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Advancing health financing reforms toward universal health coverage in Kosovo

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Executive Summary

- 1. Achieving improved health outcomes through fiscal spending would enhance human capital in Kosovo.** The country lags peers in terms of amounts allocated for healthcare and on the effectiveness of public spending to improve health outcomes, reflected in weaker health outcomes compared to peers.
- 2. Appropriate health financing arrangements can promote progress towards universal health coverage (UHC).** Simply, UHC means that all people have access to the health services they need, when and where they need them, and without causing financial hardship. Health financing arrangements are important in achieving UHC because they define how revenue is generated to pay for health services, how risks and costs are pooled across people, and how goods and services are purchased. Although public health services in Kosovo are envisaged to be free or subject to small user fees, in practice services and drugs are usually not fully available. As a result, patients incur significant out-of-pocket (OOP) expenditures which exacerbate existing income inequalities. Under such circumstances, sick people often carry the burden of funding their treatment. This financial burden can be particularly severe for the poor, or for people with chronic conditions who need medications on a regular basis.
- 3. Health financing in Kosovo has not yet been fully developed.** Resource mobilization, and consequently health spending, is among the lowest when compared to peers. Insufficient public spending causes input constraints, poor access, and low quality of care. Risk pooling could be further enhanced, and the practice of strategic purchasing is currently lacking in Kosovo. Healthcare services are paid for with a predetermined budget defined annually based on rigid input line items such as salaries, goods and services, and utilities. There are no clearly stated decisions on the three key elements of strategic purchasing – benefit package, contracting, and provider payment. Other conditions necessary for strategic purchasing are absent.
- 4. Strategic purchasing and provider-payer split could be implemented independent of social health insurance premium collection.** With the establishment of the Health Insurance Fund, Kosovo has introduced a purchaser, but it has not been performing strategic purchasing.
- 5. Introducing a targeting mechanism for exemption in social programs would ensure fairness and fiscal sustainability.** Implementing a new poverty-targeting instrument that considers observable income through a means test and informal/unobservable income through a proxy means test could improve poverty targeting, better reflect the high rates of informality in the Kosovo labor market, and serve as a foundation for targeting health insurance exemption for the poor. Such a poverty-targeting mechanism would improve the effectiveness of the social protection system and enhance targeting of exempted categories regarding health service copayment and future insurance contributions.
- 6. Instituting an effective national risk pool would allow for sharing of health and financial risks among the rich and the poor, the sick and not sick, and across municipalities.** An “effective mechanism” relies mostly on prepayment, delinking health status from payment at the point of services. With the small size of the population, it is recommended that risk is pooled at the national level. As a start, public financing for health should be consolidated to avoid fragmentation. Following the typical model in other countries, most of the funds (the “risk pool”) could be housed within the Health Insurance Fund, while the Ministry of Health would become a smaller financing agent. Budget funds going through the Ministry would then be used mostly for public health programs and major capital investment, while funds going through the Health Insurance Fund would be for individual services, which the Fund would purchase in its new role as a strategic purchaser.
- 7. The prospect of raising additional funds through a health insurance premium depends on a number of issues and warrants careful considerations.** Before Kosovo embarks on mandating contributions, as currently envisaged in the draft Health Insurance Law, it is

important to obtain clarity on the potential impact on the labor market, the funding gap that is based on actuarial costing of the benefit package, enforcement capacity, population demand for social health insurance, and potential equity risk of the flat rate premium. Evidence from global experience shows that mobilizing contributions from payroll taxes alone will not bring countries closer to UHC. Invariably, segments of the population will need to be subsidized from general revenues. Despite recent improvements, the informal sector in Kosovo remains sizable. In this context, the general budget will ultimately remain the most important revenue source for health.

Abbreviations and Acronyms

CHOICE	Choosing Interventions that are Cost-Effective
DCP3	Disease Control Priorities 3rd edition
DRG	Diagnosis-Related Group
ELM	Essential List of Medicines
FFS	Fee-for-Service
FMC	family medicine center
GDP	Gross Domestic Product
HBS	Household Budget Survey
HFA	Health for All
HIF	Health Insurance Fund
HIL	Health Insurance Law
HZZO	Croatian Health Insurance Fund
KAS	Kosovo Agency of Statistics
KHP	Kosovo Health Project
KHUCS	Kosovo Hospital and University Clinical Services
MFMC	main family medicine center
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health
MoF	Ministry of Finance
MOU	memorandum of understanding
MTOPHI	Medical Treatment outside the Public Health Institutions
NCD	noncommunicable disease
OOP	out-of-pocket
PHC	primary health care
SHI	social health insurance
THE	total health expenditure
UCCK	University Clinical Center of Kosovo
UHC	universal health coverage
WDI	World Development Indicators
WHO	World Health Organization

1. Introduction

1.1. Advancing health financing reforms to contribute to universal health coverage goals

1. Health financing reforms in Kosovo have been stagnating over the last decades. While various governments have vowed to develop social health insurance (SHI), so far this has not been implemented. One of the possible reasons is that health financing, and health insurance in particular, are complex topics that do not immediately resonate with health sector players. The exclusive focus on SHI may distract attention from the fact that a health financing instrument should only serve as a means to an end. Structural issues in health financing arrangements hinder achieving the objectives of any health system – access, quality, equity, efficiency, and financial protection – generally accepted as universal health coverage (UHC) outcomes. To date, there is a lack of understanding of how current health financing practice has facilitated or hampered the country's progress toward effective UHC.

2. The objective of this paper is to facilitate common understanding of the health financing situation in Kosovo, to serve as a basis for reaching a consensus on the way forward. The issue is motivated by a basic framework of health financing functions and how they contribute to UHC goals. Global good practices and examples from peer countries are presented in the Annex to provide comparisons with the situation in Kosovo.¹ The chapter describes the status of health financing and its implications for UHC. A long-term vision for health financing is presented and recommendations for possible short and medium term (3-5 years) policy priorities are provided based on the current situation and desirable trajectory. The exclusive focus on health financing is deliberate although other important health system functions, such as service delivery and governance, will need to move in parallel for health financing reforms to achieve their intended outcomes.

3. Kosovo's health financing system has important shortcomings which hinder its progress toward UHC. Driven by low government spending, Kosovo's total health spending is lower than that of most peer countries. At the same time, private spending on health is high and increasing, which suggests that households are not well-protected against health shocks as they frequently must pay out-of-pocket (OOP), particularly for pharmaceuticals. Health services are often of low quality, leading to underutilization and poor health outcomes. The lack of strategic purchasing means that there are few incentives for providers to improve performance, resulting in significant inefficiencies in the system. Although public health financing relies exclusively on general taxation – a mechanism best designed to provide risk pooling across population groups – in reality, health benefits are too small and the financial burden of health care falls disproportionately on the sick and the poor. Additionally, the lack of a proper poverty targeting mechanism leaves many poor people uncovered while at the same time benefiting a significant number of nonpoor with copayment exemption in public health institutions, putting the financial viability of the system at risk.

4. To address the identified shortcomings, the following recommendations are proposed regarding the overall strategic directions for health financing functions and priorities for short-term measures: Kosovo government should introduce strategic purchasing and separate the payers and providers of health services to improve the efficiency and quality of services. To improve equity, instituting an effective national risk pool will be needed and options to mobilize additional resources should be considered carefully. Priority short-term measures that could bring about concrete results for the population include piloting the management of the outpatient drug benefit package by the Health Insurance Fund, introducing contracting and case-based payment for treatment outside the public sector, and gradually expanding performance-based capitation payments for primary health care.

¹ In line with the overall Public Expenditure Review (PER), to the extent that data are available, peer countries include structural peers (Albania, Armenia, Moldova, North Macedonia, and Kyrgyz Republic), aspirational peers (Estonia, Lithuania, Latvia, Croatia, and Slovenia), and Western Balkan regional peers (Montenegro, North Macedonia, Bosnia and Herzegovina, Albania, and Serbia).

1.2. The link between health financing and UHC

5. Health financing has three key functions: (i) resource mobilization, (ii) pooling, and (iii) purchasing.² Resource mobilization incorporates the decisions to generate funds from different sources and allocate necessary resources to develop and run a health system. Sources of funds can include individuals/households, firms, the government, and sometimes external sources like development assistance. Some contributions are health-specific, while others contribute to general government revenues, which can be used to finance health. Pooling involves decisions about how financial contributions and risks are spread across individuals. It can range from OOP payments, where individuals/households pay directly for the services they obtain at the point of service, to funding services through a pre-payment system financed by general government revenues or health insurance. The third key function is purchasing, which includes decisions on what services and interventions to buy (“what to buy”) from which providers (“from whom to buy”), and the design of provider payment mechanisms and incentives (“how to buy”).

6. Appropriate health financing arrangements can promote progress towards UHC. The concept of UHC means that all people have access to the health services they need, when and where they need them, without causing financial hardship. Health financing arrangements are important in achieving UHC because they define how revenue is generated to pay for health services, how risks and costs are pooled across people, and how goods and services are purchased. It is important to note that improving health financing by itself alone will not achieve UHC. Health financing is one of several building blocks of a health system, along with service delivery and governance, and social determinants of health are also important contributors to good health outcomes.³

7. To achieve UHC, public financing should be the main source of funding for health. The two main revenue-raising modalities used for public financing are general taxation and health insurance contributions. In addition, countries increasingly tap into innovative taxes, such as health taxes on tobacco and alcohol, to mobilize additional resources that could be used for health. Health insurance contributions are raised mainly in the form of mandatory earmarked payroll taxes, and revenues from general taxation and health taxes may or may not be earmarked for health. Examples of earmarking general taxation for health include Brazil, where the Constitution includes a formula to mandate that a certain share of general revenues must be allocated to the service purchaser. Another example is Kyrgyz Republic, where the government is committed to spend at least 13 percent of its general expenditure on health under an agreement with donors of the Sector Wide Approach.⁴ Earmarking has several possible disadvantages, including introducing unnecessary rigidities in the budget process, additional economic distortions, procyclicality, and fragmentation. However, earmarking can help protect revenues for health and increase public support for paying taxes as well as introduce an element of accountability.⁵ Financing health systems from OOP spending is both inefficient and inequitable, exposing individuals and households to financial hardship when seeking care, including risk of higher and deeper impoverishment and risk of foregone care.⁶

2 Kutzin, J. 2001. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy*. 2001 Jun; 56 (3): 171-204.

3 For more details on other building blocks of the health system in Kosovo, see Nguyen et al. forthcoming 2023. “Kosovo Health System: An Assessment of Core Functions and Performance.”

4 World Bank. 2019. Primary Health Care Quality Improvement Program. Program Appraisal Document. Report number: PAD3083.

5 Cashin, C, S. Sparkes, and D. Bloom. 2017. “Earmarking for Health: From Theory to Practice.” Health Financing Working Paper No. 5. Geneva, Switzerland: World Health Organization.

6 Ajay Tandon, Christoph Kurowski, David B. Evans. 2022. “General Taxation and Social Health Insurance.” Washington, DC: World Bank.

8. Kosovo’s peer countries have adopted different combinations of funding sources and flow of funds arrangements from sources to key financing agents. In terms of revenue generation, countries do not rely exclusively on general taxation or mandatory insurance contributions. Drawing on both financing sources allows a government to cover segments of the population that would have been excluded from a system entirely financed from employment-based contributions. Typically, countries with a smaller formal sector rely more on general taxation, whereas countries with a larger formal sector rely more on insurance contributions. For example, between 87–90 percent of domestic public expenditure on health in Kyrgyz Republic in 2015–2017 came from the general budget, and mandatory health insurance contributions accounted for 10–13 percent.⁷ By contrast, in Croatia, Romania, and Slovenia, the share of mandatory health insurance contributions in total health financing is 65–70 percent.⁸ At the same time, regardless of sources of funds, countries can decide to channel most of their health revenues through the insurance agency or other form of service purchaser. For example, in Kyrgyz Republic, the Mandatory Health Insurance Fund manages about 80 percent of the total public spending on health.

9. Purchasing must be “strategic” to facilitate progress towards UHC and refer to the “what,” “from whom,” and “how” decisions. An explicit benefit package is preferable as it can help transparently prioritize services and guarantee access to those services. For contracting and paying providers, countries are moving toward output-based payment combined with incentives for quality and efficiency. Public financing can also be used to contract private providers to expand access and enable quality control by the purchaser. Further details on financing functions are presented in the Annex.

7 World Bank. 2019. Primary Health Care Quality Improvement Program. Program Appraisal Document. Report number: PAD3083.

8 Authors compilation.



Chapter 2.

Health and health financing in Kosovo

2.1. Overview

10. Compared to most countries in the region, Kosovo has a relatively young population, which means that the incidence of and mortality from noncommunicable diseases (NCDs) remain relatively low but are increasing. Children under 15 currently account for almost a quarter of inhabitants, and only 9 percent of the population is aged 65 or above, compared to 15 percent in neighboring Albania and over 20 percent in most other peer countries. The young population puts Kosovo in a favorable position concerning health and healthcare cost, which will change once the population gets older. For example, cancer incidence in Kosovo in 2019 was 149 per 100,000 population, roughly one quarter of the rate reported for Croatia in the same year; the cancer mortality rate (non-age standardized) was also four times lower. The difference is less remarkable when Kosovo is compared to Albania.⁹ Despite having a relatively low incidence, NCDs represent major causes of death and their burden is increasing. Between 2012 and 2019, the number of diagnosed cases of breast cancer increased from 200 to 500 per 100,000 and the number of diagnosed cases of cancers of the female reproductive system increased from below 100 to nearly 300. The trend can be partly attributed to improvement in diagnosis and reporting, both of which remain inadequate. The increasing trend in NCDs may be fueled by widespread risk factors such as smoking, low physical activity, and unhealthy nutrition.

11. Some child health indicators have improved recently, yet they are still far behind most peer countries. Perinatal mortality, which reflects prenatal, childbirth and neonatal care has decreased from 17.3 per 1,000 live births in 2012 to 9 per 1,000 in 2020. Nevertheless, the infant mortality rate is still high in Kosovo. The number of deaths per 1,000 live births among children under one year of age in Kosovo is around that of Albania, but more than double than that of Croatia.¹⁰ According to the 2019-2020 Kosovo Multiple Indicator Cluster Survey (MICS), the probability of a child dying between birth and their fifth birthday is 15 per every 1000 births.¹¹ The most frequent causes of infant mortality have been lower respiratory tract infections, acute infective diarrhea, perinatal issues, congenital malformations, and unclassified conditions, again pointing to weaknesses in the service delivery system.

12. The incidence of infectious diseases other than COVID-19 appears to be stable and is not a major contributor to the disease burden of the population. However, the incidence of tuberculosis is much higher than in peer countries. The incidence of tuberculosis in 2017 was 43 per 100,000 population, more than double the rate in neighboring Albania and nearly four times higher than in Serbia.¹² Nevertheless, it has been on a slow decline in recent years.

13. In summary, Kosovo's disease burden is characterized by an unfinished agenda of communicable and basic child health issues, coupled with rising NCDs. This pattern is typical for countries in the early stage of demographic and epidemiological transition. Examples of countries that have successfully gone through this period will be useful for Kosovo in developing proactive measures to curb the growth of NCDs and preempt healthcare cost escalation.

14. Kosovo's health financing system is predominantly based on the Semashko model whereby the central government assumes the role of both provider and financier of healthcare services.¹³ This includes a centrally planned provision of health care within state-financed and state-owned health facilities. Health is financed from general tax revenues. Additionally, as under the Semashko model, the government recognizes all healthcare providers as public service employees. The private sector is licensed by the Ministry of Health (MoH) but is otherwise completely independent. The MoH is responsible for the development, implementation, monitoring, evaluation, and coordination of policies in the health sector; and the budget envelope for health is largely determined by the budget allocations and appropriations passed by the Assembly based on proposals from the Ministry of Finance (MoF).

⁹ A caveat is warranted about the possibility of underreporting in Kosovo due to unreliable health statistics.

¹⁰ Nguyen et al. "Kosovo Health System: An Assessment of Core Functions and Performance" (forthcoming, 2023).

¹¹ UNICEF. MICS 2022. Available from <https://www.unicef.org/kosovoprogramme/topics/multiple-indicator-cluster-survey> (Accessed 25 April 2022)

¹² UNICEF. MICS 2022. Available from <https://www.unicef.org/kosovoprogramme/topics/multiple-indicator-cluster-survey> (Accessed 25 April 2022)

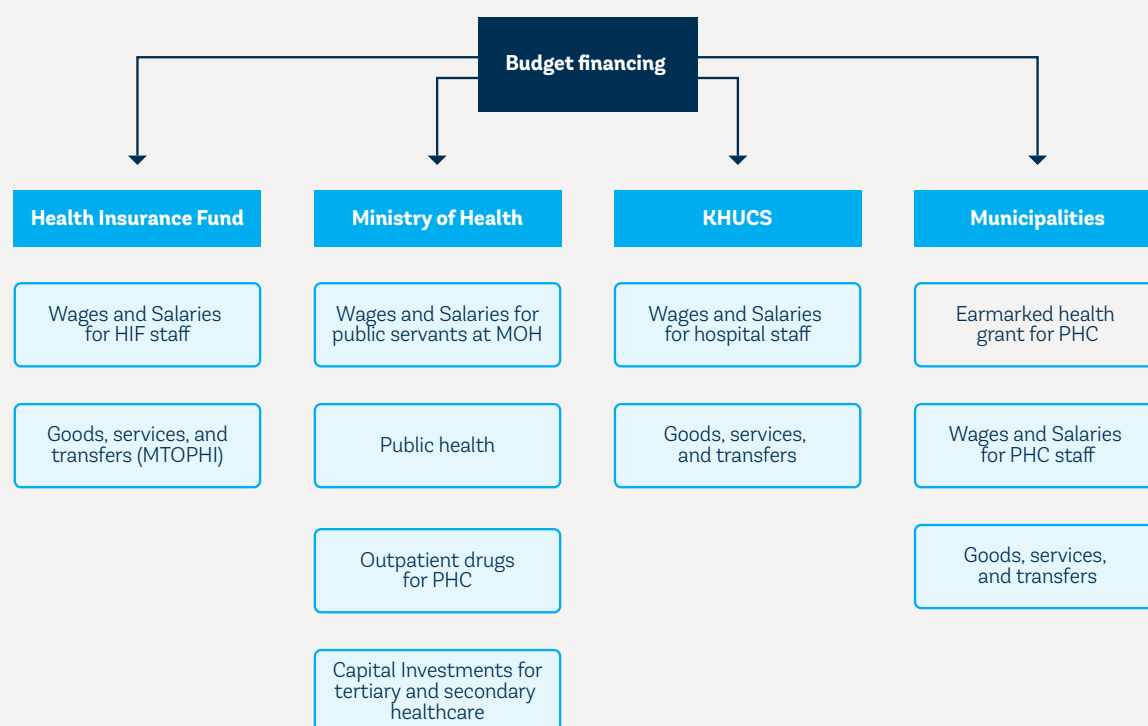
¹³ The Semashko model of health care (named after the first Minister of Health in the former Soviet Union, Nikolai Semashko), is dominated by publicly owned medical facilities, salaried health workers, and an exceptionally high degree of governmental administration.

15. The legal framework for health financing has not been fully developed. The Law on Health and the Law on Emergency Medical Services defined the framework for regulation and governance of health services in Kosovo; these laws mainly cover service delivery. In 2014, Kosovo enacted a Health Insurance Law (HIL), which gave all citizens the right and obligation to carry mandatory SHI. To date, most provisions of the law have not been implemented and Kosovo is working on having an updated HIL enacted before taking any further steps to roll out SHI. Nevertheless, in connection with the previously enacted law, the country established a Health Insurance Fund (HIF) in 2016, which has been staffed with a small number of personnel. Until now, the HIF has only been responsible for the payment of treatment outside the public sector, mainly abroad, under the so-called “Medical Treatment outside the Public Health Institutions” (MTOPI) program.

16. The public service delivery system consists of the University Clinical Center of Kosovo (UCCCK, tertiary level), seven general hospitals in the regions (secondary level), and family medicine centers (FMCs) in 38 municipalities (primary level). Each municipality has a network of FMCs comprising one main family medicine center (MFMC) and several affiliated centers (with family doctors and nurses) or medical posts (with only nurses). The general hospitals and UCCCK form the system of Kosovo Hospital and University Clinical Services (KHUCS), a centralized management structure of hospital services for the whole country.

17. Financing decisions for each major actor of the system rest with the Assembly based on budget proposals prepared by the MoF. As shown in Figure 1, the national budget transfers funds to the MoH for services under its control—mostly public health and outpatient drugs, to the KHUCS for secondary and tertiary services, and to local governments for PHC services. The HIF receives funding to cover its own operations and processes reimbursements for MTOPI.

Fig1. Current flow of public funds



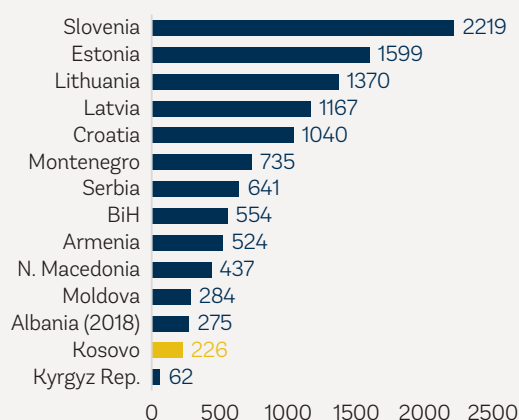
Source: Authors

18. The Government of Kosovo has consistently reiterated the development of SHI as a priority in various policy documents, yet progress so far is insufficient. The Health Sector Strategy 2017–2021 envisioned ensuring sustainable health financing as one of the strategic objectives. According to this document, by the end of 2018: the HIL would be adopted, in addition to the legal framework needed to start premium collection; a list of basic outpatient services with costing would be drafted; and the outpatient drug benefit package would be finalized together with implementation modalities.¹⁴ By mid-2023, none of these objectives have been met. The Government Program of 2021–2025 again identified rolling out SHI as one of the priorities for the health system, which would be preceded by the adoption of the revised HIL and secondary legislation for premium exemption, co-payments, outpatient drugs, pharmacy contracting, and MTOPI.¹⁵ Adoption of a law to amend the previous HIL was included in the legislative program of the MoH for 2022 but did not materialize. The National Development Strategy 2030, which recently passed through public consultations, foresees that the share of population covered by health insurance will reach 100 percent and current health expenditure as a share of Gross Domestic Product (GDP) will reach 10 percent in 2030, presumably enabled by the expansion of SHI.¹⁶

2.2. Resource mobilization and health spending

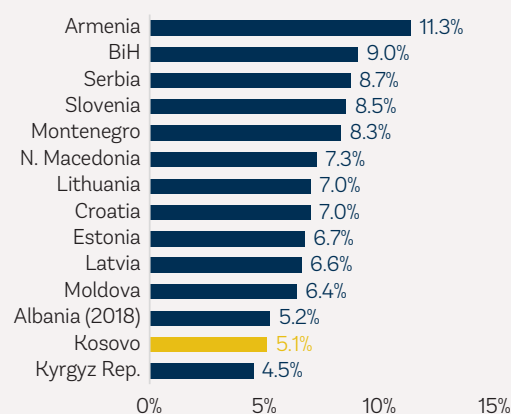
19. Total health spending in Kosovo is lower than in most structural and aspirational peers in absolute value and as a share of GDP. In 2019, total health expenditure (THE) was estimated at US\$226 per capita in nominal terms (Figure 2). That said, in terms of GDP differences were less pronounced, with Kosovo exhibiting similar health spending as Albania and exceeding spending in the Kyrgyz Republic (Figure 3). It is important to note that there is no specific optimal normative level or share of public financing for health across countries. Thus, while the level and share of Kosovo's health spending relative to peers are described here, this should not be taken as suggesting a spending target.

Fig 2. Total health spending per capita (current US\$), 2019



Source: WDI, 2022 (peer countries) and authors' calculations based on MoH and Household Budget Survey data (Kosovo)

Fig 3. Total health spending as a share of GDP (%), 2019



Source: WDI, 2022 (peer countries) and authors' calculations based on MoH and Household Budget Survey data (Kosovo)

- 14 Government of Kosovo. 2016. Health Sector Strategy 2017-2021. [https://msh.rks-gov.net/Documents/DownloadDocument?fileName=Strategjia%20Sektoriale%20e%20Sh%3%ABndet%3%ABsis%3%AB%20\(2017%20%E2%80%93%202021\)54528803.4504.pdf](https://msh.rks-gov.net/Documents/DownloadDocument?fileName=Strategjia%20Sektoriale%20e%20Sh%3%ABndet%3%ABsis%3%AB%20(2017%20%E2%80%93%202021)54528803.4504.pdf)
- 15 Government of Kosovo. 2021. Government program 2021-2025. <https://masht.rks-gov.net/wp-content/uploads/2022/06/Programi-i-Qeverise-se-Kosoves-2021-2025.pdf>
- 16 Government of Kosovo. 2022. National Development Strategy 2030. <https://kryeministri.rks-gov.net/en/national-development-strategy-2030/>

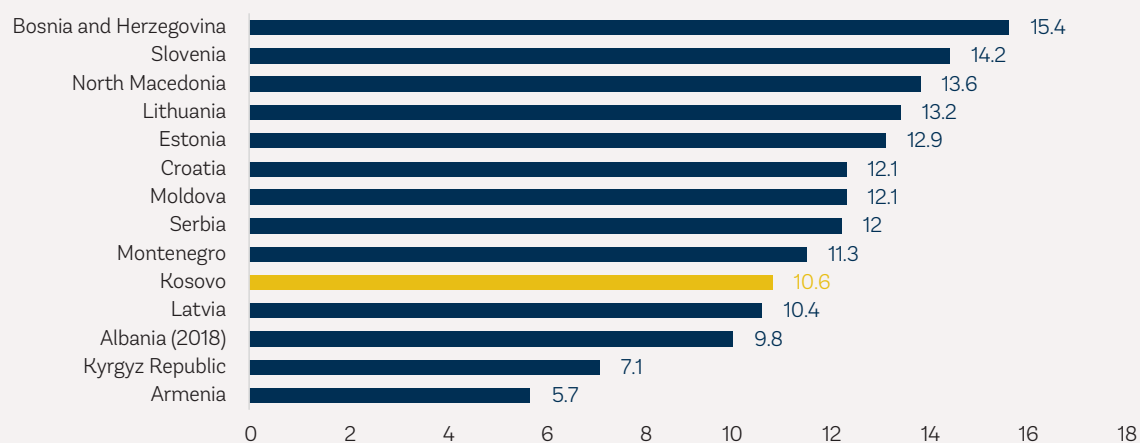
20. The low total spending is driven largely by government health expenditure that accounts for between 60–65 percent of THE. Government spending on health fluctuated around 3 percent of GDP during 2015–2019. This is the lowest value among comparator countries, with the exception of Albania (Table 1). Health spending increased to nearly 4 percent of GDP in 2020, when extra resources were made available to the health sector for COVID-19-related activities. However, this declined to 3.5 percent of GDP in 2021.¹⁷ Comparable data are not available for peer countries, although all countries experienced a rise in health spending during the peak year of COVID-19. A record high budget of EUR 296 million was adopted by the Parliament for 2023, which foresees a significantly larger envelope for health personnel in anticipation of the effectiveness of the revised wage law. Low government spending on health as a share of GDP is a combination of overall lower revenue mobilization and lower prioritization of health within government expenditures. In 2019, Kosovo spent 10.6 percent of general expenditures on health, lower than the median of 12.05 percent and average of 11.45 percent among peer countries (Figure 4).

Table 1. Government health expenditure, % GDP

	2015	2016	2017	2018	2019
Bulgaria	4.16	4.14	4.17	4.34	N/A
Croatia	5.61	5.64	5.60	5.66	6.40
Latvia	3.33	3.47	3.44	3.72	4.20
Lithuania	4.36	4.42	4.28	4.40	5.10
Romania	3.86	3.91	4.05	4.43	N/A
Bosnia and Herzegovina	6.62	6.55	6.30	6.24	6.20
Albania	N/A	N/A	N/A	3.0	N/A
Kosovo	3.10	2.95	2.88	3.05	3.2

Source: Eurostat and World Bank (Kosovo).

Fig 4. Government health expenditures as percent of total government expenditures in 2019



Source: World Bank and Kosovo Ministry of Finance

17 Authors' calculation using data from Kosovo Statistics Office (<https://askdata.rks-gov.net/>).

21. Private health expenditure has been increasing in nominal terms, from EUR 116.4 million in 2015 to EUR 135 million in 2019 (Table 2). About 84–88 percent of private health expenditure was estimated to come from OOP payments, incurred by households for medicines or at the point of service in both the public and private sectors. The OOP payments were estimated based on the Household Budget Surveys (HBSs) of 2014 and 2017, assuming the same rate of increase between 2017 and 2019 and between 2014 and 2017. A second source of private health expenditure comes from private health insurance, which covers diagnostics and treatment in the private sector. Revenue from private insurance increased from EUR 13.4 million in 2015 to EUR 19.6 million in 2019. Between 2015 and 2019, OOP payments were estimated to have increased by 12 percent in nominal terms, with the corresponding rate of increase for private health insurance amounting to 46 percent, further underscoring the adverse impact of the missed implementation of rolling out SHI.¹⁸

Table 2. Estimates of private health expenditure in million EUR (current value)

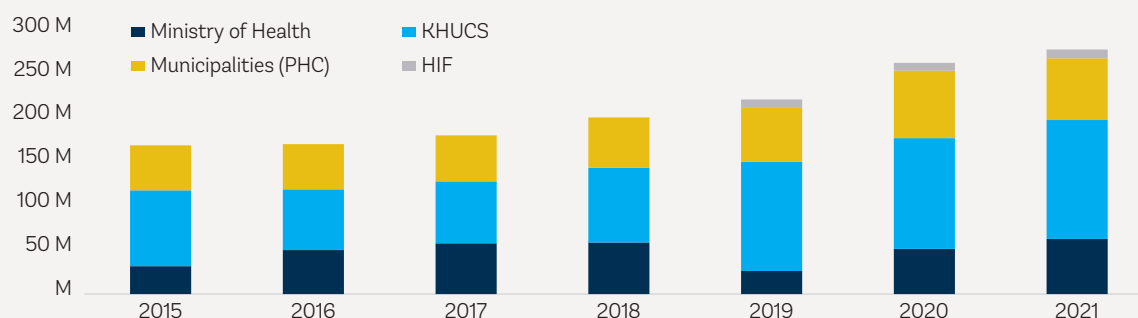
	2015	2016	2017	2018	2019
Total private exp (million EUR)	116.4	122.3	126.0	130.3	135.1
Of which:					
OOP payments	103.0	106.0	109.0	112.3	115.5
Private health insurance	13.4	16.3	17.0	18.0	19.6
OOP as share of private exp (%)	88	87	87	86	85
Rate of increase 2015-2019					
OOP payments (%)	12				
Private health insurance	46				
Private exp as % of THE	41	41	41	39	38
OOP exp as % of THE	36	36	36	34	32

Source: Vončina (2021)

22. In 2020 and 2021, due to the COVID pandemic, health expenditures were 23 and 33 percent higher, respectively, than in 2019. In 2020, expenditures through the MoH nearly doubled, and they rose further in 2021. There was a smaller increase in expenditures through KHUCS and the HIF in 2021 (Figure 5). The increase in health expenditures through MoH and KHUCS was driven by spending on goods and services (Figure 6), which more than doubled the level of MoH, increasing from 10.2 million euros in 2019 to EUR 27.1 million in 2020, and more than tripled to EUR 34.2 million by end-2021. At the KHUCS, spending on goods and services rose from EUR 41 million in 2019 to EUR 52.8 million in 2020. Municipalities increased their spending on goods and services in PHC from EUR 7.9 million in 2019 to EUR 22.4 million in 2020, followed by a steep drop to EUR 12.9 million in 2021. The MoH made substantial capital investments during this period: non-financial asset spending increased from EUR 6.4 million in 2019 to EUR 14.2 million in 2020 and EUR 12.0 million in 2021 (Figure 6). A large share of municipalities' PHC spending goes to wages and allowances by design since the PHC grant formula is primarily intended to pay for these. The total budget for PHCs also includes expenditure on essential medicines and capital investments.

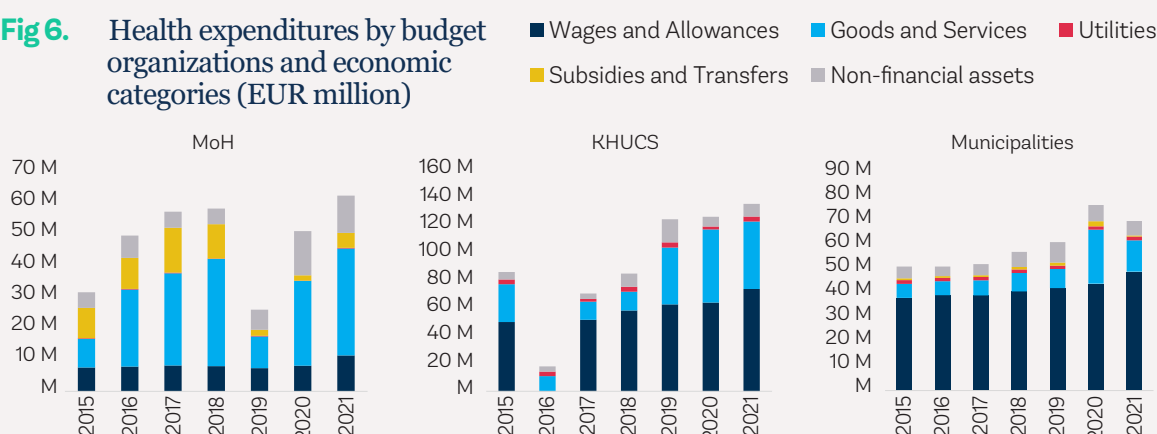
18 Vončina, Luka. 2021. Kosovo Health Insurance Fund Financing Plan 2022-2026. Technical Note.

Fig 5. Health expenditures by budget organizations (EUR million)



Source: *National Health Accounts Report, 2021*

Fig 6. Health expenditures by budget organizations and economic categories (EUR million)



Source: *National Health Accounts Report, 2021*

2.3. Risk pooling

23. Although public services are envisaged in Kosovo to be free or subject to small user fees, in practice services and drugs are usually not available. As a result, patients pay OOP at the point of service. Under such circumstances, sick people carry the burden of funding their treatment. This financial burden can be particularly severe for the poor, or for people with chronic conditions, who need medications on a regular basis. Currently, there is no mechanism to share financial risks between the sick and the healthy as well as between the poor and the better-off. Furthermore, there is no objective mechanism to identify the poor, especially considering informal income. With the planned collection of mandatory insurance contributions, continued financing from the general budget will remain crucial to provide subsidies for the population cohort lacking the capacity to pay premiums.

24. The limited size of the PHC grant and its rigid formula do not allow for risk sharing across municipalities with different socio-economic conditions and disease burden. The formula is not based on actual performance but rather on input norms which, in turn, reflect the population size documented in the 2011 Census, with a small top up for “ongoing programs.” The indicators for the ongoing programs in the Medium-Term Expenditure Framework 2023-2025 include the expected number of home visits for pregnant women and children and for palliative care, again reflecting norms rather than actual performance. Grant funds are inadequate to meet local health financing needs.

Specifically, in 2019, only eight out of 38 municipalities reported that the health grant was sufficient. Municipalities spent on average 13.5 percent more for PHC than the amount allocated in their health grant.¹⁹ This has potential equity implications because the smaller and poorer municipalities have limited fiscal space to top up PHC funding. In addition, census data does not consider differential migration patterns over the last 10 years, penalizing remote areas with more constrained mobility.

2.4. Strategic purchasing

25. The health sector in Kosovo currently lacks the practice of strategic purchasing. Healthcare services are paid for with a predetermined budget defined annually based on rigid input line items such as salaries, goods and services, and utilities. There are no clearly stated decisions on the three key elements of strategic purchasing – benefit package, contracting, and provider payment. Other conditions for strategic purchasing are also not applied.

Box 1. What is strategic purchasing?

Purchasing becomes strategic or active when purchasers of health services deliberately select the goods and services to buy and the providers to buy from. Strategic purchasing arrangements create financial incentives for providers to contribute to health system objectives. They can help prioritize cost-effective health services (e.g. primary care over unnecessary hospitalization), incentivize prevention and health promotion, and reduce wasteful spending on unnecessary services. Appropriate arrangements can also be made to pay providers more to work in underserved areas or serve vulnerable populations, while reducing incentives to collect informal fees from patients. Payments can also be made contingent on meeting accreditation standards and following clinical treatment guidelines.

The following steps are typically included in the development of strategic purchasing:

1. Establishment of an institution to pay for health services using a sufficient pool of funds – this is typically the Health Insurance Fund.
2. Creation of an institutional architecture for purchasing (licensing, certification, registration, accreditation, Health Technology Assessment, patient safety, etc.) and mechanisms for accountability.
3. Revision of the public financial management system to support strategic purchasing.
4. Granting of appropriate autonomy to providers over many spending decisions.
5. Development of IT infrastructure for the payer and providers to exchange data on health service delivery, patient outcomes, costs, etc.
6. The regulation of the relationship between the payer and providers via contracts, defining the obligations of both parties, including performance targets and quality, and clear instructions for claims submission, processing, monitoring, and reporting.
7. Creation of output-based payment methods based on claims.
8. Definition of payment rates that reflect real costs and include risk adjusters for cost differences across geographic locations, levels of care, age, gender, and other dimensions.
9. Specification of lists of covered services (benefit package) and covered medicines (an essential medicines list or formulary).
10. Definition of standard treatment guidelines with standards for the quality of care and guidelines for referrals, including any gate-keeping policies.

Source: Cashin, C, Nakhimovsky S, Laird K, Strizrep T, Cico A, Radakrishnan S, Lauer A, Connor C, O'Dougherty S, White J, Hammer K. September 2018. *Strategic Health Purchasing Progress: A Framework for Policymakers and Practitioners*. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

19 World Bank. 2020. "Policy Note on Financing Education and Health at the Local Level in Kosovo." Kosovo Local Administration Policy Dialogue Platform, July 2020.

26. An explicitly defined service benefit package is nonexistent. The benefit package regulates the scope of services the population is entitled to when seeking care in the public sector, while services in the private sector are subject to full user fees. The Law on Health defines free entitlement to healthcare services and highlights the types of services each level of care should offer. However, the definition is too broad, and since services are not explicitly defined, it is not clear to what extent: (i) the population is aware of the free services as well as the services subject to user fees; and (ii) the benefits are guaranteed. In practice, staff shortages and the lack of equipment, medicines, and medical supplies often result in unavailability of health service.

27. The outpatient drug benefit is almost nonexistent. Although there is a list of essential medicines that MoH procures and distributes for PHC, the variety and quantity of drugs is limited. Field interviews conducted for this study revealed that the quantity of drugs provided by the MoH only meets one tenth of actual needs. Often, patients must return to the facilities for drugs because they are not available on the day of their consultation, or they go to private pharmacies to avoid waiting. It is reported that most drugs, except insulin, are paid for by patients.

28. Currently, subsidies are poorly targeted in Kosovo. A key element of any benefit package is the identification of population groups eligible to receive subsidies. Exemptions currently incorporate a combination of categorical and poverty means testing targeting. The result of this approach is seemingly excessive population of patients that are exempted from user fee payments. Specifically, an estimated 70–80 percent of patients are not obliged to pay user fees when seeking care in the public sector.²⁰ At the same time, strict eligibility criteria for identifying the poor result in a significant gap in coverage – about 7 percent of the population benefits from social assistance, but the national poverty rate is close to 25 percent. When SHI is rolled out, the same group currently being exempted from user fees will likely be exempted from premium payments. Addressing the ineffectiveness in targeting of health subsidies will be crucial for the fairness and financial sustainability of insurance.

29. Contracting for services with public providers does not exist, and the type and volume of services to be expected from each provider is not stipulated. This limits the ability to ensure providers' accountability. In principle, PHC providers should play a gatekeeping role and address most health issues at their level. In practice, it is reported that PHC facilities tend to refer patients out quite easily.²¹ Similarly, hospitals are free to determine the structure of hospitalizations – volumes of care and case mix – which risks limiting access for patients with serious and costly-to-treat conditions. Additionally, performance and quality indicators are not defined and hence not monitored.

30. For purchasing to be effective, health facilities need to have a certain degree of autonomy. In Kosovo, public facilities have little to no autonomy in budget spending due to the rigid line-item budget norms and their low resource envelope. At the PHC level, as much as 87 percent of all spending is used to pay fixed costs, most of which are salaries that are centrally managed, leaving little room for management decision on spending. Healthcare workers negotiate their agreements, with specific rights and financial rewards, in a collective bargaining process with the central government, even though their employer is the local government. With the management of PHC decentralized, these facilities are reported to be sometimes influenced by municipalities in staff selection decisions. At the hospital level, KHUCS decides the annual budget and planning on behalf of general hospitals. User fees collected by the general hospitals are not treated as additional funding for the hospitals but go back to KHUCS' central budget.

31. The lack of contracting with private providers by the government represents a missed opportunity to expand access for the population and control quality of care in the private sector. Private health sector capacity has grown sharply in recent years. Between 2015 and 2020, the number of private institutions increased by 49 percent, from 1062 to 1582, with the largest increase experienced in outpatient specialist clinics.²² In 2019, private hospital beds accounted for 13 percent of all hospital beds in Kosovo. The rapid development of the private sector, both in financing through private insurance and in provision of services, has created a parallel market catering to the wealthy. If not managed well, this could threaten the success of the national risk pool when SHI is rolled out.

20 JICA. 2022. Data Collection Survey on Health Sector to Build Resilient Health Systems toward Universal Health Coverage in the Republic of Kosovo. Final Report. February 2022.

21 World Health Organization. 2019. Primary health care in Kosovo: rapid assessment.

22 Kosovo Agency of Statistics, 2022.

32. One of the preconditions for strategic purchasing is a well-functioning information system and Kosovo is still at an early stage in this regard. With the introduction of contracting and new provider payment methods, classifications of diagnoses and procedures will become of utmost importance. Health care providers currently do not produce data on diagnoses and procedures connected with patient visits. For diagnoses, the International Classification of Diseases, Tenth Revision (ICD-10), has been adopted by the Institute of Public Health, but is not widely used, and a procedure classification system has not been adopted. The main source of information is Health Statistics, managed by the Kosovo Agency of Statistics. The statistics are at the aggregate level and are not updated in real time. Furthermore, the quality of health statistics leaves much room for improvement, because even the most basic statistic – cause of death – is not available for some 20 percent of all registered deaths. Under the World Bank-financed Kosovo Health Project (KHP), the Health Insurance Fund's Information System (HIFIS) and an electronic prescription application have been developed. However, HIFIS will not be operationalized until SHI becomes functional, whereas the e-prescription application is awaiting the rolling out of the Outpatient Drug Benefit Package.

33. While many countries have moved beyond line-item budgets and adopted more sophisticated provider payment methods for incentivizing quality and efficiency, line-item budgets remain the only method of payment for hospital care in Kosovo. All wages, drugs, and supplies are purchased through the government budget. For PHC, the health grant allocation to municipalities is capitation-based and relies on input norms, with only a small number of inputs being included in the formula. Neither the capitation formula nor the line-item budgeting for hospitals provide any incentives for improving efficiency or quality of care.

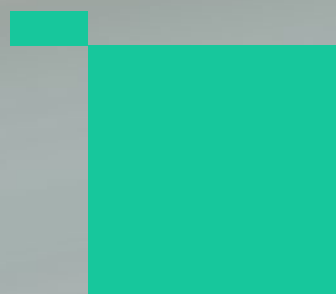
Box 2.

HIF reimbursement of treatment outside public health institutions

Kosovo has an Administrative Instruction that allows patients to get treatment outside the public health institutions and be paid by the HIF under the MTOPHI program (Administrative Instruction No. 03/2017). This includes mainly treatment outside Kosovo but also in local private facilities in some instances. Since 2018-2019, the funds for treatment outside the public health institutions has been transferred to the HIF instead of MoH. The goal of this program is to provide financial support to citizens and residents of Kosovo for health services which cannot be provided in public health institutions. Patients have the right to apply for the program through the Division for MTOPHI, after completing the full documentation (including the reference from the Counselling Commission). Medical records, Report of the Counselling Commission composed of three doctors from KHUCS, and two proforma invoices should be submitted together with the administrative documents. Final decision is made by the MTOPHI. If approved, treatment is paid by the HIF.

The HIF's management of payment under MTOPHI is best characterized as passive purchasing or pure processing of payment. The process lacks proper and standardized procedures to specify the types of services the Counselling Commission can refer a patient for treatment outside public health institutions. In addition, the MTOPHI program makes decisions on a case-by-case basis without involving the HIF in any decision-making role nor in understanding the budget limitations. The HIF is currently serving only as a payment agent, instead of developing standardized approval and monitoring processes. It does not engage in any contract negotiation with hospitals abroad. This approach has generated significant financial risk for the MTOPHI funds: for example, in 2021, the Fund spent EUR1.4 million on MTOPHI more than the budgeted amount of EUR8 million. In addition, the Fund is facing contingent liability from commitment letters issued to foreign providers which has not yet materialized as debt. As of December 31 2022, the liability was reported to be more than EUR 26 million.

Shortcomings in UHC goals associated with health financing arrangements

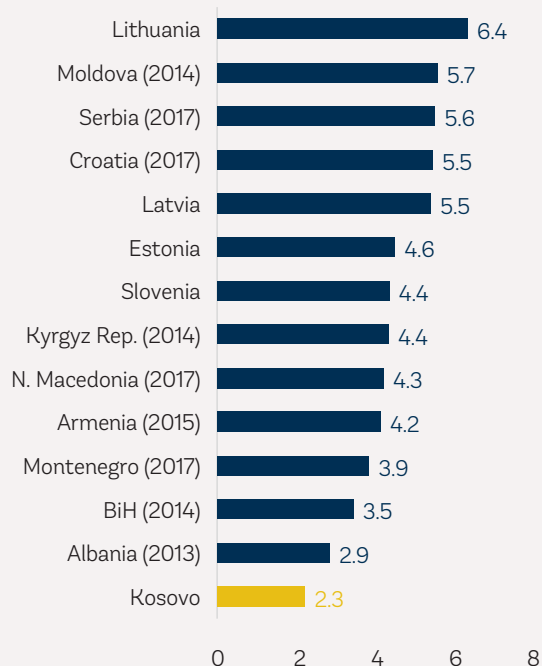


34. The lack of significant reforms in health financing over the last decades represents a missed opportunity for Kosovo to address various shortcomings vis-à-vis UHC goals of achieving access, quality, efficiency, equity, and financial protection. In fact, as seen above, key financing functions are organized in a way that disincentivizes improvements. Some constraints are highlighted below, with a caveat that observed outcomes are multidimensional and financing alone only partly explains the outcomes.

3.1. Insufficient public spending causes input constraints, poor access, and low quality of care

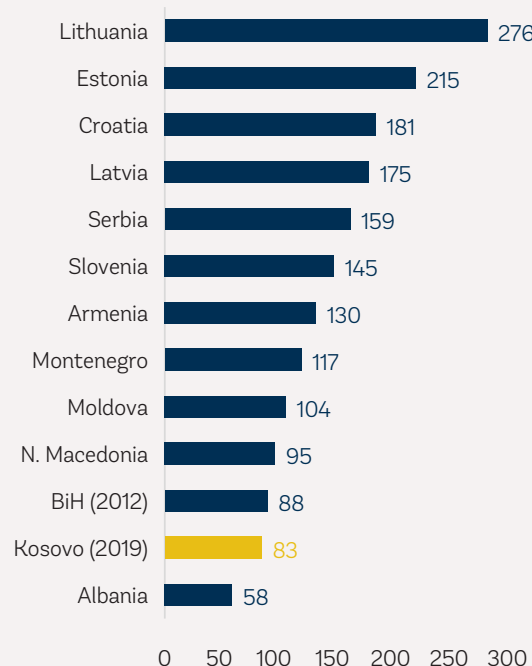
35. With only 3 percent of GDP devoted to health, Kosovo's health system faces a number of significant challenges, including inadequate funds to pay health care personnel, maintain health facilities, or purchase sufficient medicines and medical supplies. Kosovo compares unfavorably with peers in terms of inputs into service delivery and actual utilization of public services. For inpatient care, in particular, with 2.3 beds per 1,000 population, Kosovo's network of public hospitals has far fewer beds than all comparator countries (Figure 7). Similarly, the number of hospital doctors per 100,000 population is lowest among peers, except for Albania (Figure 8). The low number of beds does not necessarily mean that Kosovo needs more hospital beds, since the occupancy rate of the existing beds is also low, and care should be moved more towards PHC rather than hospitals. An additional limitation is that the data for Kosovo comes from an outdated census and pre-COVID statistics.

Fig 7. Hospital beds per 1,000 population in 2018 or latest year available



Source: WDI (peer countries) and authors' calculations based on KAS data (Kosovo)

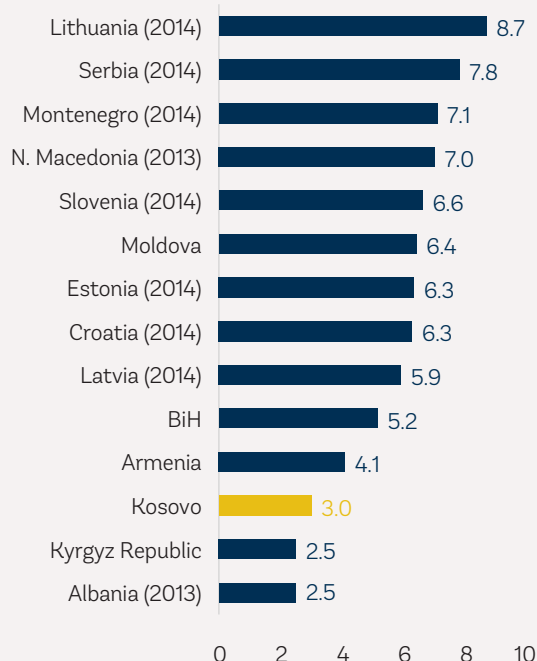
Fig 8. Hospital physicians per 100,000 population



Source: HFA, 2013 (peer countries) 2012 (BiH) and 2019 (Kosovo, authors' calculations based on KAS data)

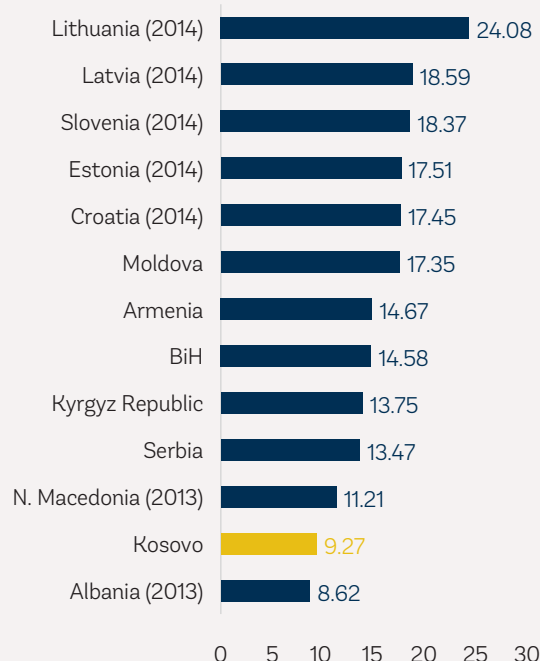
36. Service utilization is low for outpatient and inpatient care. Kosovo records fewer outpatient contacts per person than peers, except Albania and the Kyrgyz Republic (Figure 9). In 2019, the number of discharges per 100 population in Kosovo ranged from 38 percent of those recorded in Lithuania to 83 percent of those recorded in North Macedonia (Figure 10).

Fig 9. Outpatient contacts per capita, 2019 or latest year available



Source: HFA (peer countries) and authors' calculations based on KAS data (Kosovo)

Fig 10. Hospital discharges per 100 population in 2019 or latest year available



Source: HFA (peer countries) and authors' calculations based on KAS data (Kosovo)

37. Despite PHC being free and geographically accessible, citizens point to poor quality of care as an important reason for low use of services. In fact, over 33 percent of respondents in the 2017 HBS cited unavailability of drugs as their reason for dissatisfaction with public health institutions (Figure 11). Primary care capacity in terms of team composition, competencies and available equipment does not match the health needs and expectations of the population, which leads to decline in reputation and, therefore, bypassing of PHC services.²³

23 World Health Organization. 2019. Primary health care in Kosovo: rapid assessment.

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