Rebuilding a health care system: war, reconstruction and health care reforms in Kosovo

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This article explores the complexity of a health care system reforms in a post-conflict situation. It describes how the health care system was revamped immediately after the war, and then reorganized with Primary Health Care (PHC) as the fulcrum for change. It highlights the coordination problems, typical of a post-war situation when un-coordinated humanitarian assistance pours in. From the vantage points of Ministry of Health officials, the article details how the change process has gone over the years, the directions it has taken and the lessons learnt. It notes that reforms are often so fast that they outstrip the absorption capacity of the potential change agents because of their inadequate preparation for the new roles and responsibilities. This in turn threatens to undermine and weaken the very system that the reforms seek to strengthen. Several options adopted for change in Kosovo’s health care system are at varying levels of implementation today. Some commentators have questioned if the policy for the new health care system has failed. We contend that there have been major organizational successes. But there are also shortcomings. There is also a potential danger that the health care system could partly revert to the old system. While some of the successes and shortcomings may be specific to Kosovo, many lessons learnt from Kosovo apply to health care reforms elsewhere.

Keywords: conflict, health care reforms, health policy, Kosovo, reconstruction

Kosovo is a small landlocked province of the former Republic of Yugoslavia. Its population of ~2.2 million is ethnically divided with Albanians forming the majority at 90% and Serbs, the largest of the minority groups, constituting 6%. The population is young with 60% being under 15 years of age. The estimates for infant mortality immediately after the conflict ranged from 18 (Kosovo Statistical Office) to 34 (United Nations Development Programme) per 1000 live births.

The education of the health workers was poor, their prestige and salaries were low and there were no incentives, thereby reducing motivation. Informal payments flourished. The care was fragmented: one track for children, one for workers and one for the rest of the family. Vertical programmes abounded. Community-based services hardly existed. The health information system primarily served to show that the facilities had fulfilled norms.

Between 1989 and 1999, the Serbs fired most Albanian health workers. The Albanians responded by establishing a parallel health care system, the Mother Theresa Organization. They also clandestinely trained hundreds of health professionals. Although the Albanians are proud of this effort, the quality of the graduates was mediocre at best.

Albanians managing to keep their jobs could not specialize or hold a management position. Kosovo’s health care system still suffers from this lack of management experience. The traditional centralistic attitude that expects all decisions to come from the centre compounds the problem.

Reconstructing the health care system

The UN Security Council Resolution 1244 established the United Nations Administrative Mission in Kosovo (UNMIK) as an interim administration to ensure ‘basic civil administration’. The Department of Health, the predecessor of the current PISG Ministry, was the highest health authority under UNMIK.

At the end of the conflict >400 aid agencies and donors came into Kosovo. One-tenth of the non-governmental organizations (NGOs) worked in the health sector. Coordination of aid became a major task in the reconstruction of the war devastated health care system.

Seeking safety, most Serbs retreated to villages (enclaves) previously predominated by Serbs. As the Serb health professionals could not work in, and the ordinary Serbs could not access health care from, the new Albanian controlled health care facilities, they started to create parallel health care facilities. The displacement of the Serbs who had held all key positions resulted in big managerial and professional gaps.

Health care reforms in Kosovo

Health care reforms in most middle and low income countries have been driven by a combination of factors ranging from

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economic necessity through pressure to decentralize to desire to be ‘modern’. The World Bank report (Investing in Health, WDR 1993) influenced several countries to adopt the proposed reforms.

Kosovo’s situation was different. She had to choose between restoring the health system that existed before the war and creating something more modern.4

The Department of Health opted for the reforms4 of the entire health care system although it also had to launch a major reconstruction effort. Already in October 1999, the Department issued Interim Health Policy Guidelines’ produced with the help of the World Health Organization (WHO). The guidelines listed the main reforms directions:

(i) Detachment of the Ministry from direct programme implementation by decentralizing the day-to-day operations of health facilities to the district and local level; and

(ii) The task of the central level (future Ministry) would be to:

1. Set policies, provide strategic management including human resource planning, quality assurance and budgeting, and monitor the performance of the health sector;
2. Regulate the sector by putting in place and enforcing adherence to the requisite laws and promote public–private mixture of health services;
3. Adopt and promote modern management principles; and
4. Develop sustainable and equitable health care financing mechanisms.

The development of Kosovo’s health policy

Following a consultative, inclusive and iterative approach, Kosovo’s health policy (KHP) development sought inspiration from the WHO Regional office for Europe’s targets for 21st Century. Although there was some tension between relief and development agendas, the main goal was long-term reforms5–11. The policy adopted the principles of:

- Equity and non-discrimination both in service provision and employment.
- Protection of the rights of the most vulnerable groups.
- Cultural, social and professional acceptability.
- Geographic and economic accessibility.
- Effectiveness.
- Cost-efficiency.
- Quality of care and
- Sustainability.

The following fundamental changes would occur:

The cornerstone of the policy will be PHC that emphasizes family medicine and acts as gatekeeper to secondary and tertiary care.

The municipal health houses will turn into family health centres with 24-h coverage providing preventive, curative, dental, and emergency services. Given the high maternal and infant mortality in Kosovo, maternal, child, adolescent, and reproductive health will be priorities. The Ministry will issue guidelines on the tasks, structure, equipment, and staffing of the centres.

Each family doctor will cater to 2000 family members who will rate their useful elements either with primary care or with hospitals. The preventive aspects of occupational health will be integrated with PHC and hospitals will have the responsibility for the specialized diagnosis and treatment.

Has the reforms succeeded?

Family medicine

The Ministry’s first priority was Family Medicine and its immediate concerns the damaged and neglected health care facilities. Many NGOs offered help in reconstruction. To direct their work, the Ministry issued guidelines on staffing, physical space, and equipment.

The Ministry launched a postgraduate specialization programme in Family Medicine administered by the Centre for Development of Family Medicine (affiliated to the Royal College of General Practitioners, UK). So far, 400 Kosovar doctors have graduated. The Ministry mandated a 2-year orientation period in primary care after graduation as a precondition for specialization.

An upgrading programme provides training in Family Nursing. Three-fourths of all PHC nurses have completed this programme.

Dismantling of vertical programmes

The Ministry transferred the immunization programme from the Institute of Public Health to the municipal PHC and closed many tuberculosis dispensaries. The will be integrated with the hospitals as their outpatient departments for chest diseases. However, the threat of an epidemic seemed to justify a new vertical HIV/AIDS control programme.

The planned decentralization of rehabilitation services, currently concentrated in two big centres, to rehabilitation departments in the district hospitals and to PHC facilities has not yet materialized.

Management of health care

Management was one of the first areas UNMIK and some donors tried to tackle. They provided the Pristina University Hospital and the five district hospitals with international health advisers.

The first step to support PHC was to send a group of potential leaders to abroad for short-term management training. Donors also organized short training courses in Kosovo for >300 managers. A new 2-year Master’s programme in Health Care Management is expected to provide a more permanent solution.

PHC needs the support of effective hospitals. The Ministry therefore integrated the previously semi-autonomous clinics within the hospitals, purged excess personnel and prepared model organizational charts and job descriptions.

The former combined departments of neuro-psychiatry were split to enable the development of modern, independent psychiatry. Maternity units in several health houses were closed
to concentrate all births in the hospitals. Operating theatres (previously each surgical discipline had its own) were merged into operation blocks.

The legal framework

The budding PISG needed a new legal framework as many former Yugoslav laws could not accommodate the proposed changes and the Albanians did not accept even fairly modern pieces of Serbian legislation.

The Ministry drafted a set of Administrative Instructions and Office Instructions to fill the lacunae. Several laws, for example the Health Law and the Law on Pharmaceuticals have been promulgated but more work needs to be done in drafting laws and sub-legal acts to regulate the public and private sector.

Health information systems

The 1999 crisis interrupted all information gathering. Donors supported a new, modern health information system (HIS) that not only collects epidemiological information but also management, financial, and operational information. Uniform reporting formats are now in place and most health facilities have begun to comply with the reporting requirements. Nevertheless, there are still gaps and the HIS is not yet able to provide reliable data on many key indicators needed for policy planning and decision making.

A new PHC record that will bring together the notes of all health workers participating in the care of a patient is expected to foster team approach, ensure attention to prevention, and help track treatment outcomes.

Decentralization

The health care system in the Former Yugoslavia was characterized by poorly defined ownership and management accountability. Political bodies made management decisions.

Aiming at dismantling the old, centralized ‘command and control’ management system, UNMIK passed a regulation that made the municipalities responsible inter alia, for PHC, consumer protection, and public health. To support the municipalities in the development of PHC, the Ministry established the following:

- District health authorities to support and monitor the municipalities.
- Service agreement with the Ministry of Finance and Ministry of Public Services to define the basic service package (very close to the essential elements of PHC as defined in the Alma-Ata Declaration) that municipalities ought to provide and the funds needed to pay for this package.
- Health Care Commissioning Agency as an instrument for purchaser–provider split in future health care funding. It currently negotiates the service agreements and monitors their implementation.

Financing the health care system

Previously Kosovo’s health care financing was by the state via social insurance. As the post-war donor support is rapidly dwindling, a fresh mechanism of health care financing is needed.

In 2002, the health sector budget accounted for ~20% of Kosovo’s overall budget to decrease to 12% in 2005. Table 1 illustrates the growth of the budget.

In 2003, the total health expenditure in Kosovo stood at ~120 million Euros amounting to 6.4% of GDP. Countries in the region spend an average of 5.2% of their GDP. Per capita expenditure on health in Kosovo is estimated at between $50–64, half of it in the private sector.

Table 1 Overview of successive ministry of health budgets

<table>
<thead>
<tr>
<th>Year</th>
<th>Budget (EUR in millions)</th>
<th>Increase (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>41.7</td>
<td>—</td>
</tr>
<tr>
<td>2003</td>
<td>44.4</td>
<td>6.47</td>
</tr>
<tr>
<td>2004</td>
<td>49.85</td>
<td>12.27</td>
</tr>
<tr>
<td>2005</td>
<td>49.68</td>
<td>-0.34</td>
</tr>
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As part of the reforms, the Ministry of Health introduced co-payments (user fees) to raise additional funds for health care.

Discussion: where is Kosovo’s health reforms, lessons learnt?

Health care management and decentralization

The reforms has helped to streamline Kosovo’s health care system from the smallest health centres to the Pristina University Hospital.

The health workers have modern job descriptions. The training of family doctors and health care managers is ongoing. New health records are in use and key components of a new health management information system are ready.

Most former vertical programmes are now an integral part of the health care system. Most health facilities have been refurbished and re-equipped.

The management of health care facilities in general has improved. There are few stock outs, common procedures for reporting are in place and hospital waste management has improved. However, procurement and financial and human resources management need improvement.

The attitudinal and behavioural side of the reforms leaves much to be desired. Although the young generation looks forward at models typical of European Union countries, the old generation often looks backwards. Before the oppression, some of them had a powerful position. They want it back. They also want back the old system without any dubious additions, such as PHC.

Hospital doctors find PHC a useless ‘prescribe-and-refer’ revolving door. PHC doctors are fleeing from family medicine to the clinical specialties. Working in the public sector is for many young doctors a ‘necessary evil’ until they have enough expertise or money to establish a private practice. For the established clinical specialists, it is an opportunity to divert the wealthiest patients from the public sector to their private practices.

The health houses are still full of specialists who do not understand PHC. Very few managers apply such PHC principles as teamwork. Nurses with newly completed family medicine training often return to their old job without any opportunity to use their new skills.

The devolution of primary care to the municipalities took place, perhaps, too early. Many municipalities admit that they are not ready and that they have neither the requisite professional nor the managerial capacity. Yet, they are in charge and the Ministry of Health has lost its oversight role on PHC.

Most municipalities have spent little energy on defining the contents of PHC and finding the best way to deliver it. They have ‘developed’ PHC by building new health facilities, primarily for political reasons. Municipal PHC positions are often awarded as political prizes.
**Policy setting and strategic management**

The Ministry’s health policy is still a powerful instrument but the initial impetus to take the policy through has waned. Health politicians are focussing more on ‘high-tech’ clinical medicine such as invasive cardio surgery than on the promotion of PHC.

The Ministry faces difficulties in driving, and ensuring adherence to, the policy because of the small policy staff. For example, in theory, all medical graduates should spend 2 years in primary care before specialization. In practice, many start specialization immediately after the medical school owing to the lack of policy enforcement.

The flight of doctors to hospital specialties has seriously damaged PHC. The Ministry is not doing much to retain those already in PHC or to attract others to it. Seeing the Ministry’s preoccupation with ‘high-tech’, the municipalities are understandably more interested in clinical specialists than family physicians.

**Regulation of the health sector: public–private mix**

Private health centres and pharmacies are mushrooming competing with the public domain. While this is in principle a healthy development, the absence of appropriate regulation makes the control of their quality difficult.

**Development of sustainable health care financing mechanisms**

The meagre health care budget (table 1) should compel the health politicians to carefully consider their priorities. Meeting the immediate needs does, however, not leave very many resources for the reforms. The argument that PHC is the most cost-efficient way to improve health does not easily convince politicians faced with professional and popular demands for ‘high-tech’ tertiary medicine.

The co-payment system has been dogged by a number of problems and several health facilities are abandoning the scheme. Under-collection occurs and exemption rules are not respected. Some facilities apply their own co-payments with poor transparency and accountability. At best, the funds collected suffice to pay overtime for doctors and nurses.

The new Health Law calls for a health insurance system but Kosovo’s economic situation currently renders this solution impractical. How does one collect the premiums when ~50% of the population is unemployed and the majority in the informal sector are not registered and thus no mechanism to enforce payments evading taxes? The undeveloped private health insurance is not an option for those who could afford it, Kosovo will have to do with a mixed financing system, combining general taxes, social insurance, user fees etc. The administration of such a system requires expertise which Kosovo needs to develop over a period of time.

**Conclusion**

Under any circumstance, reforms as ambitious as Kosovo’s would be a tall order. Kosovo’s were particularly difficult because of major political flux, fledgling institutions of self-governance, and heavy dependence on external funding and expertise.

At the most general level, Kosovo’s experience confirms what has been seen in many other countries: the health authorities can relatively easily change structural factors such as organization (e.g. organizational charts for hospitals) and training (e.g. family medicine training). These are areas where external funding and expertise work well. They have much less leverage in changing behaviour (e.g. transparent user fee collection) and attitudes (e.g. acceptance of PHC). These are areas where one needs local leadership and commitment.

Some elements of Kosovo’s reforms seem to be slipping back. While the speed and complexity of the reforms partially explain it, the most important reason is probably that the international technical capacity to sustain the reforms and to get the local partners on board rapidly scaled down leaving major capacity gaps, for instance in the area of health care financing. It is also evident that—except for a few early local enthusiasts—the majority of Kosovo’s health professionals found some elements of the reforms an external imposition.

**Conflict of interest**

The paper has two ‘biases.’ It represents the views of Ministry officials involved in the reform process and committed to primary health care. Having been in charge of primary health care in the Regional Office for Europe of the World Health Organization, Hannu Vuori was first the de facto Minister of Health of Kosovo and then the principal adviser to the local Minister. Buwa Dragudi was first a District Health Officer and then Minority Health Coordinator and adviser with the Ministry of Health.

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**Key points**

- Post-conflict situations with near total breakdown of institutional mechanisms provide a great window of opportunity for commencing health care reforms. However, inspite of the opportunity, interested groups and political constituencies including internal reformers could undermine the initiative.
- Whether the initial impetus for health care reforms is internally and/or externally driven, heavy investments in capacity building to sustain the momentum of the reforms is mandatory. Early withdrawal of external support and technical assistance negatively impact any initial gains.
- A fast pace of implementation of health care reforms coupled with a desire to achieve quick results poses a potential danger that can seriously undermine the impact of the reforms. Reformers should continuously examine the directions and impact of their actions and take early corrective measures. Perceived gains must be critically examined and analysed.
- Reformers’ outcomes are pegged to attitudinal perspectives of the reformers rather than to per capita fiscal investments into the reforms. Care must be taken early to harness positive attitudinal changes both among reformers and service consumers if the reforms are to succeed.

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