

**PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE**

Report No.: PIDA3162

Project Name	Kosovo Health Project (P147402)
Region	EUROPE AND CENTRAL ASIA
Country	Kosovo
Sector(s)	Health (100%)
Theme(s)	Health system performance (100%)
Lending Instrument	Investment Project Financing
Project ID	P147402
Borrower(s)	Republic of Kosovo
Implementing Agency	Ministry of Health
Environmental Category	C-Not Required
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Estimated Date of Appraisal Completion	07-Mar-2014
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Decision	

I. Project 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 from 45.1 percent in 2006 to 29.7 percent in 2011, but remains high. The low estimated employment rate of only 25.5 percent and the high unemployment rate of above 30.9 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 at 40 percent by law. In 2012, Kosovo secured support from the International Monetary Fund (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. 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.

Emerging epidemiologic patterns indicate that preventing and managing risk factors for NCDs at the primary care level will be critical to improve health outcomes and financial sustainability of the Kosovar health system. Although data on service delivery for NCDs in Kosovo is limited, data from the ECA region suggest highly probable gaps in the delivery of population-based services to prevent and manage risk factors for NCDs like cardiovascular disease. Improving health results for key risk factors like hypertension and high cholesterol in Kosovo will likely require expanded coverage of health education, counseling and testing services at primary care combined with improved financial access to anti-hypertensive drugs and statins. Experience in the region, and elsewhere, also highlights the importance of strengthening primary care and its gatekeeping role in the context of health insurance.

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 increase public spending on health. 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. These are below the average for South Eastern Europe (SEE) and the EU average, which in 2011 were approximately 13 percent of general government spending and 5 percent of GDP, and among the lowest in Europe. 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 increasing public spending.

Partly as a result of limited public spending on health, Out of Pocket (OOP) spending is high and contributes to impoverishment. OOP spending at the point of service accounted for about 40 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.

Drugs account for a large share of OOP, and making them more affordable is essential to improve quality of care and health outcomes. Public spending on pharmaceuticals is very low – approximately US\$16 per capita per year in 2012. The implications of a limited budget are

compounded by weak procurement systems. As a consequence outpatients visiting public health facilities typically leave with a prescription for drugs that are then purchased at a private pharmacy and paid for in cash. This results in high OOP spending on drugs and supplies which account for 85 percent of OOP spending.

Shortages in drugs and supplies at health facilities simultaneously increase OOP spending, depress use – through poor perceived quality of care – and result in poor outcomes for those who do use care. Essential medicines, especially injectables, are lacking in the Primary Health Care (PHC) sector. At the tertiary level, as well, only 20 percent of medicines were available .

Drugs and supplies are not the only constraint to improving quality- improving provider practices will be essential to improve outcomes; this will require better incentives, skills and other quality improvement interventions. In general coverage for essential MCH services is relatively high but gaps in quality of care for those who receive services remain a constraint to improving health outcomes. To illustrate, although coverage for Ante Natal Care (ANC) is quite high with over 77 percent of pregnant women receiving 4 or more ANC visits, only about a fifth received ANC in the first trimester . Over a third of women who got ANC did not undergo basic examinations and check-ups. Communication and counseling on danger signs and healthy behaviors was especially weak. Less than half of ANC clients were informed about problems during pregnancy or counseled on using preventive medication. While clinical guidelines and protocols for many conditions have been developed, adherence tends to be poor with limited quality oversight or support, and poorly functioning referral systems. Furthermore, provider knowledge and skills may be an important underlying concern. With the deterioration of the situation in Kosovo during the 1990's the quality of education suffered as education was provided through a parallel system, and this had an impact on the quality of medical training as well.

Fragmented responsibilities for primary and secondary care combined with line item budgets do not offer adequate incentives to improve quality of primary care services and expand coverage of cost-effective preventive care services. 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 co-ordination 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 or to expand cost-effective preventive services that could lower hospital costs.

The proposed mandatory health insurance scheme could improve financial protection, particularly for the poor, and raise additional revenues to increase public spending on health. The MoH has begun a comprehensive health sector reform to address these concerns. The cornerstone for these reforms is the introduction of a mandatory health insurance system. A draft Health Insurance Law (HIL) that will provide the legal basis and overarching design for the proposed mandatory health insurance system has been approved by the Government, and is expected to be presented to Parliament in early 2014. An autonomous Health Insurance Fund (HIF), to be created under the proposed Law, will be responsible for implementing the mandatory health insurance system including collecting insurance revenues, purchasing services and monitoring and oversight of service delivery. An agency within the MoH, the Health Financing Agency, is currently responsible for purchasing health services, and will transition into the Health Insurance Fund (HIF) under the

proposed Health Insurance Law. In its current form, the draft HIL introduces a mandatory health insurance scheme which will cover a Basic Package of Health Services (BPHS) at primary care facilities and hospitals. Insurance premiums will be defined as a payroll tax set at 7 percent – split equally between employer and employee – for public sector employees and formal private sector employees. Family members of insured individuals in the formal sector will be automatically covered. All other non-exempt individuals will be required to pay a flat amount monthly premium of €3.50. The proposed HIL also includes robust protections for the poor and vulnerable groups. The poor, identified through one of the best-functioning administrative systems in the region, will be exempt from premiums and any cost-sharing. Furthermore, within the BPHS a sub-set of services, including emergency care, services for uninsured children and essential public health services are guaranteed to all. Depending on levels of enrollment among individuals employed in the informal sector and their families, the estimated additional net – i.e., after the additional costs of implementing health insurance – revenues per year are projected to in the range of €31 million to €71 million in the first year of premium collection.

The MoH plans to introduce an outpatient (OP) drug benefit as part of the mandatory health insurance scheme to reduce OOP spending on drugs among the insured. Currently, the majority of outpatient drugs prescribed to patients in primary care have to be purchased in a private pharmacy and paid for by patients in cash as public sector facilities have stock-outs. By contrast, the supply chain to private pharmacies appears to be robust: 4-5 major wholesalers supply most retail pharmacies which are well-stocked and serve patients who are unable to get the drugs from public facilities. The proposed OP drug benefit will enable patients with a prescription from public sector facilities to obtain drugs included in the OP drug benefit package from contracted private pharmacies. The future HIF will reimburse contracted pharmacies for covered drugs at a pre-negotiated rate. The OP benefit is expected to considerably expand access to drugs among the insured, and specifically among the poor. The poor, who are exempt from premiums and other cost-sharing contributions for health services, will gain access to OP benefit package drugs with no copayments, while the non-exempt will be subject to copayments to be set by the HIF. Copayment policies will regulate the demand for drugs, and will take into account potential net benefits from lowering or eliminating copayments for high public health impact drugs, such as anti-hypertensives or statins to manage NCD risk factors. Under the draft HIL, the proposed OP drug benefit will be funded through health insurance net revenues and drugs included in the package will be expanded as insurance revenues expand. The OP drug benefit will be introduced in a phased manner, starting with an initial publicly funded pilot.

The mandatory health insurance reform also creates an opportunity to improve quality and expand coverage of priority primary care services– if the right incentives are created through performance-based purchasing mechanisms. The success of the mandatory health insurance reform depends critically on well-functioning primary care services both to improve enrollment among individuals who work in the informal sector, and to assure the financial sustainability of the health insurance system. Recognizing this concern, the proposed health insurance law also enables the future HIF to enter into performance contracts for primary care, which would be funded through the net health insurance revenues. These performance contracts are a tool to incentivize improvements in quality of care and coverage for priority primary care services. Since primary care services will continue to be funded through the Specific Health Grant from the MoF to Municipalities, performance contracts could give the HIF leverage over service delivery and outcomes at the primary care level. While creating the right incentives is essential, investments to improve provider capacity to respond to these incentives – through training, implementation of clinical guidelines and pathways, and

information systems support – will be a key link in the chain to better health outcomes.

The proposed reforms have the potential to transform the health sector in Kosovo and address the main health sector constraints to improving financial protection and health outcomes. Experience from other countries indicates, however, that implementing these reforms successfully will require considerable institutional capacity and investments in systems to support implementation along with strong health sector oversight and monitoring.

II. Proposed Development Objectives

To contribute to improving financial protection from health spending for the poor and quality of care for priority maternal and child health and non communicable disease services through: (a) providing support for health sector reforms focused on mandatory health insurance and performance-based purchasing; and (b) building capacity to improve quality of care.

III. Project Description

Component Name

Improving financial protection and quality of care

Comments (optional)

Component Name

Strengthening primary care

Comments (optional)

Component Name

Project management

Comments (optional)

IV. Financing (in USD Million)

Total Project Cost:	25.50	Total Bank Financing:	25.50
Financing Gap:	0.00		
For Loans/Credits/Others			Amount
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			25.50
Total			25.50

V. Implementation

VI. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01		x

Natural Habitats OP/BP 4.04		x
Forests OP/BP 4.36		x
Pest Management OP 4.09		x
Physical Cultural Resources OP/BP 4.11		x
Indigenous Peoples OP/BP 4.10		x
Involuntary Resettlement OP/BP 4.12		x
Safety of Dams OP/BP 4.37		x
Projects on International Waterways OP/BP 7.50		x
Projects in Disputed Areas OP/BP 7.60		x

Comments (optional)

VII. Contact point

World Bank

Contact: Aneesa Arur
 Title: Public Health Spec.
 Tel: 473-6358
 Email: aarur@worldbank.org

Borrower/Client/Recipient

Name: Republic of Kosovo
 Contact:
 Title:
 Tel:
 Email:

Implementing Agencies

Name: Ministry of Health
 Contact: Burbuqe Zatriqi
 Title: Head, Division for Co-ordination of Investments
 Tel: 38649636363
 Email: Burbuqe.Zatriqi@rks-gov.net

VIII. For more information contact:

The InfoShop
 The World Bank
 1818 H Street, NW
 Washington, D.C. 20433
 Telephone: (202) 458-4500
 Fax: (202) 522-1500
 Web: <http://www.worldbank.org/infoshop>