I. Introduction and Context

Country Context

Kosovo remains one of the poorest countries in Europe although there have been considerable gains in poverty reduction thanks to sustained economic growth. The Republic of Kosovo has experienced five consecutive years of economic expansion, growing 4.5 percent per year on average since 2008. The headcount poverty rate in Kosovo fell dramatically from 45.1 percent in 2006 to 29.7 percent in 2011, but remains high. The low estimated employment rate of only 29 percent and the high unemployment rate of above 40 percent have contributed to poverty and income insecurity.

Kosovo has managed to maintain healthy public finances, but legislative and financing constraints limit the scope for expansionary fiscal policies. Fiscal deficits in 2011 and 2012 were 1.9 and 2.7 percent of GDP, respectively, leaving Kosovo with a public debt-to-GDP ratio of 9 percent. Kosovo’s euroized economy is better positioned than most countries in the region and the maximum public debt-to-GDP ratio is fixed to 40 percent by law. In 2012, Kosovo secured support from the IMF for a 20-month, €107-million Stand-By Arrangement. Still, Kosovo’s unresolved status issue
remains a key barrier to achieving political integration and socioeconomic development. However, the EU has determined that there are no legal obstacles for Kosovo to open negotiations for a Stabilization and Association Agreement (SAA), making Kosovo a potential candidate for EU membership.

**Sectoral and Institutional Context**

Kosovo has some of the worst health outcomes in Europe; Maternal and Child Health, respiratory conditions and circulatory diseases are key health priorities. Life expectancy at birth in Kosovo is 70.2 years, which is 10 years lower than the European Union (EU) average of 80.2 years. The latest available estimates suggest an Infant Mortality Rate (IMR) of 9-11 per 1,000 live births and Under Five Mortality Rate (U5MR) of 48.7 per 1,000 live births. These IMR levels are double the EU IMR of 4.1 per 1,000. Moreover, these figures are based on routine reporting and there is a high likelihood that they are under-estimates. Perinatal and respiratory conditions including TB are among the top causes of mortality across the population as a whole while perinatal causes, respiratory conditions and diarrhea account for the main causes of infant mortality. As is the case with other countries in the region, non-communicable diseases (NCDs) are an emerging priority and circulatory disease is already a major cause of morbidity and mortality.

Total health expenditure and the health share of the government budget in Kosovo are low relative to regional and GDP per capita comparators, indicating the need to prioritize health in public spending. The Government of Kosovo’s spending on health was 2.6 percent of GDP in 2012 and health accounted for approximately 9 percent of total government spending in 2012. Both the share of health in government expenditure and the share of GDP spent on health in Kosovo are below the average for South Eastern Europe (SEE) and the EU average, and among the lowest in Europe. In both the SEE region and EU public spending on health accounted for approximately 13 percent of general government spending and approximately 5 percent of GDP in 2011. Furthermore, analyses show that in 2011 health spending in Kosovo was below global averages for per capita GDP comparators indicating that there is a strong case for prioritizing health in public spending.

Out of Pocket (OOP) Spending is high and contributes to impoverishment. OOP spending at the point of service accounted for about 34 percent of total spending on health in 2011. According to the WHO, countries with OOP shares below 15-20 percent of total health spending are typically able to assure financial protection from health expenditures for their populations, which suggests that Kosovo fails to meet the WHO’s macro criterion for financial protection. The high OOP spending contributes to impoverishment in Kosovo with an estimated 7 percent increase in the poverty headcount associated with health OOP payments.

Financial barriers to access and gaps in quality are constraints to improving health sector outcomes. Low utilization levels at both primary care and hospital levels, combined with high OOP spending on health, point to the possibility that there are financial barriers to care seeking. Physical access to facilities is relatively good and unlikely to be a constraint. At the same time, shortages of drugs and supplies at health facilities point to gaps in the structural aspects of quality which depress use – through poor perceived quality of care – and result in poor outcomes for those who do use care. Increasing financial access and quality of care will, therefore, be key to improving health outcomes in Kosovo.

Improving drug prioritization and drug procurement are critical to improving access to essential medicines in Kosovo. Public spending on pharmaceuticals is very low – approximately US$12 per
capita per year in 2012 – contributing to high OOP spending on drugs and supplies which account for 70 percent of OOP spending. In comparison, Turkey, which has fairly good coverage for pharmaceuticals, spent roughly US$110 per capita per person in 2010. Prioritization is a key concern given tight budgetary constraints, and there is considerable scope to improve current prioritization systems for public drug procurements. Furthermore, there are clear indications that efficiency gains can be secured to squeeze more gains within the current drug budget.

Fragmented responsibilities for primary and secondary care and weak incentives to improve quality are obstacles to improving the quality and efficiency of service delivery. The Ministry of Health (MoH) is responsible for hospital care in Kosovo, while municipalities are responsible for primary care service delivery and receive a capitation-based grant for service delivery from the Ministry of Finance (MoF). This fragmentation in responsibilities and financing makes oversight of primary care services by the MoH difficult in the absence of appropriate incentive structures and coordination mechanisms. Provider payments from Municipalities to primary care facilities are based on line item budgets, and do not offer strong incentives to focus on improving quality of care. Payments to hospitals are also based on line item budgets. Although the MoH has initiated performance contracting with hospitals these are yet to be fully implemented and there is considerable scope to expand the focus on improving quality.

The Ministry of Health (MoH) has embarked on a far-reaching health sector reform initiative that seeks to address many of these concerns. The MoH in Kosovo has set an ambitious reform agenda to improve the quality, appropriateness and efficiency of health service delivery and improve financial protection. The reform agenda is focused on:

(i) Improving strategic purchasing: to improve service delivery and accountability through the introduction of purchaser-provider separation with the creation of a purchasing agency within the MoH, the Health Financing Agency (HFA), and strengthening incentives in payment mechanisms. Performance Based Contracting with hospitals has begun but is at an early stage. Performance contracts for primary care have not been introduced yet.

(ii) Introducing mandatory health insurance: to raise more revenues for the health sector (estimated additional revenues per year range from € 38 million to € 85 million ) and improve financial access to health services. A Health Insurance Law is being finalized. The proposed mandatory health insurance will be funded through a combination of general tax revenues, citizen premiums and revenues from cost-sharing. The poor will be exempt from insurance contributions. As part of the mandatory health insurance scheme, the government proposes to initially roll out an outpatient drug benefit to improve financial protection by addressing high OOP spending on drugs.

(iii) Procurement reforms: to improve the efficiency with which drugs and supplies are procured to improve the availability of life-saving drugs at health facilities, which will contribute to both improvements in quality of care and lower OOP spending. Groundwork for these reforms will begin over the next few months.

Considerable institutional capacity will be needed to implement these reforms effectively.

**Relationship to CAS**

The main objectives of the Country Partnership Strategy (CPS) 2012-2015 (Report No. 66877-XK) of May 1, 2012, are to support Kosovo to (i) accelerate broad-based economic growth and employment generation; and (ii) improve environmental management. The CPS recognizes health as a priority citing the low health outcomes in Kosovo, and highlights the need for major investments in quality of basic health care services. The proposed Project is not, however, included in the list of proposed lending in the CPS due to constraints in the lending envelope for Kosovo at
the time of the CPS. However, IDA resources became unexpectedly available to support a health sector project in FY14. The proposed Project directly addresses the health concerns identified in the CPS.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The proposed PDO is to support health sector reforms in Kosovo in order to improve financial protection and the quality of care for priority health services.

Key Results (From PCN)

The possible PDO indicators under consideration and from which 3 to 5 indicators will be selected are as follows:

(i) Percentage reduction in average unit price relative to baseline for the X [To be defined] most frequently dispensed multi-source pharmaceuticals.

(ii) Percentage of Ante Natal Care (ANC) cases in [a defined reference period] who receive the complete package of ANC services [to be defined based on Ministry of Health protocols].

(iii) Health Insurance Fund is functional [specific benchmarks that must be satisfied for this will be specified].

(iv) Percentage of employees in the public sector and VAT registered firms and individuals in the exempt category who are enrolled in the mandatory health insurance scheme.

(v) Percentage of health facilities that achieved contractually-specified performance targets in a [to be specified] reference period [disaggregated for hospitals and primary care facilities].

(vi) At least X pharmacies offer the outpatient drug benefit package.

III. Preliminary Description

Concept Description

To achieve these objectives over a five-year period, the proposed Project will support the health sector reforms in three major areas: (a) Performance-based purchasing, including the introduction of a performance-based purchasing arrangement with municipalities for primary care; (b) Procurement of drugs and supplies; and (c) Introducing mandatory health insurance in order to improve financial protection and access to services and to improve the quality of priority health services. In addition, the Project seeks to support the MoH with reform communication and citizen engagement to better manage the reform effort.

Component 1: Support to Health Sector Reforms (US$13 million)

This component aims to build institutional capacity to design and implement health sector reforms in Kosovo in the three major areas mentioned above. Activities under this proposed component will build institutional capacity to design and implement the reforms through a combination of capacity building including training, equipment and some limited renovation. No new construction is envisaged.

Implementation will proceed in phases. The initial phase will seek to strengthen existing arrangements and implement new performance-based purchasing arrangements and initiate pharmaceutical procurement reforms. The second phase of implementation will focus on implementing mandatory health insurance starting with the introduction of an outpatient drug benefit. The specific activities proposed under this component are described below.
Support for performance-based purchasing. The policy objective of activities proposed under this area is to build capacity in the MoH and its purchasing agency, the Health Financing Agency, to act as a strategic purchaser of health services. This includes support to develop and finalize by-laws and regulations and building capacity to contract facilities and municipalities on performance-based contracts, monitor and manage contract performance, and pay providers. In addition, activities will focus on building the capacity of health facilities and municipalities to report on, track and manage performance. Investments in information solutions for purchasing and payments will also be supported. Facility-level information systems to track, report and manage performance, are currently being piloted and are expected to be rolled out to all health facilities with support from Luxembourg Development Cooperation (LuxDev).

Improving procurement of drugs and supplies. The main policy concern informing activities in this reform area is to gain economies of scale and lower unit prices through greater negotiation power. Proposed activities will support the development and implementation of a transparent and competitive tendering process for multi-source drugs and reference pricing for single source drugs with framework agreements (where individual facilities can place their own orders with wholesalers based on centrally negotiated agreements). There are no current plans to create a publicly managed supply chain. Proposed activities will also support improvements to the prioritization process and an e-procurement system to support pharmaceutical purchasing.

Implementing mandatory health insurance. Activities proposed under this reform area will seek to support the design and implementation of the proposed mandatory health insurance system. This includes support to the Ministry of Health and the Health Financing Agency/ future Health Insurance Fund to make the necessary modifications to laws, by-laws and regulations, to develop and implement information solutions needed to support health insurance and build institutional capacity in the Health Insurance Fund to pay contracted providers, develop quality improvement systems and build institutional capacity to accredit health facilities and private pharmacies.

Developing and managing an outpatient drug benefit. Activities proposed under this reform area will assist the Government of Kosovo to develop the institutional capacity for managing an outpatient drug benefit. This includes developing a transparent, evidence based process for deciding which drugs to cover and how to set limits in the system (for example reimbursement rates, copayments, selective benefits for certain vulnerable populations etc.). Proposed activities will also support the design and implementation of a tracking and transaction monitoring system to prevent abuse and misuse of reimbursed medicines. In addition, activities will support the improvement of existing treatment standards and train health professionals and benefit administrators on implementing the outpatient drug benefit. Once basic elements of the management system are in place, activities will support the initial development of the benefit package and its roll-out.

Building supply-side capacity to improve service delivery. Activities proposed under this reform area will support investments in infrastructure with limited infrastructure upgrades (but no new construction) and equipment to improve providers’ capacity to deliver high quality priority services at the primary care level. Mechanisms and funding for maintenance would be a key consideration when planning investments in equipment. Furthermore, any investments proposed would complement those planned or made by other international development partners in Kosovo.

Reform communications and citizen engagement activities. Drawing on lessons from reform initiatives in other countries, this component will also assist the Ministry of Health to implement
communications activities to inform the public about the reforms, gather citizen feedback and align reforms with citizen expectations.

Component 2: Enhancing service delivery (US$10 million)
The main policy objective underlying this component is to improve the quality of services at the primary care level, particularly for the poor, and to strengthen the stewardship of the Health Financing Agency (HFA) in the MoH, and subsequently the Health Insurance Fund (HIF), over primary care service delivery. This component would finance performance-linked capitation payments from the HFA in the MoH to municipalities based on annually renewable performance agreements which specify performance indicators, goals, reporting and independent verification through a concurrent technical audit. This would supplement the current capitation-based payments from the Ministry of Finance to municipalities for primary health care. As the mandatory health insurance system becomes effective, the HIF is expected to take over the HFA’s role, and eventually the performance-linked capitation payments may be co-financed and eventually entirely supported through the HIF’s revenues. The current proposal for the Health Insurance Law provides for the HIF to enter into performance contracts for primary care.

Component 1 will build capacity to implement performance agreements under the ‘purchasing’ focus and detailed implementation guidelines for primary care performance agreements, including detailed criteria for triggering payments and the frequency of disbursement, will be included in a performance agreements operational manual. Financing under component 2 will therefore be used entirely for performance-linked capitation payments, and will finance only the incremental costs of improving quality of primary care services. Financing for independent verification through a concurrent technical audit will be covered under component 3. The performance agreements operational manual will be a condition for disbursements under component 2.

Component 3: Monitoring & Evaluation and Project management (US$2.5 million)
This proposed component will support the operational costs of implementing the project, including project coordination and supervision, Monitoring & Evaluation (M&E), fiduciary management (financial and procurement), including audits of project accounts and a concurrent technical audit to verify performance improvements in primary care facilities.

The final institutional arrangements will be determined during the preparation process. At this stage, however, it is envisaged that a Project Coordination Unit (PCU) be set up within the MoH with overall responsibility for managing the proposed Project (technical and fiduciary). The PCU will be responsible for procurement, disbursement, monitoring and reporting on the use of Project funds. It will include core staff responsible for coordination and fiduciary management and will consist of a full-time Project Coordinator, a procurement specialist and financial management specialist who would report to the Secretary General of the MoH. Details on Project institutional and implementation arrangements will be set out in the Project Operational Manual.

### IV. Safeguard Policies that might apply

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V. **Financing (in USD Million)**

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<td><strong>Total</strong></td>
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