSK, with the same or similar services offered in the respective organizational units of general hospitals at tertiary and secondary level.

HUCSK is responsible for provision of quality healthcare services by aiming at performance, efficiency and effectiveness, in accordance with the Health Law. HUCSK shall ensure that healthcare services are provided in a transparent manner. It shall also endeavour to create synergy effects through the coordination of specialized healthcare services, and to ensure a high level of transfer and sharing of professional knowledge and experience, and in this way guarantee the high quality of healthcare services in all its constituent units.

HUCSK supports and promotes educational and scientific activities of the departments of the Faculty of Medicine at the University of Pristina, other accredited institutions of medical education and local and foreign research institutions, within its organizational and functional units, constitutive parts of HUCSK. Educational and scientific activities within HUCSK shall be implemented in accordance with applicable laws, statutes of healthcare institutions, part of HUCSK, and internal acts of HUCSK approved in accordance with this Statute.

Employees of HUCSK do not belong to the civil service of Kosovo, in accordance with Article 62, paragraph 6 of the Health Law. An employee of HUCSK performs its duties and responsibilities within HUCSK, based on the contractual relationship with the health care institution – organizational unit of HUCSK, in accordance with the Labour Law and the Health Law. The contract of an employee shall provide the opportunity for performance-based payments to employees in HUCSK, according to the determined criteria established by the relevant Professional service and Health Financing Agency (hereafter, the HFA), in accordance with the Health Law.

In case of a positive financial result, the healthcare institution/organizational unit of HUCSK, based on the decision of its Steering Board, has the right to conduct independent hiring of healthcare professionals within HUCSK on the recommendation of the relevant Professional Service, given that this does not put in risk the financial stability of HUCSK.

The main objective of forming new public entity, HUCSK, is to improve the quality of care through integration and continuity of service provision across all three levels of the health care system which is a **driver** in line with the AQH Project objectives. Although HUCSK is not yet fully operational, potential weaknesses/**resisters to change** could be defined as follows:

- Capability of Steering Board and its members to take decisions that ensures effective and efficient operation of HUCSK and its constituent units;
- Capacity of Management structure as well as professional line services to effectively integrate services and ensure continuity of care within respective service units and sub-units with clearly defined roles and capabilities, referral pathways etc.
- Absence of performance based contracting and performance based pay of staff with clearly defined performance criteria and methodology;
- Absence of information system, that would enable efficient allocation of financial resources, informs budgeting, planning and performance monitoring.
- Speed and degree of transition new duties and funding to HUCSK, etc.

At this point of time it is difficult to clearly determine possible AQH project support to HUCSK, it is recommended to explore options during inception phase in close coordination with LuxDev and KHP projects.

9.1.2.6. Chambers/Professional Bodies

The Law on "Chambers of Healthcare Professionals" regulates Establishment of health sector Professional Chambers in Kosovo [19]. According to this law the chambers of healthcare professionals in the Republic of Kosovo are **independent organizations** (with their headquarters in Pristina and will not have branch offices) that protect and represent the professional interests of their members, assure high standards of the code of ethics and medical deontology, promote and protect the activity of healthcare professionals in public and private healthcare institutions, provide continuous professional education in order to offer more qualitative healthcare services and other services dealing with healthcare care.

Chambers will **adopt statutes** for internal functioning and organization, representation, powers and responsibilities, rights and obligations of members, the basic provisions for elections and appointments, financial matters, disciplinary responsibilities and other issues important for their operation.

The membership in Chambers is mandatory for all doctors. The law stipulates establishment of the following **professional chambers**: Chamber of Doctors; Chamber of Dentists; Chamber of Pharmacists; Chamber of Physiotherapists; Chamber of Nurses, Midwives and other healthcare professionals.

The main purpose of Professional Chambers is: provision of professional independence, contribute to improving the quality of health care, protect their professional, social and economic interests, provide counseling, information and various other services to its members, promote high standards of professional conduct, facilitation for exercising professional activities; promote and protect the activities of health professionals in public and private healthcare institutions; develop and implement a **postgraduate specialization education programs and processes** to ensure high quality healthcare services and other services related to health care; promote and carry out on-going professional development and long-term learning processes.

Main responsibilities of chambers are: approval of the code of professional ethics (code of ethics); registration and maintenance of the registry of health professionals and co-workers and keeps the register of all healthcare institutions; issuance of licenses, re-licensing and revocation of licenses; implementation of **professional supervisions** through the engagement

[19] Law No. 04/L-150

of experts of corresponding fields; cooperation with state and local authorities addressing the issues of healthcare and cooperation with other professional associations in the country and abroad; **performance of the professional** and legal supervision of the work of healthcare professionals; verification of legality of the specialization process, organization of the specialization exam, organization and supervision of sub-specializations; **planning and implementation of the continuous professional education**; intermediation in disputes between the chamber and the users of healthcare services; organization of the honoured courts regarding the determination of the violations and professional obligations of the members of chambers and imposes disciplinary measures; determination of the membership fee for the members of chambers; determination of the fee for licensing, re-licensing and other permits for the exercising of professional activities based on legal authorizations; issuance of ID cards and ID numbers for the members of chambers; and at the request of members, issues certificates, certifications and other documents based on the official evidence of the chamber.

The Governing bodies of Chambers are: Assembly; the Chairman of the Chamber; the Managing Council (11 members); the Supervisory Council for Budget and Finances (7 members); the Ethical Council (5 members); the Court of Honor (5 members); the Prosecutor of the Chamber (Prosecutor and deputy); the Permanent Commissions[20] of the Chamber. The members of the assembly of chambers are elected for a mandate of four (4) years.

The Assembly is the highest body of the chamber, and has the following responsibilities and authorizations: approves, amends and supplements the statute and other normative acts; approves - the code of professional ethics, the work program of the chamber; work regulation of the chamber; elects and dismisses - the chairman, deputy chairman and the members of the ethical council, the head and the members of the supervisory council, the head and the members of the court of honor, the prosecutor of the chamber, head and the members of permanent commissions of the chamber approves and dismisses the members of the managing council of the chamber; determines -the membership fee for the members of the chamber, the compensation amount (fee) for the members, the licensing and re-licensing fee and the amount of the fee for the issuance of certificates, certification and other documents for which the chambers maintain official evidence; reviews and approves the work reports of the bodies of the chamber; the financial report; takes the decision for the dismissal of the council of the chamber and declares the premature elections;

Sources of funding: In the (3 year) transition period the Budget of the Republic of Kosovo will finance the operations. Thereafter the Chamber will have the following main sources of funding: membership fees; fees for licensing and re-licensing and the fees for the issuance of certificates, certifications and other documentation; and gifts and other donations as well as other incomes in conformity with the law. During transition the budget funds are deposited to the treasury account of MOH. The latter ensures funding for implementation of the Chamber activity. After transition the chamber opens its own account in treasury and assumes full responsibility for management of mobilized/collected resources.

At present the Chamber of Doctors is established, while other chambers are in the process of formation. Chamber of Doctors has elected president, and two vice presidents, as well as 134 members. Since November 2013, Chamber of Doctors developed Statue, Ethical Code, established Ethical committee, Ethical Court, and elected Court of Honor. Collection of membership fees has not yet been initiated as fees are not yet defined and approved, as well as no mechanism is defined for depositing the membership fees to the Treasury account of MOH. Possibly membership fee collection will only initiated after the chamber will have its own account in the Treasury after the transition period in 2017.

Although a plan of action for 2014 is developed, **resisters to change** include the delayed financing from the MOH, absence of building (currently temporarily located in the Center of Family Medicine Development, possesses 1 room, 1 table, 3 -5 chairs and one desktop). The

[20] Commissions: ethical issues, licensing health professionals, specialist education, continuous professional education, budget and finance, of solidarity and mutual help

2014 annual budget for the operation of all five chambers is only 200000 Euros. Due to the funding and office space limitations Chamber of Doctors cannot initiate a selection process of office management staff. Furthermore, main functions of the Chamber are housed within the MOH at present, such as CPD committee; Ethical Committee, Licensing and Accreditation committee and Specialization Board. All these functions should gradually be transferred to the chamber, though no mechanism of transfer is defined yet.

Drivers for change are the potential of the AQH project to support its organizational development through:

- While LuxDev will assist in legal establishment of Chambers, the AQH can provide technical assistance for the development of operational manual (e.g budget formulation, financial management, membership and other fee collection and registration etc.); Training in operation procedures; Development of the communication strategy and implementation plan; Development of unified member registry in close coordination and cooperation with LuxDev. Though in interim, the Excel based registry can be developed, data collected and inputted into the system.
- Support in refinement of the Continuous Professional Development through provision of TA for i) revision and refinement of current CPD programs for doctors and nurses, ii) development of the needs based CPD programme, iii) types of CPD activities and revision of credit points/weights, iv) in close partnership with LuxDev development of the CPD register for doctors and nurses; v) assist in CPD budget planning; Train facility CPD coordinators (1 per each hospital and MFMC) in competency based needs assessment methodology and planning; Assist in the preparation of Plan of CPD activities (in country and in the region) and communication to the members.

9.2. Local Governments, Municipalities

Local Governments, municipalities, are responsible for delivering of outpatient health services in their administration. The Municipal Directorate of Health and Social Welfare (DHSW) is the key institutional actor responsible for the administration of PHC. It works closely (in theory) with the Main Family Medicine Centre (MFMC) in planning the PHC services to be delivered in the municipality and mobilizing the necessary resources.

A Municipal PHC Strategy, approved by the Health Board of the Municipal Assembly and based on the Family Medicine (FM) standards, guides the planning of the services. The DHSW is responsible for the medium-term and annual health budget, which are negotiated with the Municipal Directorate of Finance and Budget.

Based on the key informants interviews of issues related to the **resisters** to change of municipal health authorities revealed are:

- Many municipal health authorities lack expertise so implementation suffers. There is a lack of a management culture in small municipalities and sometimes a lack of basic facilities like telephone and computer.
- The situation is further complicated with the change of municipal health authorities due to the local elections.
- Municipal health authorities are not supporting primary health care providers as fully as they should. For example if the centrally supplied drugs run out, municipalities find difficult to cover the gap. Procurement units in municipalities are disconnected from PHC providers and thus causing problems with required supply of medicines and consumables.
- Fragmented monitoring and evaluation of PHC services is another weakness of the system. Municipalities report to NIPH and never receive a feedback that can be used for further planning and performance improvement purposes. The PHC Division of MoH is not expected to poses PHC performance information, thus leaving them shorthanded for evidence based policy development.

While the **drivers** of change of the Municipal health authorities include their prime interest to improve PHC service quality and performance, to ensure attainment of this objective will

require intensive capacity building of DHSW and local governments. Introduction of performance based capitation payments, planed under the WB financed KHP project, will equip the DHSW and PHC facility management with basic training and tools, whereas AQH project can focus on day-to-day assistance and local capacity building to these structures in performance monitoring, planning corrective actions, budgeting and accurate and timely reporting.

9.2.1. Kosovo Health Project (KPH)- using loan funds from the World Bank

The main objective of the WB-supported KHP is to contribute to improving financial protection for the poor and quality of care for selected Maternal and Child Health (MCH) and Non Communicable Disease (NCD) services through: (i) support for health sector reforms focused on mandatory health insurance and performance-based purchasing; and (ii) building capacity to improve quality of care.

The project will support:

- **Building of HFA/HFI institutional capacity** through finalization of policy, regulation, and operational systems design, support health Insurance Information system design and institutionalization, development of outpatient drug benefits and ensure citizen engagement through intensive communications
- **Improve quality of care** through: i) provision of necessary maternal and child health equipment to thee hospitals; building up the maintenance system for existing equipment at PHC and hospital level; ii) support the MoH in implementation of the quality of care strategy and build capacity of quality coordinators and provision of trainings to the professional line services; iii) introduction of strategic purchasing function with particular emphasis on designing parameters for strategic purchasing of PHC services, including developing performance indicators, contract monitoring and payment terms; and iv) build the capacity of Municipality staff, including primary care facility staff, to measure, report on and improve performance, as well as performing independent annual technical audits to verify basic data for performance payments.
- **Strengthening of the PHC** through development of a performance-linked capitation payments operational manual and financing of performance-linked capitation payments.

The proposed project will be implemented over the course of five years (2015-2019) mainly focusing on the central level, but with pilot sites in Pristina and Prizren, and is planned to commence in September 2014

Potential AQH Project Links

- **Monitoring PHC Performance -** the KHP plans to build PHC capacity for monitoring performance through trainings, though it will not focus on assisting providers in improvement of quality. Thus the AQH can play a vital role in mentoring PHC providers to improve service quality and consequently monitoring performance on a regular basis.
- **Electronic (E-)Prescribing** - introduction of E-prescribing, will potentially allow the PHC management (supported by the AQH), to monitor prescription practices and design actions promoting rational use of drugs. However this will be conditional on the extended package of outpatient drug benefits.
- **Reform communications and citizen engagement activities** – The AQH can play a complementary role in informing and raising awareness among the population through its Health Promotion and Education (HPE) activities. While the KHP will support development of a communication strategy with health-related messages and run a communication campaign at the national level, the AQH can support reaching out the

population per each Municipality through local mass media means, using HPE channels/strategies.

- **Quality of Care (QoC)** – The KHP plans to support the MoH in the development of the QoC strategy and support its implementation through training of quality coordinators at Municipal and facility levels. Therefore, AQH can focus on handholding of quality coordinators and provision of assistance and mentoring in day-to day operations, with particular emphasis on PHC providers at selected facilities.
- **Line Services** - The KHP plans to assist the Line Services, yet to be developed. AQH will consider focusing on MCH Line service capacity building through supporting the definition of provider competencies at each level of health care system, regionalisation of the emergency obstetric and neonatal services including referral guidelines, while UNFPA and other UN agencies will focus on staff training at PHC and hospital level.
- Build the capacity of Municipality staff, including primary care facility staff, to **measure, report on and improve performance**. As stated above there will be a one-off capacity-building intervention, while providers will require more assistance in the deployment of new procedures into the practice, where AQH can be instrumental.

9.2.2. Health Support Programme (LuxDev)

The second phase of the Health Support Programme supported by LuxDev (2015-2018) will mainly focus on the central level for the activities related to MOH capacity building and introduction of the concept of Accreditation, while the HIS component aims at expanding pilots to all public health institutions. The project will mainly support:

- **Capacity of the MOH in fulfilling its core functions and responsibilities** through i) building MOH capacity in evidence-based policy/ decision making and M&E mechanisms and ii) assisting the MOH in the process of handing over responsibilities/skills/resources to organizations established in HSS
- **Support management and evidence-based policy/ decision making in the MOH** through i) adjusting and optimizing the MoH's organizational, work processes and tools according to its redefined roles and responsibilities; ii) strengthening reporting and analytical capabilities; iii) ensuring decisions are evidence-based, communicated to relevant stakeholders and translated into action
- **Support the MOH in finalizing the pilot phase of HIS** and **integrating it into all public health institutions** through i) rolling out hardware and software to all public health institutions and ii) assisting the MOH and other key public institutions in ensuring optimal use of HIS
- **Support the introduction of the concept of Accreditation of health institutions by** assisting the MoH in developing a road-map for the introduction of the concept of Accreditation and elaboration of standards of care at all levels
- **Continue to support the system of Continuous Professional Development (CPD)** by enhancing the processes of professional Accreditation, supporting the professional Chambers and supporting activities directed towards CPD

Potential AQH Project Links

- **Operationalization of the HIS in all public health facilities**, including all units of the Municipal PHC system will allow the AQH project and its direct beneficiaries to obtain data for analysis and decision-making. While the LuxDev project will mainly focus on training of staff in HIS, the AQH Project can focus on development of facility based capacities for data quality assurance (data quality audit), data analysis and evidence based planning.
- **Standards of Care -** As the AQH project progresses, it is expected that there will be significant inputs to development and implementation of new management standards including the use of guidelines, protocols and SOPs. The LuxDev project plans to assist the MoH in elaboration of the standards of care at all levels of the health care system.

It is not clear whether this task of the LuxDev project will also address implementation at individual facilities, or of topics such as regulation of patient referrals and feedback mechanisms to ensure continuity of care. Therefore, close coordination and collaboration will be important to promote a "single approach".

- **Continuous Professional Development (CPD) -** this is another area of potential synergy between the two proposed projects. The AQH is oriented towards building a CPD system that addresses the needs of providers, while the approach that will be deployed by LuxDev in support of CME system is not yet developed. A proposed approach could be that LuxDev concentrates on the development of the CME system at a central level, while AQH will support building the capacity of the providers in the development of the needs based CPD programs through application of needs-assessment methodology.
- **Support to the new professional chambers - The** LuxDev project will assist the newly established Chambers in organizational development, while AQH can be instrumental to build their capacity in operationalization of their functions. The set of activities under this component will require very close collaboration and coordination with the LuxDev project to build on synergies and to avoid any unnecessary duplication.

9.3. SDC-Supported Organisations

9.3.1. Association of Kosovo Municipalities (AKM)

The Association of Kosovo Municipalities (AKM) was established in 2001 after the first democratic Municipal elections following the war. The AKM is a non-profit organization with judicially skilled staff representing the general interest of its members, who are the local Municipal authorities in Kosovo.

The **Mission of the AKM** is to create efficient, sustainable and democratic local government through high quality performance in providing service according to needs of its citizens.

The main objectives of the AKM are:

- Improvement of legislative structures of self-government and practical efficiency and their implementation;
- Stimulating decentralization of power through practical support and co-participating on equal basis, between central and local authorities;
- Expanding public support on local democracy that includes citizens and business community and increasing the trust in self organization and their readiness to take part in local government;
- Increasing the number of competencies, knowledge and Municipal capacities to ensure high and effective quality in local services;
- Finding alternative financial sources for Municipalities;
- Support in development of the AKM through interested stakeholders within and outside the country.

The main activities of the Association include participation in the development and approval process of different laws related to local self governance; development of policies and regulations in specific thematic areas; development of guidelines for implementation of new policies; technical assistance for organization of various meetings; training in different thematic areas; cooperation with donors for provision of grants to Municipalities; and representation of Municipalities in the Parliament and thematic Parliamentary Committees (eg Health and Social Protection, Budget and Finance).

Potential AQH Project Links

- **Enhanced Health Facility Planning (eg Financing & Activities) -** In the short to medium perspective of the AQH project, AKM can be instrumental to allow transparency in

budget allocation and monitoring of expenditures by each unit of the Municipal PHC system. In the long term, the AKM can be instrumental for raising and addressing these issue of further increasing autonomy of the health facilities.

- **Reorganization of health service delivery at PHC to ensure service quality** (including staff ratios, firing/hiring procedures and rules, patient flows, home visiting, staff exchange and support from other levels/or other fields of specializations etc.)
  – Reorganization of the service delivery according to the competencies of GPs, nurses, and specialists may be required to deliver rational and efficient health care services. It is understood that Municipalities have no leverage on these issues, since staffing norms and salaries are defined by the Government / MoF , while the Labour Law and internal regulations of MFMC restrict replacement of specialists until their retirement, regardless of their performance. Flexibility to ensure the most rational delivery of health care, at the PHC level in particular, will require more inputs for such decision-making from local levels and facilities. Thus the AKM can initiate discussions of these issues internally and lobby at the central government and parliament level.
- **Management guidelines and regulation of PHC facilities** – the AKM and the MOH Department of Health Services / Division of PHC can support development of Municipal regulations on effective management of the PHC system in a participatory manner with wide representation of Municipal Directors. The given approach will build the ownership of Municipalities to improve management practices.
- **Budget planning and monitoring guidelines and training** – the AKM has extensive experience in provision of training to Municipalities. While the relevant Education Institutions will develop the training curricula, training of Municipal Directors can potentially be delegated to AKM (to be considered as an option). This will ensure that performance-based capitation payments are deployed in an efficient manner and meet the needs of particular PHC facilities. AKM can also promote development of Municipal Action Plans for strengthening of PHC system which in its turn should guide the budget allocation process.
- **Zoning and patient enrolment (list)** - Zoning of catchment area and patient enrolment lists, which is key activity for implementation of the Family Medicine concept and potential performance-based payments, is a time and resource intensive exercise. AQH can advocate AKM to take lead in these areas (at least in pilot Municipalities) and facilitate implementation, and this could also be supported by P4H involvement.

9.3.2. Private Sector Development Programme

(a) EYE Project

The Swiss Cooperation Strategy for Kosovo 2013-2016 includes the creation of youth employment as one of its domains. The Enhancing Youth Employment (EYE) project has tried to match training programs to job opportunities.

The project has a clear focus on labour market issues coming from demand of private organisations. The main partners are firms with 50 employees or more, with 2-3 year histories.

(b) Promoting Private Sector Employment PPSE – Kosovo

The objective of the latest SDC contract with Swisscontact is to strengthen the competitive ability of three sectors of the economy and thereby create jobs for young people in the private sector.

The focus of the project lies in the development of the tourism, food processing and probably private health service sectors. Through this new project, it will be possible to continue the many years of commitment in Kosovo including activities promoting SMEs and vocational training and to take further advantage of established relationships and networks. The start date was 1 October 2013 and

Health is starting to be considered because of the dynamic growth recently shown by the private health sector (there are now1400 licensed private health-related facilities in Kosovo) in tandem with an increasing trend of the population to seek healthcare in private and public hospitals in Macedonia.

Estimations are that patients spend Eur 20 million for health care in Macedonia, with Eur 80 million spent abroad in total. There is confidence that the private health sector in Kosovo can grow and absorb the demand that is directed towards foreign countries, and by doing so generate jobs in Kosovo.

Potential AQH Project links

While the AQH will promote the strengthening of the public sector, the EYE and PPSE projects will promote the private sector.

However there is plenty of scope for overlap, which should be explored over time. Although there is the potential for well trained public sector staff to move into the private sector, the private sector can allow skilled staff to stay in the private sector and in the country by being able to earn a sufficient salary.

There may, for example, be opportunities to develop training program modules (eg for managers), Quality Management (eg Accreditation-type) and other common standards and procedures together. There may also be opportunities to develop Public Private Partnerships, such as using private labs to carry out diagnostic blood tests for the public sector, and perhaps with better quality and cheaper prices if efficiencies of scale are maximised.

Yet another approach might be to develop private wards in the public hospitals, with potential input from private companies in the design and investment. This might help bring money into the public hospital system, as permitted under the new legal statutes.

However, having in mind the need to keep the focus of the project, it should not get involved with these two last points (PPP and private wards in public hospitals).

9.3.3. DEMOS -Local Governance Project

The SDC-funded 4-year DEMOS Project (on local governance) is implemented by the NGO Helvetas Swiss International Cooperation. Its objective is to strengthen democratic governance and decentralisation through making Municipalities more efficient in running public services.

It is in its inception phase, it is now identifying Kosovo Municipalities and areas of public management and other public entities to be supported. With the adoption of a number of indicators, 16 Municipalities have been selected. Those Municipalities will get assistance from the project in the areas of waste collection and management, employment, management of parks and public spaces, and public transport.

Potential AQH Project Links

As the AQH is planned to address issues of health system management at Municipal level, the Project can have relevant synergies with the DEMOS project in its efforts to strengthen the capacity of the Municipalities to deliver public services. As the presence of vulnerable people have been among the criteria for identifying pilot Municipalities, it is likely that both projects may work in the some of the same Municipalities and this is recommended.

AQH initiatives to promote more autonomy and competent management at health facility level, similarly to DEMOS aims, are part of the same overall efforts to make decentralisation work in Kosovo.

The DEMOS project could help in providing and making contacts to assist the AQH Project to begin activities with the Municipal leaders. Also, the DEMOS Project could provide strategic and technical guidance and support for the AQH Project in working with the Municipalities. The

area of Procurement could be a key focal point of mutual benefit to both projects. It is highly likely more areas for coordinated activities would evolve over the course of both projects.

9.3.4. Kosana NGO

Kosana NGO is supported by Solidar Switzerland, and its main role and skill is in advocating for social dialogue to promote a number of initiatives for access to healthcare including but not limited to Social Insurance. Their main modus operandum is to collate facts and then use these to promote discussions and develop suitable IEC materials that will change people's ideas. The organisation facilitates discussions by seeking to explain issues clearly and asking questions such as the needs of the clinical staff to meet patient care requirements.

Kosana has also collaborated with the Diabetes Association to promote better services for patients, and is also interested to be involved in supporting the work of the new Professional Chambers, the Health Insurance Fund, and the possible Line Services.

Potential AQH Project Links

It is clear that Kosana could provide experienced and effective advocacy support for development of improved feedback mechanisms from patients and clinicians to higher levels of management. One area of particular interest would be for Kosana to support the idea to bring more transparency to the PHC budgeting and planning process at the Municipality level.

Such potential for cooperation and perhaps even contractual agreement should definitely be sought during the Inception Phase of the AQH Project.

9.3.5. Community Psychiatry/Clinical Psychology project

Carried out in cooperation with the University of Basel, this project has accomplished remarkable success over the past few years since 1999, developing a modern system of mental health facilities including an inpatient Psychiatric Unit in Pristina. This has led to at least 10 Community Based Mental Health Centers being constructed usually near the Main FM Centers in major cities. WHO have been involved in training clinical staff at some of the sites.

Another major focus has been the strengthening of the postgraduate training programme, both theoretical and practical in nature, together with a programme of Continuous Professional Development, including a module for family doctors integrated into the FM training curriculum.

Currently there is limited ongoing support for the ongoing functioning of the mental health care services, with an emphasis to licence more Clinical Psychologists which is proving to be more difficult than expected.

Potential AQH Project Links

Coordinated activities between the PHC level and the Mental Health services could result in more being done to target those who are being forcibly repatriated from abroad, especially the hundreds of children who are often traumatised by this experience. All cases are documented, and with some coordination between the 2 trained clinical psychologists and the PHC services in the vicinity support could be offered locally to each of them.

This would involve ensuring that the PHC doctor is given the final responsibility and carry out the medication policy. Primary care could be strengthened by a care manager, (eg a nurse practitioner) who is trained in short, specific Mental Health interventions such as problem-solving therapy.

There should be supervision by a psychiatrist/ psychologists of the care manager. The psychologists could also be a primary care clinical psychologist. The psychiatrist/psychologist should also available for consultation on behalf of the GP. This could be aided by improving

detection of depression and anxiety, expressed through somatic complaints, by screening with brief questionnaires, and by making educational materials and patient information more widely available.

Care should be stepped, which means that the most simple interventions first be offered according to algorithms for the use of medication. A contract or an agreement between doctor and patient should determine what the treatment process will look like, with consideration given to the treatment preferences of the patient.

Ideally, there would be routine outcome monitoring, measuring the systematic and periodic mood or anxiety symptoms using ICT, so that treatment decisions are supported.

9.3.6. P4H

The P4H - Social Health Protection Network is a response to the global challenge that some 100 million people are pushed into poverty each year because of costs incurred in paying for health care out of pocket (OOP) at the time of need. Many more are too poor to even consider going to a doctor in the first place.

The main thrust of P4H efforts is coherent, enhanced support for the creation and extension of sustainable health and social protection systems for UHC/SHP, based on the values of universality and equity. The launch of P4H is an important landmark ushering in coordinated international support to accelerate countries' transitions to UHC/SHP, and the it aspires to contribute to the Millennium Development Goals 1, 4, 5 and 6.

It aims to provide coherent, enhanced support for:

- Reducing direct payments (out-of-pocket payments) for health services;
- Raising sufficient funds domestically for health;
- Improving efficiency and equity in the use of resources;
- Harmonizing economic and social objectives;
- Integrating health financing reform with health sector reform, and ensure that the development of national health plans through processes such as the International Health Partnership (IHP+) are consistent with and complement the development of health financing strategies, and vice versa;
- Linking health financing reform with a country's social protection framework.

P4H works through provision of coherent technical support for the development and implementation of policies and strategies for UHC/SHP; by facilitating stakeholder participation and change processes, networking and alliance-building; facilitating international and regional collaboration and inter-country exchange; through mobilizing additional financial and technical resources for UHC/SHP; and advocating for the right of access to quality health care and financial risk protection.

Potential AQH Project Links

The P4H approach could bring high level leaders together, and catalyse major stakeholder to coordinate and cooperate strongly together to improve the access to health care through the new financing mechanisms and the need for coherent leadership (eg that supported by the AQH Project at Municipal level) to maximise their impact.

9.4. UN Agencies

9.4.1. WHO, UNFPA, UNICEF

Three UN organizations, WHO, UNFPA and UNICEF will continue to support the health sector of Kosovo with main focus on:

- **Improved governance of the health care sector** through: i) human and technical capacity building of the MCH department of the MOH; ii) development of Clinical Practice Guidelines (CPGs) for effective perinatal care and maternal care at PHC; iii) support the MoH in the development of MCH administrative instructions; iv) development of national and Municipal level master trainer capacity; v) revision of teaching/learning curricula of the Medical Faculty, Nursing and Midwifery department of the Medical Faculty and the CPD program for family doctors and family nurses;
- **Strengthening of planning and monitoring capacity of the MoH and other stakeholders for MCH** by: i) development and implementation of LMIS and HIS for reproductive health; ii) support in the development of Emergency Obstetric and Neonatal Care (EmONC) system; iii) training of NIPH on data collection and analysis and RH research methods; iv) institutionalization of maternal and neonatal mortality audits as per WHO guidelines; v) funding MCH related research and operational studies.
- **Capacity Building of providers** by provision of trainings related to MCH, reproductive and sexual health, Sexually Transmitted Infections (STIs), Prevention of Mother to Child Transmission of HIV (PMTCT), Effective Perinatal Care (EPC), infant and child feeding, breastfeeding, management of childhood illnesses, and establishment and training of the RAE health mediators network.

Potential AQH Project Links

- **Clinical Practice Guidelines -** developed by UN agencies can be utilized by AQH and support provided to the management and clinical staff of selected health facilities at all levels of care in regular deployment of guidelines, monitoring and planning of further performance improvements.
- **EmONC system** not yet developed, intends development of facility standards and referral standards. These can be performed in close coordination and collaboration with AQH project. Moreover, the AQH project through its provider capacity-building activities can reinforce implementation of EmONC system in targeted health facilities, thus improving the quality of emergency maternal and neonatal care.
- **RAE health mediator network -** AQH project can capitalize on the developed RAE community mediator network and use for empowerment of RAE communities in targeted project sites.

10. Organisation, Management & Administration

10.1. Overall Approach

The planned AQH project will operate at both vertical levels through the health system, and horizontally across the healthcare-related stakeholders. The primary focus will be on enhancing management approaches and coordinating the varied parties, including at higher political levels.

The organisation of the health system is in a state of flux, with large health projects (KHP, HIS) about to commence but still in the final planning stages, and the structure of the MoH also undergoing change, in particular with the development of the HFA.

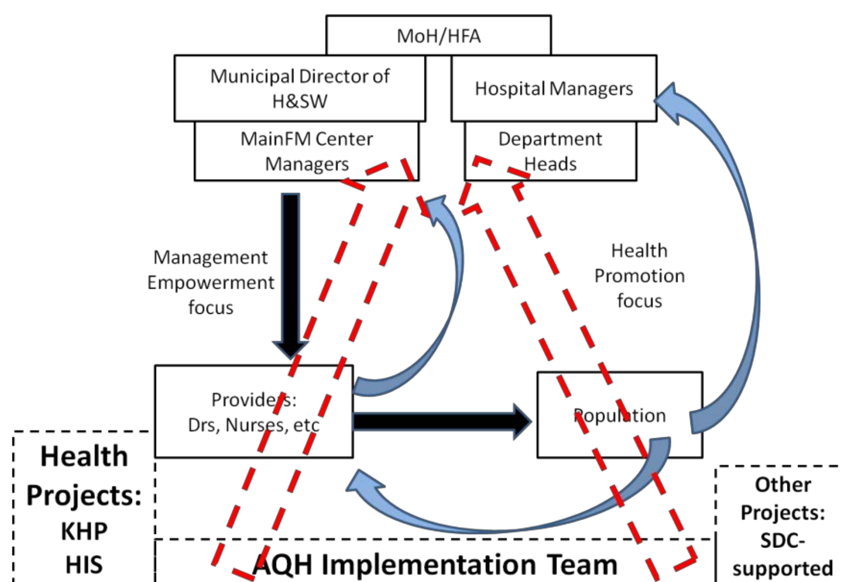
The Consultant Team therefore recommends a **6-month Inception Phase** for the AQH Project, in order to confirm the final concrete thematic areas and objectives and activities to be involved in and their phases, the pilot sites to focus on, to further study the reasons for health seeking behaviour in addition to issues of quality of care, to build the project staff, and to agree cooperation and, where necessary, contracting agreements with local partners/organisations.

The implementer will be the winner of an International Tender Process, and will likely be a Consulting Company/ Organisation/Consortia with substantial experience and capacity to provide a variety of skilled consultants with specific health system and management skills to coordinate and implement this highly technical project. The international Team Leader will be someone with demonstrated leadership, sound managerial and health systems knowledge.

A good local team will also need to be recruited, including one or two people with a deep understanding of the political situation and with a good reputation with the majority of stakeholders.

The Figure 8 below highlights the overall strategy of the AQH Project, to work from the viewpoint of the medical staff and the population, to feed their needs back up (red dashed arrows) to the management structures in order for the system to respond to what really matters, to what will really make a difference to people's health:

Figure 14: Overview of Project Implementation Strategy



10.2. Pilot Sites (PHC level and Hospitals):

It will be important to work on some aspects of the AQH Project Implementation at specific pilot sites, Municipalities and health facilities, while other aspects can be carried out simultaneously at the central level (i.e. in Pristina with national institutes/organisations).

The Table below highlights how the various Project Objectives might be carried out in between these levels.

COMPONENT	OBJECTIVE	General Health System Activities	Specific Pilot Site Activities
1- Provider Focus	1. Facilities at PHC and referral levels supported to improve clinical care practices in "selected" thematic areas in order to ensure patients receive appropriate, timely and cost-effective care.		X
	2. Facility management standards, at least at the PHC level, are reviewed and refined, in order to allow a system of effective supportive supervision and monitoring processes and to promote consistency of best practices across the levels of the health care system.	X (Develop standards in close cooperation with MoH Dept. for Quality /LuxDev)	X (Implement standards)
	3. Health care professionals (especially at PHC level) have increased access to relevant educational training information in order to improve their health-related knowledge and understanding in selected thematic areas for the benefit of their patients	X	X (Intensive support for use of training materials in some sites)
	4. The Chamber of Healthcare Professionals of Kosovo is supported to develop and function, in particular, to promote sufficient, relevant and regular Continuous Professional Development programmes for the PHC (and hospital) health care staff.	X	
2-Management Focus	1. Facility heads of PHC will be better able to carry out basic planning and budgeting functions for their facilities in order to argue for allocated and, if possible, appropriate funds.		X
	2. Health service managers (at Municipal and MoH levels) are enabled to understand, evaluate and respond effectively in order to meet the needs of the facility staff at the PHC level.	X (Develop training modules)	X (Implement feedback mechanisms)
	3. Issues are identified that should result in greater efficiency and implemented through pilots to promote long term cost savings and rationalization.	X (if activities are carried out centrally eg with MoH Central Warehouse)	X
	4. Policy-level analysis and evaluation of data (evidence-based) is improved at the relevant managerial level(s) for relevant, efficient, "provider-oriented", long term decision-making.	X	
3- Population Focus	1. The health education needs of the population are assessed in relation to available IEC materials in order to address the information gaps (including those of the vulnerable groups).	X	
	2. Appropriate IEC materials are developed (created/adapted), produced and distributed to the relevant population at selected sites on issues of selected thematic areas, while simultaneously strengthening mechanisms of delivery (PHC facility staff, schools, home visits, media etc) and monitoring.	X	X
	3. The patient/population feedback mechanisms to the health providers and managers are improved (systems developed, transparency achieved, responsiveness assured) in order to ensure that ideas for improvements (including those arising from complaints) are identified and appropriately addressed.	X	X

10.3. Selection of Pilot Regions/Municipalities

There needs to be a careful selection of the pilot Municipalities based on what is justifiable, first, by the fact that there is inequitable sharing of resources and problems among the Municipalities with disproportionate ratios of vulnerable people compared to the resources available. Second, the project will not be in condition to test models and innovations throughout the countries: therefore it needs to concentrate efforts in a manageable number of Municipalities that can serve the demonstration purpose for subsequent rolling out of successful initiatives.

In the search of the indicators that could suggest a higher proportion of presence of vulnerable people, a range of indicators were collected and gathered in an extensive spreadsheet/ database. Among those, the ten described below were considered the most relevant. High scores were given to Municipalities that had indicators suggesting higher presence of vulnerable people.

The methodology of the scoring and ranking is explained below, so that Municipalities with:

- highest proportion of **RAE community** members in their population scored higher;
- the lowest **per-capita budget** in 2012 were considered to be the poorer ones and were given higher scores;
- the lowest **PHC per-capita expenditure** in 2012 were considered to be less capable to respond to the health needs of the population and received higher scores;
- higher proportion of people receiving public **poverty related social benefits** were considered the poorest and received higher scores;
- higher proportion of **female lone parents** in the total female population received higher scores;
- lower number of **doctors per 1,000 inhabitants** were considered as having more people in vulnerable position and were given higher scores;
- the highest number of **inhabitants per health facility** were also considered in worse condition to serve its vulnerable population and received the highest scores.
- lowest **PHC visits per capita** were considered to be less able to respond the needs of their vulnerable population and received the highest score;
- highest incidence of **TB cases per 10,000 inhabitants** were considered to be in poorest conditions and received the highest scores;
- highest proportion of their population **not covered by water supply** system were considered to have higher proportion of people in vulnerable conditions and received the highest scores;

First, the methodology for making the selection ranked all Municipalities according to each indicator individually. Second, a score was given according to the ranking, where the worst one scored 38 and successively in decreasing order (37, 36, 35, etc. sequentially) to the best one.

When two or more Municipalities had the same value for the same indicator, they received the same score for that indicator. After the Municipalities received the scores for each of the ten indicators, the scores were added up for each Municipality and the Municipalities ranked again, this time considering the total result of the sum of scores. The Table below shows the final result.

Table 3: Ranking Selected (available) Indicators for Municipalities

Municipalities	TOTAL SCORE	AVERAGE	CLASSIFICATION
Ferizaj	298	29.8	1
Vushtrri	291	29.1	2
Malishevë	288	28.8	3
Shtime	286	28.6	4
Rahovec	283	28.3	5
Lipjan	279	27.9	6
Viti	277	27.7	7
Klinë	275	27.5	8
Hani i Elezit	273	27.3	9
Podujevë	272	27.2	10
Fushë Kosovë	267	26.7	11
Skenderaj	265	26.5	12
Gllogoc	261	26.1	13
Deçan	257	25.7	14
Kaçanik	257	25.7	15
Pejë	254	25.4	16
Prizren	248	24.8	17
Gjakovë	245	24.5	18
Mitrovicë	243	24.3	19
Gjilan	241	24.1	20
Suharekë	231	23.1	21
Kamenicë	228	22.8	22
Dragash	227	22.7	23
Obiliq	223	22.3	24
Novobërdë	221	22.1	25
Istog	220	22.0	26
Prishtinë	220	22.0	27
Junik	191	19.1	28
Mamushë	183	18.3	29
Kllokot	135	13.5	30
Graçanicë	131	13.1	31
Shtërpcë	124	12.4	32
Ranillug	112	11.2	33
Leposaviq	100	10.0	34
Mitrovica e V.	74	7.4	35
Partesh	65	6.5	36
Zveçan	60	6.0	37
Zubin Potok	57	5.7	38

Below is a table that highlights the above ranking system, but taking into account other factors in deciding on the selection of pilot sites for the project. It should be noted that Ferizaj and Vushtrri are municipalities that also have City Hospitals financed through the MoH and a very well developed private sector network.

The numbers/rankings given are not final, since not all data for all facilities is available, but this could be finalised during the inception period of the AQH Project and used to help decide which facilities will be targeted.

	Municipality	1. Needs: based on Indicators (Health, Finance, Staffing etc)			2. Links to Key Projects & Hospital/s			3. Geography (for logistics purposes eg on same routes, proximal sites etc)	4. Willingness (of the leaders to be involved)	5. Final Decision	
		Score	Ranking (Lowest Rank has most priority)	Ranking Top 16	Health Support Programme (LuxDev)	DEMOS Local Governance Project (SDC)	Kosovo Health Project (WB)			Final Score	Final Ranking
1	Deçan	25.7	14	1						1	
2	Dragash	22.7	23							0	
3	Ferizaj	29.7	2	1						1	
4	Fushë Kosovë	26.7	11	1						1	
5	Gjakovë	24.5	18			1				1	
6	Gjilan	24.1	20							0	
7	Gllogoc	26.1	13	1						1	
8	Graçanicë	13.1	31			1				1	
9	Hani i Elezit	27.2	9	1		1				2	
10	Istog	22	26							0	
11	Junik	19	28			1				1	
12	Kaçanik	25.7	15	1		1				2	
13	Kamenicë	22.8	22			1				1	
14	Klinë	27.5	8	1						1	
15	Kllokot	13.5	30			1				1	
16	Leposaviq	10	34							0	
17	Lipjan	27.8	6	1		1				2	
18	Malishevë	28.7	3	1						1	
19	Mamushë	18.2	29							0	
20	Mitrovica e V.	7.4	35							0	
21	Mitrovicë	24.3	19							0	
22	Novobërdë	22.1	25			1				1	
23	Obiliq	22.3	24							0	
24	Partesh	6.5	36			1				1	
25	Pejë	25.4	16	1		1				2	
26	Podujevë	27.2	10	1						1	
27	Prishtinë	21.9	27		1	1	1	1		4	
28	Prizren	24.8	17		1		1	1		3	
29	Rahovec	28.2	5	1		1				2	
30	Ranillug	11.2	33			1				1	
31	Shtërpcë	12.4	32			1				1	
32	Shtime	28.5	4	1		1				2	
33	Skenderaj	26.5	12	1					1	2	
34	Suharekë	23	21							0	
35	Viti	27.7	7	1		1				2	
36	Vushtrri	30.1	1	1						1	
37	Zubin Potok	5.7	38							0	
38	Zveçan	6	37							0	
	TOTAL	**816.2**		**16**	**2**	**17**	**2**	**2**	**1**		

Column 1 summarises the findings of a more detailed database of selected and available indicators developed during the Consultancy. From the results, scores were developed, and this has led to rankings of each Municipality according to needs based on the 10 indicators listed above.

Column 2 shows the Municipalities being focused on by other major projects which are related to the AQH project.

- The Health Support Programme (funded by LuxDev) is piloting a comprehensive Health Information System in the two biggest regions, Pristina (6 Municipalities) and Prizren (5 municpalities) covering nearly half of Kosovo population, and it would be wise to link the AQH project to these areas in order to support the development and implementation of the HIS, and to use it for the benefit of the health care at the facilities.
- The WB-supported Kosovo Health Project will implement Performance-Based Capitation payments and support for implementation at the facilities could be key to

ensuring that this works in a way that increases the quality of healthcare at the PHC level.

- Also the DEMOS local governance project will work to support the Municipalities, and their interaction, understanding and relationships with Municipalities could provide excellent synergies with the AQH project for initiatives related to financing mechanisms for the PHC facilities. It will be advisable that the AQH Project selects some pilots covered by DEMOS in order to leverage the impact of SDC-supported interventions and synergies including the need to further enhance Municipal level transparency.

Column 3 highlights the geographic location of the facilities. This could be a factor to ensure the maximum efficiency of the project, by linking adjacent Municipalities for the sake of limiting AQH Project travel expenses and staff time. However, this is not a key concern, since Kosovo is compact and does cover not a large area.

Column 4 reflects the willingness of the Municipality and PHC leaders to be involved in the pilot AQH Project reform activities, which could be important to facilitate progress, especially in the early stages of the Project.

Finally, **Column 5** highlights the overall scores per Municipality, and will result in a ranking which can be used as an important factor for deciding those Municipalities to approach to be involved in the initial AQH Project activities.

In addition to completing and finalising the indicators for Column 1, there may be other unrecognised factors that could be included in this table. This will be for the Implementer to finalise during the Inception Phase of the Project.

10.4. AQH Project Management

The AQH Project tender should be for one implementing company/agency, since continuity and communication among the staff will be vital for such a complicated and technical project.

It will be ideal if there is a full time international project leader to guide and coordinate the project, preferably with a health (management) background and experienced in successful project leadership, policy-making and political discussions.

This project leader should coordinate a strong team, both national staff and short term international experts. This team will be, in some ways, the tool for implementing the majority of the Project activities, through enhancing clinical competences, feedback mechanisms, developing managerial capacities, and coordinating health promotion activities. The strength of this team will be reflected as a high proportion of the Project budget.

There should be a mechanism for on going coordination of the Project with the MoH and other major health projects. This is probably best carried out through regular, scheduled, meetings with the leaders of the MoH and preferably in cooperation and collaboration with the World Bank-supported KHP and the LuxDev Health Support Programme. It is recommendable that a high level steering committee group be set up with power to approve work plans, reports and make decisions in any matter related to changes in the design, directions and principles of the original Project.

11. Resources

11.1. Staffing/Technical Skills

The demands of the AQH Project will require a large, skilled, and experienced staffing team if the objectives of the Project are to be achieved. Suggestions for the required positions are shown in the Table below:

Possible Annual Staffing Requirements

	Full Time International Staff	Person Months
1	Experienced Project Leader with medical management background (full time including housing and benefits)	12
	Full Time National Staff	
2	Admin Office Manager	12
3	Admin Accountant	12
4	Clinician (Internal Med/FM) respected at political levels	12
5	Clinician (Internal Med/FM)	12
6	Health financial/budgeting expert	12
7	Health financial/budgeting expert (could also be x2 junior Public Health graduates)	12
8	Supply/Logistics Manager	6
9	Procurement/contracts officer (Goods and Services)	10
10	Procurement/contracts officer (Grants)	10
11	Communications & Health Promotion – promote health successes/activities to public, proactive arguments for more health funding, to reduce constraints	12
12	M&E officer	12
13	Translator	12
14	Translator	12
15	Translator (part time)	6
16	Part Time national Consultants (clincians, laboratory, supply/stock experts, maintenance system etc)	12
17	Legal Expert (Called on as needed)	3
	Short Term International Experts	
18	Clinical & Public Health Expert (Int med/FM)	6
19	Procurement Expert (Part time, or full time for 2 years)	6
20	Management (Hospital/Project)	6
21	Health finance/ budgeting/ accountancy expert	4
22	Health Promotion (IEC) Expert	4
23	Part Time International Consultants (eg Clinical (Internal) Medicine, Equipment maintenance, Laboratory, drugs supply management, Supply Logistics)	12

National members of the team will be assigned to be the liaison staff for specific municipalities; the defined members will liaise with 3 to 4 munipalities.

11.2. Preliminary Estimation of AQH Project Costs over 4 Years

Based on the Project implementing team's technical skills, and the interventions described in this Report, a preliminary estimation has been made of the breakdown of costs for the AQH project.

The 3 main areas of funding will cover the (a) office running costs, (b) the administered project funds and (c) funds to be made available as appropriate for optional activities including contingencies.

Decisions on the use of (c) optional activities/contingencies (see Section 11.7) will need to be decided as the project unfolds, giving priority to link these to strengthen management capacities (eg vehicles for laboratory centralisation), and other possible uses related to other Project activities/capacities as funds are available (eg screening/diagnostic equipment).

OFFICE COSTS	250,000
NATIONAL AND INTERNATIONAL STAFF (Full Time)	1,250,000
AGENCY ADMIN FEE (e.g. 20%)	300,000
TOTAL: OFFICE RUNNING COSTS	**1,800,000**
OBJECTIVE 1: PROVIDER FOCUS	1,500,000
OBJECTIVE 2: MANAGER FOCUS	1,500,000
OBJECTIVE 3: POPULATION FOCUS	900,000
TOTAL: AQH ADMINISTERED PROJECT FUNDS	**3,900,000**
TOTAL: BASIC AQH PROJECT	**5,700,000**
OPTIONAL ACTIVITIES/CONTINGENCIES (see Section 11.7)	1,800,000
TOTAL: AQH PROJECT plus Optional Activities	**7,500,000**

12. Risk Assessment

12.1. Government Elections

Many key actors in the health system may change in the coming elections, and it is not known who, if anybody, will be replaced, and by whom. This includes key positions in the MoH, and also in the hospitals and at the Municipality levels.

Thus it is important that the AQH project is not linked too strongly to the views of any particular individuals, and is able to adapt to whatever the new political perspectives and foci may be.

12.2. Budgetary funding

It is clear that the health system is currently underfunded, and this will continue to pose a major risk to all health-related projects. This will be particularly true for those projects that require increased management or maintenance costs, especially those that will procure technical equipment. The AQH project, by focusing on improving existing management mechanisms, minimises this risk. In fact, by targeting improved efficiencies in the existing system, the Project may directly address this issue.

The Consultant Team repeatedly heard it said that the AQH Project should aim to support the population's acceptance for the new mandatory health insurance scheme that is being planned through the KHP subject to promulgation of the Health Insurance Law by the Kosovo Parliament. The argument is that as people will be forced to pay for their health insurance, they will expect a higher level of healthcare because of the increased funding for the public health system.

However, this is not a logical argument, and one which should **not** strongly influence the design of the AQH project. This is because, as the KHP is being designed, it is becoming apparent that the initial benefits of the new mandatory health insurance scheme at the PHC level will only serve to (a) decrease the gap in PHC funding by a quarter - if current budget line allocation structure is not changed (b) allow additional patient choice of dispensing of 1-2 types of (e.g. diabetic) medication which is already freely available to those in need. At the hospital level activities will commence to (c) change the health financing mechanisms and (d) to provide some equipment for discrete (e.g. MCH) areas of health service delivery. Thus the benefits for the general population will not be quickly perceived by the population, especially if some of these activities are conducted initially at a limited number of pilot sites.

Also, despite the commencement of collection of health insurance premiums early on in the KHP, the distribution and use of these funds will take time to be established, likely leading to a time-lag in producing any tangible results. For all these reasons, the AQH project cannot demonstrate directly the benefits of the KHP initiative - only of its own activities e.g. small grant scheme for PHC - which will hopefully provide good synergies with the developing KHP.

Due to recent increases (25%) in salaries and wages of health staff of the public sector, it can be assumed that in 2014 and 2015 less budget will be allocated for goods and services and capital investments - at least for an interim phase until the health insurance system is up and running. This may negatively affect availability of essential medicines, diagnostic means and potentially implementation of CPD which consequently may negatively affect affordability and quality of healthcare services in public healthcare sector.

12.3. Capitation-Related PHC Budget Allocations

There is disquiet with the accuracy of current Capitation Payment system used to allocated budgets for the PHC facilities. The Team have not been able to assess this in depth, but initial data do appear to show significant discrepancies in the budgets per patient between the

various Municipality PHC facilities. Failure to address this issue can lead to continuing inappropriate funding allocations between the facilities, which is likely to reduce the impact of AQH activities where funding levels are particularly inadequate.

12.4. Municipal-Level Transparency

By focusing firstly on the PHC level of care, it will be vital to work closely with the Municipal authorities, especially in the area of making the budgetary allocations to PHC facilities more transparent. However, there may be many hidden agendas at this level (e.g. pressures to allocate funds in certain directions, pressure to reduce PHC spending and reallocate it elsewhere etc.) and this could reduce the ability of the Project to make effective steps forward.

It will therefore be important to work closely with other influential Projects such as the KHP and the HIS, and to select pilot areas where there is commitment to be involved.

The AQH Project should make its primary focus to support facilities to meet the clinical standards of care chosen as thematic areas, and from this position move forward to engage in the more sensitive areas of improving transparency and budgeting issues. This will help to reduce any perceived tensions and will allow for activities to progress no matter what the reactions may be to the more sensitive issues.

12.5. Private Sector

Continued conflicts of interest with the private sector poses a threat to any initiatives to bring about improvement to the public sector. A proportion of public sector staff receive financial benefits from the private sector, both from referring cases to clinics/pharmacies there, or directly by referring cases to themselves working there. This could in theory mean that poorly functioning equipment, or lack of supplies in the public system mean there are more opportunities to refer to the private sector.

Such conflicts of interest are worse at urban areas than in the rural ones, and in hospitals more than in PHC clinics. This is because in the rural areas served by the PHC clinics, staff are usually known members of the community whom they serve, and are less likely to want to unnecessarily benefit to the detriment and cost of their "neighbours". In urban areas, there is more anonymity, and therefore less necessity to "do the right thing".

Therefore the AQH project, by making its first priority to build up the capacity of the PHC system, reduces the risks of failure from pressures from the private sector.

In addition to that, it is known that some PHC health workers carry out home visits outside the working hours for which they are privately paid by the patients. When the project make the call to introduce home visits as part of the normal routine work of the PHC facilities, it is likely that there will be some resistance to adopt such routines.

12.6. Performance Based Capitation implementation

The KHP stresses the use of Performance Based Capitation payments to bring funds obtained from the mandatory health insurance to the PHC facilities. In the latest WB project documents, it appears that allocation of funds will be made if certain numerical targets of PHC performance are achieved.

This can have a number of detrimental unintended effects, including pressuring the facilities to divert funds from other needs to ensure that they reach these targets. Thus water pipe, boiler or building repairs unrelated to the targets may be put on hold, despite being agreed as priorities in the annual budget plans that the AQH project plans to support.

To mitigate such issues, it will be very important to keep clear channels of communication with the KHP as it develops, and to feedback the consequences of such target setting to the relevant authorities in order to make adjustments in implementation. Funding according to input and process indicators may be a more appropriate route to achieve results, always bearing in mind that whatever additional funding the KHP provides, it is still insufficient to satisfy the real needs of the PHC facilities.

13. Open Issues

13.1. Establishment of HUCSK and reorganization of SHC and THC

New health regulations have been approved for the governance and management of the HUCSK. The Project could be involved in using its management capacities and experience to help ensure (through limited and targeted actions) that the potential for positive improvement resulting from these reforms is achieved. Thus the HUCSK board would be provided with support in order to analyse and improve the functioning and flow of funds across the vertical Line Services i.e. SHC and THC levels

In the initial stages, the AQH Project could support assessment/ inventory/ mapping of available human and technical resources and SWOT/gap analysis, and facilitate functioning of Line Services coordination bodies.

Even so, final decisions on the exact management structure of the hospitals (e.g. orientation towards Line Services) still need to be made, and involvement of the Project will also depend on the interest of other projects/organisations to be involved (e.g. WB through the KHP, LuxDev through the follow on project etc.). Therefore, the project should watch closely what will happen with the HUCSK, particularly in case any initiative taken may have some influence on PHC services provision and the working of the referral system.

However, there is much work that needs to be done to ensure that the potential for positive improvement resulting from these reforms is achieved. This is likely to be a complicated and difficult process, with many influential (including political) interests at stake.

While the Team has included some specific activities to improve management processes at the hospital level in the scope of the Project, this is not the core focus. How far the project should go to support the new structure is not clear at this stage, and will depend on the interest of other projects/organisations to be involved (e.g. WB through the KHP, LuxDev through the follow on project etc.).

Based on the final decisions of the government, it will also depend to some extent on the skills and capacity of the AQH implementing agency to address how this will be implemented, including the idea to develop Line Services and the potential to implement some form of Public Private Partnership (PPP).

13.2. Private Health Sector Conflict with the Public Sector

The conflict of interest between public and private sector is well known and there was an attempt to regulate by not allowing public servants to be deployed at the same time in the private sector. However, the Parliament of Kosovo removed this provision from the Health law, and the problems related to this remain.

What else could be done to address this issue? Can anything be attempted to further develop mechanisms and systems and regulations (e.g, Accreditation) to ensure quality service provision in the private sector. This will be a step forward for the overall Health Insurance agenda, as at a later stage the HFA/HIF may start contracting private providers as well (as indicated in the KHP document).

13.3. Accuracy of Capitation Calculations

The accuracy of current Capitation-Related calculations for allocating PHC budgets is questionable. Can anything be done (e.g. a formal study/assessment, zoning) to address this issue to ensure more appropriate funding allocations between the facilities? This may require cooperation with a number of Ministries such as the Ministry of Finance, Ministry of Public Administration and Ministry of Local Administration.

13.4. Management/Epidemiology Training for Long-Term Planning

Policy-level planning capacity should be improved, including the ability not only to collect accurate and appropriate data and information, but especially to analyse it from a public health (epidemiological) and long term efficiency viewpoint.

Whose capacity should be strengthened in order to carry out these activities? First, there is the HFA who will soon take over significant responsibility for managing the payments to the providers linked in some way to quality of services. Secondly, there is the NIPH who collate health data and provide analysis. Thirdly, there are the managers of the HIS who will manage input of data. And fourthly, there is the MoH who must use the data for advocating the priority of healthcare and make the final policy decisions.

Which of these agencies should take the lead role in data analysis, and what should be the form of cooperation between these various actors? If too much power is given to one of these agencies (especially if it not the MoH), then the danger of unproductive competition between them could become an issue, leading eventually to winners and losers. It is not clear how these issues will be resolved, and who can be involved in doing so.

13.5. Development of Professional Chambers

LuxDev is showing interest in supporting the development of the Professional Chambers. Will cooperation with the AQH Project be needed to develop particular aspects, such as establishing systems for the monitoring and support for Continuing Professional Development of health staff? These issues may need to be clarified in the Inception period of the AQH Project.

13.6. Support Secondary/Tertiary health facilities managed by Serbian Minority

Funding of up to Eur5 million has been offered to support the development of secondary healthcare facilities in Municipalities run by the Serbian minority. However, this has not been used, and it appears that there is an impasse in accessing it.

There are needs for this to be used to modernise and update some of the existing facilities, or even to expand them. It is recommended that the final outcome of the decentralization process based on the Ahtisaari's plan be awaited. Then, if favourable, a possible option would be to use a proportion of the AQH Project funds (or funds from elsewhere) to create additional 2-3 Project team positions to advocate for the utilisation of the promised resources.

13.7. Optional Implementation Activities/Procurement Items/Contingencies

The 3 Objectives described in Section 6.3 present the main activities of the project. At this stage it is not exactly calculated what the costs of these will be, but some rough estimates have been made.

These estimates indicate that, in addition to implementing the objectives, there could be some additional funds remaining that could be used to cover activities that the Consultant team consider to be optional, and which have been described in other sections (in particular in Section 6.3b).

A number of "non-core" options for funding by the AQH Project have been listed in the Report, including screening tests for neonates (phenylketonuria/ hypothyroidism) and specialised testing equipment for specific municipalities/regions (Hemorrhagic Fever, Brucellosis), cold chain equipment, an MRI scanner, MoH Central Storage Warehouse re-organisation, and the hiring of additional consultants to advocate for allocation and utilization of funds to develop facilities run by Kosovo-Serbian staff.

Below is a list that summarises some of the options described earlier in this Report that could be considered for funding when it is more clearly known what these remaining funds may be:

There are plenty of needs within the health system of Kosovo, in addition to these, and it is recommended that unused Project funds be kept for contingencies and allocated flexibly as the Project evolves.

Finally, another possibility to be considered it the provision of **scholarships for Masters courses** abroad in the selected thematic areas, including the area of hospital/facility management. The Project would fund scholarships for PHC or FM related master course abroad for 5 to 8 doctors from the selected municipalities. Doctors would sign a term of commitment to return to the place of origin after the conclusion of the course.

14. Annex 1: Mission Agenda: February 14 – March 23, 2014

Mission Team:
P. Campbell (PC)
T. Gotsadze (TG)
M. Berisha (MB)
J. Costa (JC)
L. Cela (LC)

Date	Day	Time	Activity	Place/City	Experts (Int'l)	Expert (Local)
14.02	Fri	11.00	**PC & TG arrive**		PC, TG	
		13.00	Meet with Local Consultants	Pristina	PC, TG	MB, LC
		15.30	Meet at SDC for Briefing	Pristina	PC, TG	MB, LC
15.02	Sat	10.00	Peter and Tako Meeting	Pristina	PC, TG	
		12:00	L Cela, local consultant	Pristina	PC, TG	MB, LC
		15.00	M Berisha, Local Consultant	Pristina	PC, TG	MB, LC
16.02	Sun	10:00	Team discussions	Pristina	PC, TG	
		14:00	M Berisha, Local Consultant	Pristina	PC, TG	MB, LC
17.02	Mon	11.00	Team discussions	Pristina	PC, TG	MB, LC
18.02	Tue	10.00	Main Family Medicine Center, Pristina Municipality incl Municipal Directorate for Health & Social Welfare	Pristina	PC, TG	MB, LC
		13.00	Secretary General	MOH	PC, TG	MB, LC
		15.00	Quality of Care Division	MOH	PC, TG	MB, LC
19.02	Wed	9:00	Visit to MFMC , Punkta (on the way) in Fushe Kosova FM Center FM Punkta of	Fushe Kosova Village Miradia/Lower Suburb Fushe Kosova	PC, TG	MB, LC
		15:00	Lux-Development (HMIS) (Aferdita and Poul)	MOH	PC, TG	MB, LC
20.02	Thurs	09.00	Site visit to 2 ary Hospital	Gjilan Hospital (1)	PC, TG	MB, LC
		11.00			PC, TG	MB, LC
		13.00	Regional IPH	Gjillan Hospital (1)	PC, TG	MB, LC
		15.00	Site visit		PC, TG	MB, LC
21.02	Fri	09.00	Center for Development of FM CDFM	Division of MoH	PC, TG	MB, LC
		10.30	Center for CPD of Nurses	Division of MoH	PC, TG	MB, LC
		14.00	Meet SDC	SCO	PC, TG	MB, LC
		16.00	UNICEF	UNICEF	PC, TG	MB, LC
22.02	Sat	10.00	Team Discussion	(2)	PC, TG	MB, LC
					PC, TG	MB, LC
		13.00		(2)	PC, TG	MB, LC
		15.00			PC, TG	MB, LC
23.02	Sun	**08.55**	**JC arrives**		JC	
		11.00				
		13.00		Pristina	PC, TG, JC	
		19.30	Meet Fried Didden, SDC partner in Clinical Psychology and Psychotherapy	Pristina	PC, TG, JC	
24.02	Mon	09.00	Meet NIPH	Pristina	PC, TG, JC	MB, LC

		11.00	Association of Municipalities of Kosovo	Pristina	PC, TG, JC	MB, LC
		14.00	Peter meeting with SCO Kosovo	Pristina	PC, TG, JC	MB, LC
		16.00	Meet WB Team	Fushe Kosovo	PC, TG, JC	MB, LC
25.02	Tues	09.00	Travel to Prizren	Prizren	PC, TG, JC	MB, LC
		10.15	secondary Hospital Prizren	Prizren	PC, TG, JC	MB, LC
		13.30	Main FMCenter Prizren	Prizren	PC, TG, JC	MB, LC
		16.00	Urgency Medicine Center Prizren	Prizren	PC, TG, JC	MB, LC
26.02	Weds	09.00	Meet SCO-Kosovo	SCO-Office, Pristina	PC	MB, LC
		10.00	Meet WHO and UNFPA	UNFPA Offices	PC, TG, JC	MB, LC
		11:00	Meeting with the Minister of Health	MOH	PC, TG, JC	MB, LC
		13.00	Meeting with Dr. Ilir Hoxha from KoSana	Pristina	PC, TG, JC	MB, LC
		15.00	Meet Sigrid Meijer/Heini Conrad, Program Manager, Swisscontact (Promoting Private Sector Employment)	SCO Office, Pristina	PC, TG, JC	MB, LC
		17.00	Team Discussion	Pristina		
27.02	Thurs	10.00	SDC LGProject _ Saranda	Pristina	PC, JC	LC
		10.00	HIS Presentation by LuxDev/NIPH	Gorenje	TG,	MB
		12.00	Max Glesener (Regional Rep for the Balkans of LuxDev)	Gorenje	PC, TG, JC	MB, LC
		13.30	FM Center in Ajvalia	Ajvalia	PC, TG, JC	MB, LC
		19.00	Team Dinner with SCO-Kosovo Office	Pristina		
28.02	Fri	08.30	Debriefing with SCO-Kosovo	SCO-Office, Pristina	PC	
		09.00	Chamber of Medical Professional	Pristina	TG, JC	MB, LC
		11.00	Meeting with SCO/WB	Pristina	PC	
		13.30	Meet Dr. A. Qavdarbasha HFA	Pristina	PC, TG, JC	MB, LC
		15.00	Visit UCCK	Pristina	PC, TG, JC	MB, LC
		19.00	Meal with WB	Pristina	PC, TG, JC	MB, LC
			MARCH			
1.03	Sat	09.00	Team Discussions/Planning	Pristina	PC, TG, JC	MB, LC
		11.00		Pristina	PC, TG, JC	MB, LC
		13.00		Pristina	PC, TG, JC	MB, LC
		15.00		Pristina	PC, TG, JC	MB, LC
2.03	Sun	09.00				
		11.00	Preliminary Report Writing			
		13.00	Preliminary Report Writing			
		15.00	Preliminary Report Writing			
3.03	Mon	09.00	**PC & TG depart**			MB, LC
		11.00	Meeting Mr. B. Fusha Director of the Pharmaceutical Division MOH	Pristina	JC	MB, LC
		14.00	Meeting with the Global Fund	Pristina	JC	MB, LC
		15.00	Team Debriefing		JC	MB, LC
4.03	Tues	09.00	Site Visit – Joao with the NIPH MICS team	Dragash	JC	MB,
		11.00	Meeting Dr. I. Humolli NIPH	Pristina		LC
		15.00	Preliminary Report Writing		JC	MB, LC
5.03	Weds	09.00	Visit to the Telemedicine Center of Kosovo Director Dr. I. Lecaj	Policlinic	JC	MB, LC
		11.00	Meeting with members of the Health Promotion Commission		JC	MB, LC
		13.00	Meeting with Dr. M. Shehu Community Development Initiative		JC	MB, LC
		15.00	Meeting Dr. S. Selimi European Commission		JC	MB, LC
6.03	Thurs	09.30	Visit to the Pharmaceutical Unit and Warehouse of the MFMC Pristina	Pristina	JC	LC
		11.00	Visit to the Central Drug Warehouse of the MOH	Pristina	JC	LC

		14.00	Meeting MOH Director of Budget and Finance	Pristina	JC	LC
		15.00	Meeting with IMF Mr. J. Sulemani and Mr. S. Thaqi	Pristina	JC	LC
7.03	Fri	09.00	Data gathering and Analysis and Preliminary Report Writing	Pristina	JC	LC
8.03	Sat	09.00	Preliminary Report Writing	Pristina	JC	LC
		15.00	Preliminary Report Writing	Pristina		
9.03	Sun	09.00	Preliminary Report Writing		JC	
10.03	Mon	09.00	Meeting at the MF PPP Directorate Mr. L. Sylejmani	Pristina	JC	LC
		11.00	Visit to the Private Hospital – International Medicine Hospital	Lipjan	JC	LC
		15.00	Preliminary Report Writing – Data gathering and analysis	Pristina	JC	MB, LC
11.03	Tues	09.00	**Field Visit:** • Malisheva MFMC • Bellanica FMC • Trpeza FMC • Orllat FMC • Drenas MFMC • Prekaz FMC	Malisheva Bellanica Trpeza Orllat Drenas Skenderaj Mitrovica	JC	LC
12.03	Weds	09.00	Preliminary Report Writing – Data gathering and analysis	Pristina	JC	LC
13.03	Thurs	09.00	Mtg. Mr. Rrezart Halili – Medical Chamber of Kosovo	Pristina	JC	LC
		10:00	Mtg with Procurement Division of the MOH	Pristina	JC	LC
		14:00	Mtg Ms. A. Baraku Chief Inspector – Health Inspectorate at MOH	Pristina	JC	LC
		15:00	Meeting with Dr. M.Vuthaj MCH Officer and Dr. B. Maxhuni MCH Project Coordinator	Pristina	JC	LC
14.03	Fri	12.00	P Campbell arrives back in Kosovo	Pristina	PC, JC	
		14.00	Feedback discussions/handover with J. Costa	Pristina	PC, JC	MB, LC
		15.00	Mission Team Discussions/Planning	Pristina	PC, JC	MB, LC
15.03	Sat	09.00	Feedback discussions/handover with J. Costa & M. Berisha & L. Cela	Pristina	PC, JC	MB, LC
		11.00	Mission Team Discussions/Planning	Pristina	PC, JC	
		13.00	Mission Team Discussions/Planning	Pristina	PC, JC	
		15.00	Mission Team Discussions/Planning	Pristina	PC, JC	
16.03	Sun	09.00	Report writing		JC	
		09:45	JC departs	Pristina	PC	
17.03	Mon	09:00	Update briefing with SCO-Kosovo,	Pristina	PC	
		11:00	Report Writing with local consultants	Pristina	PC	LC,MB
18.03	Tue	05:30	LC Departs to attend the Health PPP Workshop Tirana Albania	Pristina - Tirana		LC
			Visit management at UCCK and Management Training Course NIPH/UCCK, Telemedicine Center.	Pristina	PC	MB
19.03	Wed	09:00	Visit Gracanica (Health facility attended mainly by ethnic Serbs, and RAE community)	Gracanica	PC	SDC
		14.00	Visit Mitrovica (North) health facilities : Hospital and Policlinic and	Mitrovica	PC	SDC
		18:00	LC comes back from Health PPP Workshop Tirana Albania	Tirana - Pristina		LC
20.03	Thurs	10:00	Meeting with Pierre Weber, Luxembourg	Pristina	PC	LC

			Ambassador			
		13:00	Meeting with LuxDev	Pristina	PC	LC
		15:00	Report Writing with L Cela	Pristina	PC	LC
21.03		11:30	Final Meeting with SCO-Kosovo	Pristina	PC	
		14.00	Visit to American Hospital (Private Hospital	Gracanica	PC	LC
		17.00	Meeting with Dr. Osman Veliu, Director of Health & Social Welfare, Skenderaj	Pristina	PC	LC
			Update PPT on Themes; Final wrap up with SCO-Kosovo		PC	
22.03	Sat	09.00	Report Writing	Pristina	PC	
		14.00	Final meeting and planning with L Cela and M Berisha	Pristina	PC	LC MB
		17.00	Report Writing	Pristina	PC	LC
23.03	Sun		P Campbell Departure			

15. Annex 2: Trainings Delivered to PHC Staff

Modules/Topics	Duration (hours)	# Trained	# Remaining to be trained	Name of Municipalities for future training needs
IMCI/MISF WHO	3 days	Family doctors and nurses	15 participants TOT	Trained PHC staff of Kosovo, 8 Family Medicine Training Centers, around 250 participants
ANC/KAN Dartmouth USA	3 days	Family doctors and nurses	2004-2006	Trained PHC staff of Kosovo, 8 Family Medicine Training Centers, around 250 participants
Family Planing UNFPA	3 days	Family doctors and nurses	16 TOT in CDFM	320 PHC staff 8 TCFM
LMIS UNFPA	3 days	Family doctors and nurses	24 TOT in CDFM	250 PHC doctors and nurses in 8 TCFM
"Myths and misconceptions versus evidence on contraception"UNFPA	Seminar	Family doctors	22	PHC
"Oriented Program for Reproductive Health of Youth and adolescent" WHO	Training 3 days	Family doctors and nurses	24 TOT in CDFM	Health personnel in MFMC Prizren
Grouth Standards WHO	TOT 3 days	Family doctors	16 TOT in CDFM	Health personnel in MFMC Pristina
STI-UNFPA	TOT 3 days	Family doctors	16 TOT	CDFM
Substance misuse - KHF	TOT	Family doctors	5 trainers	CDFM
PALT- KHF	TOT 2 days	Family doctors	16 Family doctors TOT in CDFM	120 PHC Family Doctors in 7 Municipalities of Kosovo
KRCT	TOT 3 days	Family doctors and nurses	16 Family doctors and nurses TOT in CDFM	Around 800 health professionals of PHC in Kosovo
Association of diabetic specialists	TOT 3 days	Family doctors	30 trainers of family medicine	CDFM

16. Annex 3: Stakeholder Analysis Summary

Stakeholder	Interest/Commitment to Project	Capacity for change (Possible contribution to project)	Actions of project to strengthen capacity of stakeholder
MoH	Have an interest in improved access to quality health care, for which the project is aiming at.	Development and institutionalization of the quality of care strategy, introduction of the health insurance system and strengthening of the HFA/HIF capacity in strategic purchasing of services, delegation of CPD function to the Professional Chamber, integration of fragmented health system through introduction of Line services, institutionalization of HIS system	Build capacity of the MoH PHC and Quality of Care, Strategic Management departments and Health Inspectors in provision of supportive supervision of the service quality at all levels of the health care system; Support HFA/HIF in supervision and monitoring of PHC performance; Contribute to the evidence based policy development at the MOH.
NIPH	Interested in improved quality of public health services, enhanced health knowledge of population and capacity of health workforce	Delivery of master level training courses in health management; monitoring indicators and standards of health facilities; collate health data and provide analysis	Support strengthening of NIPH capacity in data collection, analysis and development of policy recommendations; Utilization and revision of health management training curricula for short term modular training of MOH, Municipal and health facility heads
HUCSK	Interested in improved integrated quality care provision	No capacity available at present	To be defined during the inception period
Association of Municipalities	Increasing the number of competencies, knowledge and Municipal capacities to ensure high and effective quality in local services	Development of management, budget planning and monitoring guidelines and regulations for PHC facilities and training to Municipal Health and Social Welfare Department staff	Support AKM in the development of management, budget planning and monitoring guidelines for Municipalities; Use their capacity in delivering management training courses and supporting Municipalities in practicing modern management functions. Zoning of catchment area and patient enrolment list development, being time and resource intensive exercise, AQH can collaborate with AKM to take lead in these areas (at least in pilot Municipalities) and facilitate implementation
Professional Chambers	Interested in improved quality of care through capable and professional health personnel	Contribute to improving the quality of health care, through promotion of high standards of professional conduct, develop and implement a postgraduate specialization education programs and carry out on-going professional development. They have poor capacity at present, with insufficient staff, funding or facilities.	Support building professional chamber capacity in development and implementation of the CPD system, supportive supervision of the health personnel performance
WB KHP	Interested in improved financial access to health services, performance of health facilities and overall enhancement of service quality	Support introduction of the performance based financing of PHC, enhancement of procurement and equipment maintenance systems, institutionalization of e-prescription practices, capacity building of national and facility level quality coordinators in performance monitoring and continuous	The project can play a vital role in mentoring PHC providers to improve service quality and consequently monitoring performance on a regular basis. The AQH can play a complementary role in awareness raising and information of population through its Health

Stakeholder	Interest/Commitment to Project	Capacity for change (Possible contribution to project)	Actions of project to strengthen capacity of stakeholder
		quality improvement; assist Line Services; Build the capacity of Municipality staff, including primary care facility staff, to measure, report on and improve performance.	Promotion and Education (HPE) activities. While the KHP will support development of communication strategy, messages and run a communication campaign at the national level, the AQH can support reaching out the population per each Municipality through local mass media means, HPE channels/strategies. AQH will consider focusing on MCH Line service capacity building through supporting definition of provider competencies at each level of health care system, regionalisation of the emergency obstetric and neonatal services including referral guidelines, while UNFPA and other UN agencies will focus on staff training at PHC and hospital level. The project will ensure regular support to providers in the deployment of new procedures into the practice.
LuxDev	Have an interest in improved governance of the health care system, evidence based planning and decision making, improvement of care quality, for which the project is aiming at.	Introduction and roll-out of HIS system, training of facility staff in deployment of HIS system, and support to: • establishment of the HFA HIS system • MoH restructuring and governance • evidence based policy making • establishment and organizational development of professional chambers and line services	The project will complement the LuxDev initiatives for the development of the CME/CPD/LLL system at a central level. Specifically, AQH will support building the capacity of the providers in the development of the needs based CME/CPD programs through application of the needs assessment methodology. While the LuxDev project will mainly focus on training of staff in HIS, AQH project can contribute to the development of facility based capacities for data quality assurance (Data quality audit), data analysis and evidence based planning. LuxDev project will assist newly established Chambers in organizational development, while AQH can be instrumental to build their capacity in operationalization of their functions
UN Agencies	Interested in improved quality of sexual and reproductive and child health services, improved access to services as well as level of information and health education of population	Capacity building of health workforce in sexual and reproductive health, child health; integration of emergency obstetric and neonatal care services from PHC to tertiary care, finance operational research and build MOH capacity in evidence based MCH service planning and provision. Furthermore, supports health information and education of population with particular emphasis on RAE communities.	AQH will capitalize on CPGs and training capacity developed by UN agencies and support their application in practice; It also supports the community health groups to strengthen health knowledge and empower the people in the communities in their health seeking behaviour.

Stakeholder	Interest/Commitment to Project	Capacity for change (Possible contribution to project)	Actions of project to strengthen capacity of stakeholder
DEMOS LGP	Are willing to cooperate, but currently do not see direct concrete links due to their interest in other important topics (i.e. parks, water, transport)	In addition to providing and making contacts, could provide strategic and technical guidance and support for the AQH Project in working with the Municipalities. Area of Procurement could be a key focal point.	May provide an extra voice/ support for development of Municipal management capacities
Private Sector Development Project (PSDP)	Are interested to coordinate and cooperate with the AQH Project to find synergies	Could support e.g. development of private labs to cater for public services, could help to design/ provide training modules to build management capacity.	AQH Project can provide ideas and limited support for linking the development mutually beneficial of public/private health activities
Kosana NGO	Would be interested to cooperate and support AQH Project activities relevant to their mandate and skills	Could provide experienced and effective advocacy support for development of improved feedback mechanisms from patients and clinicians to higher levels of management.	At the least, could work together on shared thematic issues, and could make contracts with this NGO to carry out certain activities
Clinical Psychology And Psychotherapy	Very interested to cooperate to support and develop mental health services through the AQH Project	To develop collaborative care between the PHC and Mental Health Care services, with strengthened capacity of PHC staff supervised by trained psychiatrists/ psychologists.	Could strengthen the current activities through input of skilled staff and funding for relevant activities.
P4H	In view of AQH Project focus on affordability (and access) to health care, especially for the most vulnerable, P4H could become an important partner to move this forward.	Could bring high level leaders together, and catalyse major stakeholder to coordinate and cooperate strongly together to improve the access to health care through the new financing mechanisms and the need for coherent leadership to maximise their impact.	AQH Project could provide a focal point (ideas and feedback) for P4H entry to support the country

17. Annex 4: ToR of the Consultant Team

Terms of Reference for a Team of Consultants to develop
the Affordable Quality Healthcare (AQH) Project
in Kosovo

Introduction

The Swiss Cooperation Office Kosovo (SCO-K) is requesting the services of an experienced team of consultants (international and local), to conduct an identification mission for designing the Affordable Quality Healthcare (AQF) Project, in line with the Cooperation Strategy 2013 to 2016. These Terms of Reference (ToRs) outline the framework upon which the prospective consultants shall provide their services to SCO-K. With a financial volume of about CHF 7.5 million, AQF shall support the modernization and improvement of the health system of Kosovo over the period January 2015 to December 2018. A continuation with a second phase of four years and beyond is foreseen based on the results of the initial project.

The consultants, whose work is planned to commence mid-February 2014, are expected to visit the country, carry out an evaluation and develop the rationale and design within a period of maximum 3 months.

Project Background

Health System Situation

Kosovo has been struggling with an under-performing health system, and a financial situation that precluded substantial investments in a modern system. Donor activities have been extensive, but not transformative due to the rigid and ineffective health system.

The country has some of the worst health indicators in South Eastern Europe and ranks below neighbouring countries. Life expectancy at birth is 69.88 years (71 for women and 67 for men), while the infant mortality rate with 9.5 deaths per 1,000 live births and under-five mortality with 11.2 deaths per 1,000 live births, are the highest in the Balkans.

The health system continues to operate under a direct provision model, where the financing, risk pooling and provision of health care is integrated and managed by the Ministry of Health (MoH), financed from the general state budget rather than from a system of health insurance. While the level of government spending in Kosovo is among the lowest in the region, with about 3% of GDP, a large proportion of total health expenditures, about 40% are "out of pocket" contributions from patients.

Corruption in healthcare is a concern, as is the health status of Roma, Ashkali and Egyptian communities, whose access to health facilities is limited due to financial concerns and, in some cases, poor treatment and discrimination. The Serb minority benefits from services offered in parallel health care structures, funded by the Serbian Government. The EU-led process of normalization of relations between Serbia and Kosovo is expected to enable an incremental integration of such structures into Kosovo's mainstream system.

An important reform in primary health care has been the introduction of the Family Medicine concept, aiming to provide personal, comprehensive and continuing care for individuals in the context of the family and the community. The primary responsibility over primary health care stands with the Municipalities, a devolution that took place perhaps too early considering the Municipalities have neither the requisite professional nor managerial capacity.

Utilization of services at all levels of care is low, suggesting possible financial barriers to access, as well as low confidence in the capacities and quality of health services. Despite the low number of beds (220 per 100,000 inhabitants as opposed to an EU average of 570 per 100,000 inhabitants), the

average daily bed occupancy rate in 2012 was 54% in regional hospitals and 65% in tertiary care. This could be due to a number of reasons including transport issues, poorly perceived quality of services by the population, out of pocket costs, and the possibility that the referral system is not functioning properly.

Health System Strategy

Kosovo's actual reform agenda has the potential to transform the current centralized health system towards a contemporary system that offers comprehensive preventive, diagnostic and treatment services and increasingly meets the heath concerns of the population as a core aspect of human development. The initiated reforms are ambitious and comprehensive and require extensive support for successful implementation.

Performance improvement in health facilities will require a modern organizational role for managers, featuring professional responsibility and autonomy as well as related management information systems. Therefore, management and leadership must become central themes of human resource development in the future.

In order to change this situation, Kosovo is now embarking on an ambitious reform agenda that intends to improve the quality and efficiency of services as well as the financial protection, thereby improving access for vulnerable groups. The new Heath Law of May 2013 envisages many new tools for improving the quality of care. Notably, a separation of purchaser and provider functions is aimed with the establishment of the Health Financing Agency (HFA), as the authority for purchasing care from health facilities through the use of performance contracts.

Such contracts aim to lead to improvements in service delivery, greater efficiency, better quality and improved responsiveness of services to patient needs. The HFA is considered the predecessor of a public Health insurance Fund to be established once the respective Law is approved by the Parliament. Moreover, the new Health Law envisages the establishment of the University Clinical and Hospital Service (UCHS), which will have an important role in quality monitoring, support and coordination for improving the quality of care in an integrated matter.

International Support

The extensive post-conflict donor support to the health system in Kosovo has shrunk considerably. Lux Development is an important donor, supporting MoH mainly in the establishment of a Health Information System, as well as in improving maternal and child health, in a partnership with WHO, UNICEF & UNFPA. Other donors are also present with limited interventions, Italy supporting specialized treatments in cardio-surgery, Japan, France and Turkey with small scale interventions.

The World Bank is now considering supporting the health sector reforms with a highly subsidized loan (IDA funds) in the range of 25 Mio USD. Anticipated areas of support are the implementation of the mandatory health insurance and enhancing the inclusion of primary health care in reforms, through performance incentives. The scope and modalities of this intervention shall be defined in early 2014, with the support becoming effective in autumn 2014. The Health Sector Working Group is led by Lux Development and serves as a platform for policy dialogue and coordination.

The Swiss project will offer a valuable contribution in the implementation of these systemic reforms, particularly in promoting the consideration and inclusion of socially vulnerable communities.

Switzerland (HH/FOM) has played a very important role in the reconstruction and rehabilitation of the psychiatric care system in Kosovo since 2001, through several projects at all institutional levels, including infrastructure building, staff-trainings and sensitization of the population.

The long-term Swiss support has been decisive in embedding the concept of community-based mental health care as well as the introduction of specialized tertiary treatments in psychiatric care. Swiss presence to the sector has been continued in the frame of the Migration Partnership Strategy with Kosovo.

In 2012, Switzerland initiated a project supporting the MoH to diversify the range and scope of psychiatric care offered, through establishing a post-graduate training in clinical psychology. There are important synergies to be pursued with other Swiss interventions in Kosovo, notably those that aim at enhancing skills and employability, improving local governance, rural and urban infrastructure and promotion of hygiene.

A comprehensive Health Sector Assessment conducted in the beginning of 2012 recommended the following areas as entry points for a potential Swiss intervention, and based on these recommendations, SDC has decided to include health as a new domain of cooperation for the period 2013-2016.:

- support the implementation of reforms, particularly in establishing a sustainable health insurance scheme;
- improve service delivery at the primary and secondary level, with a special focus on vulnerable groups, such as Roma, Ashkali and Egyptians (RAE);
- health promotion and literacy, with a focus in schools.

The SDC Health Portfolio

As set in the Country Cooperation Strategy 2013-2016, the goal of SDC's interventions in health is to contribute to the development of a sustainable health care system that offers qualitative services to its population, including socially vulnerable communities.

The SDC Health portfolio consists of two main interventions:

- **Contribution to World Bank's Improving Quality of Health Care in Kosovo**
  In September 2013, SDC initiated a cooperation with the World Bank (WB), offering technical assistance to the Ministry of Health (MoH) in further developing the health insurance, piloting the service line in Maternal and Child Health and analysing gaps and deficiencies in current pharmaceutical procurement policies. Continuation of this support beyond June 2014 (when the current EFO arrangement comes to an end) through a Trust Fund is under consideration.
- **Affordable Quality Health Care Project**
  The bilateral Affordable Quality Health Care in Kosovo (AQH) Project is planned to commence in January 2015. It will have a budget of approximately CHF 7.5 million, will have a duration of 4 years, and will be subject to an international tender following WTO rules and procedures. The winner of the tender will be selected to implement both the inception and follow-up phase. Beneficiaries of the project include (a) the citizens in the target geographic region, in particular the socially vulnerable groups who shall benefit from easier access and better quality services; (b) health professionals shall benefit from targeted trainings and professional development; while (c) heads of health facilities shall benefit from leadership and management capacity development.

Overall goal: The AQH Project contributes to the development of a sustainable health care system in Kosovo that offers qualitative services to its population, including socially vulnerable communities. The Project shall contribute to the following objectives:

Objective 1: Enhance the access to quality health care services, particularly for socially vulnerable communities.

Objective 2: Improve the performance of health facilities through targeted professional development and upgrading management skills of health professionals.

Based on the recommendations of the preliminary assessment, in light of changes induced by the initiated reforms (as reflected in the draft Health Sector Strategy 2014-2020), and taking into consideration existing and prospective donor support, the anticipated options for intervention include the following:

- Support the development of leadership, management and administration capacities at primary and secondary health care level, in order to enhance the autonomy of health facilities, improve the efficiency of service delivery and increasing the responsiveness of services offered;
- Strengthen the primary health in its capacity as gatekeeper, by reinforcing the referral system to secondary and tertiary healthcare;

- Improve the quality of services delivered by institutionalizing respective clinical treatment protocols and guidelines;
- Enhance clinical and professional skills of health practitioners through Continuous Professional Development Programmes and other on-the-job training;
- Support health promotion and health literacy initiatives, targeting particularly vulnerable groups, in order to facilitate access.
- Develop specific financing and access mechanism schemes to include socially vulnerable communities.

Main Tasks of the Consultants

The AQH Project has three core themes: universal access to health care by the population, the quality of healthcare service provision, and an emphasis on covering the vulnerable groups of society. The consultants will look at ways to improve the health care system, will aim to strengthen the existing health system at the local level, with a focus on institutional strengthening and autonomy, management and professional skills of health professionals

Based on the findings of the consultants' mission to Kosovo, on the goals and objectives of the envisaged AQH Project, on the national strategy, and in cooperation with existing and prospective donor support, the consultants will design a 4-year health support intervention which should encompass the following:

Main Guiding Questions

i) What are the main factors limiting the quality of care delivered? What entry points may be envisaged (are there other entry points beyond the above anticipated by SCO?);

ii) What are the underlying factors limiting access to services (discrimination, perception of services, gender, financial barriers, physical access)?

iii) What are the entry points to be pursued? This should take full account of partnerships with (a) policymakers in the MoH, as well as other international actors involved in the implementation of reforms, such as the WB, Lux Development, (both these actors are in the phase of finalizing their plans for mid-term interventions), WHO, UNICEF, and UNFPA; (b) Municipal authorities who are co-responsible for primary health care and engaged in the definition of priorities and implementation of actions; (c) existing continuous medical education institutions as well as to the newly established Medical Chambers which lead continuous medical education activities of health professionals; (d) civil society organisations who could support health promotion and literacy initiatives targeting vulnerable groups and minorities;

iv) What are the opportunities and synergies related to other SDC activities in the country and region? How could the project leverage other Swiss interventions in order to maximise impact e.g. those that aim at youth employment, enhancing skills and employability in health care, improving local governance rural and urban infrastructure and promotion of hygiene.

Specific Tasks

Plan and elaborate the Project Document, including a stakeholder analysis, logical framework and key indicators with baseline data:

- Consider whether or not, and the rationale, to select specific geographic regions, with the potential for the Project to achieve concrete results in the targeted areas, promoting policy adjustments, and potential to scale up at the national level. Selection of pilot Municipalities could be influenced by the range of vulnerable people to be reached as well as on the potential of synergies with other Swiss interventions at the Municipal level
- Consider which are the categories of vulnerable people that should be targeted (minorities, women, poor people, inmates, mentally sick). Also consider to address specific groups of vulnerabilities (mentally sick, drug abusers, NCDs, autism, MCH), and mechanisms to reach them. Consider suggesting strategies or concrete actions to address these issues

- In view of WB's intervention at PHC level, consider the opportunities for the project to complement their work in primary health care and any expansion into secondary health care level.
- Consider to support the development of leadership, management and administration capacities at the secondary health care level (and possibly also, in close cooperation with the WB, at the primary care level), in order to enhance the autonomy of health facilities, improve the efficiency and responsiveness of health service delivery. Such changes will likely require retraining programmes, and may also be supported by introducing performance incentives and putting in place required control and accountability mechanisms. Special emphasis will be given to the identification of complementarities and synergies with the upcoming World Bank intervention, in particular the component strengthening primary health care
- Consider improvement of the quality of services through institutionalizing relevant clinical treatment protocols and guidelines with likely focus on MCH issues
- Consider enhancing clinical and professional skills of health practitioners through Continuous Professional Development Programmes and other on-the-job training
- Consider supporting health promotion and health literacy initiatives, targeting particularly vulnerable groups (consider a focus on RAE), in order to facilitate access
- Consider whether it would be appropriate to develop evidence and rationales for the most appropriate financing and access mechanism schemes to include socially vulnerable communities
- Prepare a thorough stakeholder analysis including the main stakeholders, their influence, interests and roles, strengths and weaknesses. Identify possible drivers and restrainers of change.
- Provide preliminary reflections on implementation and steering arrangements: the features, size, skills, expertise, strengths the project implementers should possess; and the partnerships with local institutions, civil society, community groups, patients' associations that should be considered. Take into consideration also the need to ensure high transparency and solid control mechanisms of fund flows within the intervention to limit the potential for corruption.
- Identify the main risks related to the intervention, and mitigation measures that can be adopted.
- Develop a baseline and preliminary indicators for the project monitoring system.

Approach

The consultants should utilize a participatory approach, and assess the situation in Kosovo at its various levels including: from urban to rural; from tertiary care to primary care; from top-level managers to clinical staff to nurses to patients.

The Project design should aim to be comprehensive and integrated around a key central vision, with room to adapt as circumstances demand.

Aspects to be taken into account are the make-up and size of the Project implementers, the main components/categories of focus of the work, and the development of expected realistic indicators, all linked to the available budget and timeframe, but with a perspective that goes beyond this initial 4-year funding period.

Consultant Team and Logistics

The Project Development Team will be composed of three international consultants and two national consultants. SCO Kosovo will support this mission through the local office and also through the services of an international consultant with experience of developing health systems in the context of the former Socialist republics. In addition to the role of leading the Project Development Team, this consultant will further accompany the SCO in elaborating the tender dossier and selecting the implementing partner.

The overall responsibility for the outcome of this identification mission is with the international consultants, and primarily with the above-mentioned Team Leader. The local consultants shall assist the identification mission by providing expertise and inputs on the specific health context. Specific responsibilities of the consultants throughout this identification mission shall be discussed and agreed directly with the Team Leader. All consultants have their own contract with SDC.

An interpreter (English-Albanian-English) will be hired by the SCO Kosovo to facilitate the communication during this mission. The SCO-Kosovo and the SCO Coordinator will be responsible for the overall organization, and will offer to the mission all logistics support required (reservations, transportation) and provide all documentation.

The Project Development consultants should possess the following qualifications:

International Consultant 1-Team Leader: Health Systems and Primary and Secondary Health Care (already selected)

- Medical physician background and more than 10 years experience of working in Former Soviet Union (FSU)
- Proven experience as Team Leader managing project development and implementation in FSU
- Knowledge and proven expertise on health system reforms
- Working experience in continuing education for medical staff
- Experience of working with other multilateral donors (WB, ADB)
- Fluent oral and written knowledge of English
- Good communication skills

International Consultant 2: Health Systems and Clinical Care

- Medical physician background and experience with appropriate qualifications
- Good knowledge and proven expertise on health system reforms (Western Balkan/Kosovo/Albania will be an asset);
- Working experience in continuing education for medical staff
- Experience of working with other multilateral donors (WB experience would be an asset)
- Excellent oral and written knowledge of English
- Good communication skills

National Consultant 1: Health Systems and Primary Clinical Care

- Medical physician background and experience with appropriate qualifications
- Good knowledge of the health care system of Kosovo at both primary, secondary and, preferably, tertiary levels
- Experience of working with both the Ministry of Health and with international agencies
- Sufficient oral and written knowledge of English
- Good communication skills

International Consultant 3: Health Care Management and Financing

- Hospital/health programme management background
- Experience of developing health financing systems, preferably related to health insurance schemes and contract management
- Excellent oral and written knowledge of English
- Good communication skills

National Consultant 2: Health Care Management and Financing

- Hospital/health programme administration background
- Experience of working with both the Ministry of Health and Ministry of Finance and knowledgeable of local regulations regarding financing and management of healthcare services.
- Preferably, experience of working with international agencies
- Excellent oral and written knowledge of English
- Good communication skills

Consultants' Time Schedule

The mission shall take place from February 14th until March 17th 2014. An indicative timeline is attached to the present ToRs (Annex 4). A final schedule shall be developed under the leadership of the Team Leader, in coordination with team members and SCO Kosovo.

The contractual assignment will encompass:

Description	Int'l Consultant 1 Team Leader (Days)	Int'l Consultant 2 (Days)	National Consultant 1 (Days)	Int'l Consultant 2 (Days)	National Consultant 2 (Days)
Preparation, documentation, desk study	3	3	1	3	3
Mission to Kosovo, including the travel time and debriefing in SCO-Kosovo	20	17	20	21	20
Debriefing Berne (possibly)/Consultation with SCO-Kosovo (part. On proposed scenario	2	2	1	2	1
Write-up of Preliminary report	7	6	5	2	5
Final Report	5	2	1	2	1
Total	**37 Days**	**30 days**	**28 Days**	**30 Days**	**30 Days**

Outputs of Consultancy

The consultants shall provide a comprehensive mission report, consisting of the following:

Table of contents

Executive summary

1. Context
2. Relevance
3. Coherence with strategic framework
4. Elaboration of options for interventions
5. Objectives
6. Intervention Strategy
7. Beneficiaries & Outreach
8. Partnerships
9. Organisation, Management & Administration
10. Resources
11. Risk assessment
12. Open issues

During the debriefing with SCO Kosovo and SDC Berne at the end of February 2014, the consultants shall present a concept note with a maximum of three intervention scenarios. The consultants shall present and justify the recommended options. During the rest of the mission, the team shall proceed further elaborating the intervention scenario agreed with SDC (chapter 5-11 of the mission report): The report shall be written in English. A first draft report shall be delivered to SCO Kosovo not later than 28 March 2014. SCO Kosovo reserves the right to request changes in the report or additional information. The final document revised based on comments and remarks of SCO Kosovo shall be submitted by latest 1 May 2014.

The consultants shall not disclose to third parties the information made known to him/her under this Project without an explicit authorisation to the SDC HQ. It is not in the responsibility of the consultants to promise any kind of future activities with financial consequences for SDC.

Documentation to be provided by SCO- Kosovo

- Swiss Cooperation Strategy Kosovo 2013 to 2016
- EP Affordable Quality Health Care
- EP Contribution to the World Bank's Improving Quality of Health Care in Kosovo
- Law on Health, May 2013
- WB's Aide Memoires
- Kosovo Health Sector Strategy 2014-2020 (1st draft)

Description of Int'l Consultant Activities	Consultant
1. Pre-Mission	
Preparation, documentation, ; desk study (local consultant)	1,2,3
2. Mission to Kosovo, including the travel time and debriefing in SCO-Kosovo	
Arrive, meet local consultants	1,2
Briefing with SCO-Kosovo, MoH, WB	1,2
Discussions/planning with local consultants	1,2
Visit to city hospitals, individual/ group interview with medical staff and managers, patients, observations	1,2
Field visit to rural areas, interview/focus groups with medical staff and managers, patients, observations	1,2
Joao Costa arrives	3
Team meeting to discuss progress and planning	1,2,3
Further visits to city organisations and sites based on findings from field visits	1,2,3
Begin write up and discussions for preliminary presentation of findings. **Debriefing with SCO-Kosovo**	1,2,3
Debriefing in Bern (Team Leader)	1
Continue to write up findings	2
Assessment of Health Financing issues, plans	3
Team work and planning meetings	1,2,3
Continued site visits and meetings based on latest findings and planning	2,3
Team Leader and Consultant 2 depart	1,2
Continued site visits and meetings based on latest findings and planning	3
Team Leader Returns	1
Final wrap up discussions and planning	1,3
Consultant 3 departs	3
Team Leader Conducts final meetings and prepares presentations	1
Final Debriefing with SCO Kosovo, Team Leader departs	1
3. Post-Mission	
Write-up of Preliminary Report	1
	2
	3
Write up of Final Report	1
	2
	3
TOTAL DAYS	
Outputs	
Presentations for SCO- Kosovo **(March 2014)**	
Presentation for SDC- Bern **(March 2014)**	
Preliminary report **(April 2014)**	
Final Report **(May 2014)**	

Timeline columns: February 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28; March 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31; April 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Key

Peter Campbell	1
Tamar Gotsadze	2
Joao Costa	3
Peter Campbell in Germany	

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