EUROPEAN CENTRE FOR MINORITY ISSUES

KOSOVO/A CIVIL SOCIETY PROJECT

KOSOVO/A STANDING TECHNICAL WORKING GROUP

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SECOND MEETING:
HEALTH SECTOR REFORM AND RECONSTRUCTION
UN GOVERNMENT BUILDING, PRISTINA
26 MAY 2001

ECMI Report # 14

August 2001

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European Centre for Minority Issues (ECMI)
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ECMI gratefully acknowledges the generous support of the Royal Danish Ministry of Foreign Affairs (FRESTA/Secretariat for Peace and Stability), the Stability Pact Fund of the German Ministry of Foreign Affairs and the Swedish Foreign Ministry.

Published in August 2001 by the European Centre for Minority Issues (ECMI)

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I. INTRODUCTION

On 26 May 2001, the second meeting of the Standing Technical Working Group was held in the KTC room, Government Building, Pristina. The session addressed issues of access to health care and the reconstruction of the health sector in a post-conflict society. The event brought together over forty participants representing all sections of Kosovo/a society, including political party representatives, representatives of minority groups and specialist NGOs as well as local and international experts in the field of health.

In a series of preparatory meetings, the Steering Committee for Health selected several key issues for discussion at the session. These issues had been agreed in preliminary discussions based on a study of the current state of the Kosovo/a health system, which had been especially compiled by Michael Waters of Cambridge University (see Appendix 3). In the concluding meeting of the Steering Committee before the session, an agenda was agreed for the day's deliberations and a number of objectives were identified.

These objectives were:

- To analyse and assess the challenges facing Kosovo/a with regard to obtaining equal access to health care and the reconstruction of a unified system of health
- To encourage the active participation of civil society in the formulation and application of tested health policies and programmes in Kosovo/a
- To offer suggestions and recommendations regarding health policy and strategy as well as the planning needs relevant to Kosovo/a
- To critically engage with the positive and negative developments brought about by the international response to the Kosovo/a health system

The programme for the second session sought to address six broad areas of health sector policy. These included a discussion of how the health care system in Kosovo/a functions as an overall system of health; the provision of primary, secondary and tertiary health care; issues of health education and drug abuse, as well as the provision of equal access to health care services. The programme of the second meeting is appended below (Appendix 2).

The session was chaired by Dr Gylnaze Syla, who had also chaired earlier meetings of the Steering Committee. Brief presentations on each topic were provided by local and international experts and Dr Arben Cami, representing UNMIK, provided an overview of the successes and limitations of the international response.

In the ensuing debate, specific problems concerning the experience of rebuilding a health system in Kosovo/a were identified and discussed. Contributions were also made concerning the individual and collective experience of gaining access to health care provisions in a war-torn society. The session generated lively debate and discussion on each of the issues at hand. Key points from the discussion are outlined below.

II. SUMMARY OF THE DEBATE

a. The functioning of the Kosovo/a health system as an overall system of health

Parallel structures: cooperation or integration?

1. The meeting recognised that the reconstruction and rehabilitation of the health system in Kosovo/a faced major challenges. The present fragmented system had resulted from a legacy of centralisation, neglect and the development of parallel structures. In this context, the meeting noted the necessity of establishing an integrated system of health care in Kosovo/a.

2. The meeting drew attention to the continued existence of parallel structures in the provision of basic health care services. It was noted that this hindered the aim of establishing an equitable and comprehensive health care system and posed an added burden by the need to finance duplicative facilities and staff.

3. In this context, the meeting noted the efforts of the international implementation agencies to establish an overall policy framework. However, it was equally noted that the establishment of a policy framework that would lead to a longer-term process of health sector development and reform required wider consultation with the broader health community of Kosovo/a. It was proposed that a policy framework be established which reflected this.

4. The meeting noted the fundamental need for a policy framework to maximise the efficient use of available resources and to guide the development of the health sector. The need to provide for regulation of the overall, at local and municipal level, was also noted.

5. It was further noted that the full integration of the health system provided an opportunity to improve interethnic relations based on common values.

Relationship between public and private provision

6. There was widespread agreement that the public provision of health services should predominate in Kosovo/a. The meeting however recognised that public financing would be limited and could not support as modern or as comprehensive a health service as was desired. In this context, the meeting recognised the need for a mix of public and private health provision.

7. Where private practice was, however, allowed it should be governed by proposals regarding the establishment of clear regulations of conduct, including controls on the private practice of public employees and the establishment of minimum standards.

8. The meeting noted that transparent rules and regulations regarding private practice was one safeguard against under the table payments and discrimination in equitable health care provision.

Funding the health system and health insurance

9. The meeting acknowledged that health sector funding needs to remain within the limits of resources available to Kosovo/a for the foreseeable future. In this context, the meeting highlighted the need for reliable and current demographic statistics as a reliable foundation on which to assess the real needs of the health system and formulate policies and priorities.

10. It was further noted that this information would be of importance for estimating budgets, allocating resources and planning necessary training programmes.

11. The need to explore funding options consistent with the level of health provision required was also noted. It was proposed that this include social insurance, general tax revenues and user fees. The establishment of a system of co-payment by users of health services was also proposed, although it was suggested that provisions be made for the exemption of vulnerable groups.

12. There was general concern at the uncertain base for meeting recurrent costs in the future and the continued investment of donors. In this regard, the meeting drew attention to the imbalance of health provisions that would be created once the NGO community had terminated its operations.

13. In this context, the meeting highlighted the need to establish a scheme for the payment of health insurance and invited the cooperation of the World Bank in exploring an implementation programme.

14. The question of ensuring adequate basic salaries for doctors was also raised. It was emphasised that this was an essential measure to safeguard against potential corruption in the medical profession. It was also noted that financial support was needed for upgrading the status of nurses and paramedics as well as relevant administrative and support staff.

b. Primary Health Care Provision

Better use of qualified nurses as health practitioners

15. The meeting noted the need for a better allocation of manpower resources in health care provision. It was proposed that the skills of qualified nurses be better utilised and that their role be extended to cover the provision of ante- and postnatal care. It was also proposed that nurses be deployed in an educative role through a programme of outreach to remote areas, this was deemed particularly important with regard to matters of hygiene and reproductive health.

16. To support this, it was further proposed that a structured, long-term plan be developed to assist in the rational utilisation of human resources. This included the rational allocation of posts to facilities, the identification of areas of duplication where care could be more effectively delivered at a lower level of competence and the development of a sustainable training programme incorporating a provision for career development. The meeting encouraged doctors to assist in this process.

Decentralising primary health provisions

17. In this context, the meeting highlighted the need to develop an adequate programme of incentives to encourage medical personnel to work in peripheral areas.

18. It was felt that a more decentralised approach to primary health care, which varied according to the specific needs of the beneficiary population, would be more efficient and equitable in the short-term and also contribute to the longer-term reform of the health sector.

19. It was proposed that rehabilitation efforts therefore be focused on the decentralisation of the system. In was also noted in this context that decentralisation would serve to correct the tendency to specialist visits.

c. Equal Access to Health Care

Equal distribution of resources

19. The meeting drew attention to the continued separation of health care facilities for all communities in Kosovo/a, this included patients as well as providers. The importance of taking steps to remove this separation as a means of promoting an equitable health system was emphasised.

20. The meeting noted the need for minority communities to be fully integrated into the localised system. It was emphasised that the health system should be non-

discriminatory in both provision and employment. The danger of creating an ethnic imbalance in the provision of services and facilities was also noted.

21. In this context, attention was also drawn to the need to improve access for the disabled as well as those in dire poverty. The importance of raising the level of awareness amongst medical personnel of attendant diseases relating to these groups was also noted.

Emergency transport and access to specialised units

22. The meeting noted the essential importance of guaranteeing access to health care for minority groups. In almost all cases this was directly related to problems of security and freedom of movement. Attention was also called to the logistical challenges posed to minority groups by the need to access emergency facilities.

23. Reliable access to safe transport and facilities was deemed to be the key to safeguarding minority access to health care provision, especially in emergency cases. There was also a need for reliable and sustainable channels of communication. It was proposed that a system of safe corridors be initiated to ensure unhindered transport of patients to and from medical facilities.

24. The meeting also drew attention to the provision of evacuation programmes. It was noted that the criteria for deciding cases of evacuation appeared arbitrary; concern was also expressed at the capacity to sustain such programmes over the long term.

d. Secondary and Tertiary Health Care Provision

Geographic distribution of health care facilities.

25. The meeting noted the need to prioritise the equitable provision of secondary and tertiary health care, particularly in view of the acute problems of access prevalent in rural areas.

26. The continuing problem of achieving an equitable distribution of personnel among the available facilities was highlighted. Attention was also drawn to the concentration of specialists in Pristina and a shortage of personnel in provincial hospitals and other peripheral structures.

27. In this context, the need for reliable statistics and information to facilitate the organisation of the location and size of facilities and services was proposed. The need to upgrade outpatient facilities to hospital status was also proposed.

The availability of advanced services and specialist training

28. The meeting noted the essential importance of high quality and ongoing training for the development of professional medical personnel. In particular, it was proposed that training should be coordinated to widen the skills and abilities of medical practitioners as well as to redress the lack of specialists not presently available in Kosovo/a.

29. The meeting highlighted the need to encourage interethnic cooperation amongst highly qualified specialists, which might later serve as an example throughout the health system. It was proposed that a step-by-step approach be adopted to confidence building, which sought to draw on good relations between certain minority groups as a bridge between groups bearing greater enmity to each other.

30. In this context, it was proposed that the medical community in Kosovo/a also seek to nurture relationships with foreign centres of excellence in neighbouring countries

in order to develop exchange programmes and sharing of facilities. It was further proposed that this training should be focused on those who could in turn transfer their knowledge to others through an integrated training programme.

Training needs for other medical personnel

31. The meeting further highlighted the need for an integrated training programme which included other health personnel such as technicians, laboratory assistants and specialist personnel. Particular attention was drawn to the lack of personnel skilled in health systems management.

e. Drug Abuse and Supply

Need to formulate an overall policy

32. The meeting noted the need to establish an essential drugs programme with an emphasis on questions of prevention of drug abuse and supply reduction. It was proposed that a regulatory agency be established to control the supply of drugs based on criteria of need, efficacy and evidence-based prescription.

33. It was further proposed that this programme adopt a community-based approach which built on the existing structures of familial support in Kosovo/a.

Provision for rehabilitation

34. In this context, the meeting noted the lack of formal provisions for the rehabilitation of drug addicts in Kosovo/a. It was proposed that the long-term establishment of a drug rehabilitation centre be explored.

Prevention campaign through education and supply reduction

35. The need to increase public awareness of the direct and derivative effects of drugs, particularly AIDs and hepatitis, was noted. It was proposed that a public

information campaign be initiated to this end and that local NGO be invited to participate in such a campaign.

36. Concern was expressed at the mushrooming of private pharmacies. It was proposed that appropriate policies and strategies be developed to regulate these practices, and a policy of licensing be adopted to enforce standards.

f. Health Education

37. The development of a comprehensive and long-term programme of health education was also deemed essential to the effective functioning of a health system in Kosovo/a. It was noted in this regard that the adequate provision of health education impacted on many areas of health care provision and services.

38. It was proposed that health education be incorporated into the school curriculum at an early age.

39. It was further proposed that health education be targeted at vulnerable groups. In this context, it was suggested that counselling centres be established to target education of youths on such matters as AIDs awareness, sexual health and all forms of drug addiction. The possibility of subsuming health education under existing immunisation and vaccination programmes was also highlighted.

39. The meeting also noted the importance of mainstreaming health education in civil and other institutions and in occupational health. Include info on basic sanitation and environmental health.

g. Dialogue with UNMIK and JIAS

The summary of the dialogue which follows has not been reviewed by any of the participants. In line with the Group's wishes at the constitutive session, this brief summary will be distributed to add transparency to the proceedings.

At the final session of the meeting, JIAS was represented by Hannu Vuorri (Co-Head of Health and Welfare Department). UNMIK was represented by Arben Cami (Primary Health Care Officer, Department of Health and Social Welfare) and Peter Schumann (Co-Director, Department of Public Services). Erik Schouten also attended the session in his capacity as Head of Mission of the World Health Organisation in Kosovo/a. The Chair welcomed the representatives of the international implementation agencies.

Working Group 1

The first speaker acknowledged the contribution the international implementation agencies had so far made to the reconstruction of the health system in Kosovo/a and requested their further input and cooperation. The debate then turned to individual points considered by the first working group:

Functioning of the Kosovo/a Health System as an Overall System and Provision of Primary Health Care

The speaker raised the issue of the existence of parallel health care structures in Kosovo/a. It was felt that there was a pressing need to address ways of establishing channels of cooperation and integration between the ethnic communities in order for the health care system to function as an overall structure. This situation had been further compounded by the lack of clarity between the responsibilities of the public and private health care systems as well as the regulation of medical personnel employed in these sectors. It was proposed that there should be greater consideration placed on the licensing of medical practitioners and that the existing pool of trained medical staff, especially nurses, should be better utilised. It was also proposed that there should be greater decentralisation of services.

The JIAS representative welcomed the idea of greater integration and acknowledged the need to establish a uniform health care system. He admitted, however, that certain groups were unwilling to accept UNMIK as an authority and that this situation presented UNMIK with operational problems that impeded the development a uniform health care system. This issue would, however, soon be addressed through high-level meetings with government representatives in Belgrade, although it was unclear what the outcome of this dialogue would be.

On the issue of the licensing of medical personnel, UNMIK could nevertheless claim to have made progress. A licensing board had already been established and had been operational since 2000. Steps still needed to be put in place to address the accreditation of certain sectors of the medical profession, such as lab technicians and physiotherapists, but UNMIK was aware of the situation and the considerable amount of work that remained to be done. A greater level of professionalisation also needed to be introduced into the nursing profession, especially through education. At present, the effect utilisation of nurses was unworkable as the existing standard of nursing education was inadequate to deal with many areas of health care provision. In order to address this, a root and branch reorganisation of the present educational provisions would have to take place and this should reflect international standards. This, it was conceded, would cause a lot of unhappiness.

In relation to the regulation of the public and private health sectors, the representative of JIAS responded that legislation was being drafted to address this issue as a matter of priority. In the end, the balance between public and private health provision was an economic as well as ideological question and UNMIK was presently considering the funding report of the World Bank and examining other health care models, such as Slovenia. It would be a mistake, however, to think that private health care was more prone to corruption than public facilities. Studies showed that high levels of corruption existed in both.

On the issue of decentralisation of services, the representative of JIAS pointed out that regulation of health care services was primarily in the hands of the municipalities. To ensure adequate provision of health services, UNMIK was seeking a form of service agreement with the municipal authorities. It was hoped that this process would be concluded by the end of June. The UNMIK representative added that he was very considered at the level of health service provisions at municipal level, and especially at the sizeable turnover of personnel.

Equal Access to Health Care across Ethnic Divides

The importance of ensuring equal access to health care provisions was also noted, in terms of practical issues of mobility and safe transport of endangered minorities, especially in the case of emergency health care. The speaker also raised the need to extend this provision to other groups and emphasised improving access to medical

care for the handicapped. It was proposed that the distribution of health care be examined. The speaker also requested greater clarification on the development of long-term strategies towards financing the health system, particularly in terms of prioritising infrastructural development.

The JIAS representative responded that any distribution of health system in Kosovo/a was inevitably going to disappoint. The planning of a modern medical health system was based on prioritising economic and qualitative realities. Given the relative geographic size of Kosovo/a, there was a need to look hard at the balance between specialist and general provision of health services. The present system was wasteful in terms of specialisation and would be more effective if concentrated. On the issue of ensuring equal access to medical care, the JIAS representative recognised that UNMIK had not done enough in this area and that he would take note of this deficiency. This was, however, a contentious area, as much good work that has already been done could not be publicised for fear of endangering the parties involved. The Head of the Department of Health added that this was an issue that the health institutions were not competent to resolve. They did not possess the material or financial resources to deal with this, but that it should be addressed at a higher-level.

In relation to long-term funding of the health system, UNMIK confirmed that some form of health insurance was a definite goal of the World Bank. However, it was recommended that expectations had to be realistic. Health insurance was normally funded through direct taxation but few in Kosovo/a were in a position to sustain this. It was unsure whether the existing funds would ever be recuperated from abroad so the long-term strategy was to accumulate sufficient funds to achieve an adequate level of health care provision. As Kosovo/a was still dependent on outside donors, it was stressed by the UNMIK representative that the key to development in this area was capital investment.

Working Group 2

The second working group had concerned itself with three issue areas. The speaker nominated by the working group addressed each of these areas in turn.

The Provision of Secondary and Tertiary Health Care

The speaker noted that in relation to the geographic distribution of health facilities in Kosovo/a there was a need for the existing capacities to be used in a more rational manner. This included prioritising the capacities of clinics dealing with serious diseases, such as tuberculosis, and establishing training programmes in health care administration and management to bring them in line with international standards. It was proposed that Kosovo/a seek channels of cooperation with outside countries to provide specialist health care, such as cancer treatment, and that these channels could be further exploited as a means of specialising the skills of existing medical personnel. With respect to the issue of interethnic cooperation, the speaker proposed that interethnic training events be organised amongst highly qualified specialists. This, it was suggested, might serve as an example to other professionals and improve levels of accountability.

The representative of JIAS responded that the question of geographic distribution of services had already been addressed earlier in the discussion but concurred that there was a need for greater rationalisation of resources. Two examples of this were the existence of wards devoted to specific diseases that no longer warranted such resources and the fact that many diseases can be treated more effectively on an outpatient basis.

The JIAS representative welcomed the inclusion of the inter-Balkan cooperation in matters of health provision and indicated that some activity was already taking place in this area. One such example was the twinning of training hospitals and the exchange of personnel. It was noted, however, that this could result in the brain drain of scarce talent, especially in areas where there was already a shortage of personnel. The indication that accountability of medical personnel should be improved was also welcomed.

Issues of Drug Abuse

The concern about an increase in drug usage in Kosovo/a society was also noted. It was proposed that more needed to be undertaken in terms of prevention. The possibility of building a rehabilitation centre for drug addicts was also raised.

The representative of WHO noted that until the recent WHO report on drug usage in Kosovo/a there had been no clear picture of the extent of the problem. Although drug usage in Kosovo/a was not above the normal European level, it was indicated that the availability of legally prescribed drugs was an area of concern. This was mainly due to the lack of regulatory control of pharmacies. The representative of UNMIK added that a policy of withholding abusable drugs from patients without a prescription was already in place in many health houses, but this needed to be re-implemented. It was also noted that some facilities for rehabilitation of drug abusers were already in place but that the general level of service was widely disliked. Drug abusers in Kosovo/a tended to deal with the issue through the support of their families and the unwillingness to exclude drug abusers was praised. The UNMIK representative conceded, however, that there was a need for better rehabilitation services.

Health Education

There was agreement on the issue of mainstreaming health education and the need to introduce it at all levels of the school curriculum. It was felt that this area of health care should be strengthened and special emphasis was placed on the provision of education in reproductive health.

The floor was then opened to further questions from members of the Group. One speaker questioned the exclusion of war invalids and rape victims from the discussion another raised the issue of corruption.

The UNMIK representative replied that a war invalids committee had been established six months previously and was currently looking into a large number of cases. For victims of rape, it was noted that guidelines had been established but more needed to be done at all levels. On the issue of corruption, UNMIK noted that this was a key issue in all areas of civil administration and a determined effort needs to be made on all sides to tackle the problem.

The session closed with an expression of thanks to the facilitators and implementation agencies. It was proposed that the STWG reconvene later in the year to assess developments and improvements in the issue areas addressed. These would be tracked by the Steering Committee on Health, who pronounced themselves in favour of continuing their activities outside the formal framework of the sessions.

The participants also proposed a number of follow-on activities to maintain the momentum of the session. It was deemed important to disseminate information on local initiatives in the field of health so as to ensure complemantarity between them. One way of doing this would be through the establishment of a dedicated website. It was also proposed that an electronic mailing list, or discussion group, be established as a means of initiating a virtual network of health experts and advisers on post-conflict health policy. The Group further suggested that follow-up meetings take place to explore the issues raised in greater depth and to encourage wider consultation and discussion on matters of health. To facilitate this, ECMI has drafted a preliminary list of recommendations (see below). There was also a request for ECMI to explore links to expertise and technical know-how from other countries.

III. TRAINING MODULE – WHO, GENEVA

A follow-on training module on health has been scheduled to take place at the John Knox Centre of the World Health Organisation in Geneva, from 26 to 31 August. This event is a collaborative venture that has been designed to marry both the activities of the STWG with those of the WHO's programme 'Health as a Bridge for Peace' that was initiated in 1997.

The training seminars will run over four days and involve a structured process of instruction focusing on imparting essential knowledge and skills pertaining to the formulation and drafting of health policies and strategies in Kosovo/a. As well as imparting knowledge and skills, the programme aims to take account of the following objectives:

- To focus on the conditions of the health system and provision of health care prevalent in Kosovo/a with the aim of developing solutions to these problems;

- To operate in specifically chosen smaller working groups to elaborate concrete proposals intended to address the real problems of all communities in Kosovo/a;
- To integrate the skills and experiences of the STWG and the WHO in order to adapt general policy objectives to local conditions.

Participants will again be made up of a representative cross-section of Kosovar society, including representatives from all political parties, minority groups and local specialist NGOs. On the whole, the group for the training module on health will be more experienced in the issues at hand than has been the case with previous meetings and seminars. As the activities of the STWG have developed, this has filtered back to the political parties who have now requested that they be allowed to nominate a specialist in health policy from amongst their ranks.

At the time of writing, the training programme has not yet been finalised. However, a preliminary agenda has been agreed by ECMI and the Public Health Advisor of WHO, Kosovo/a, which is in line with the working procedure of the STWG and draws on the lessons learnt from ECMI's previous training in Flensburg.

In a preparatory meeting organised by the ECMI Regional Representative, the participants of the training session will discuss background documents relating to the present state of the health system and health care provision in Kosovo/a. The three documents that will form the basis for the workshop have been chosen for their relevance, timeliness and accessibility in a language the participants can understand. The documents are: the WHO's own revised 'Health Policies for Kosovo'; the European Agency for Reconstruction's Strategy 2001/2002; and a document identifying implementation strategies for health policy in Kosovo/a that is in the process of being drafted by DFID.

The purpose of the training workshop will be to generate a policy-oriented discourse, aimed at elaborating the recommendations which the Group had previously drafted as a result of the STWG meeting on health, and to explore practical provisions for their implementation. After an initial debate on the existing health strategies and policies, smaller working groups will be tasked with identifying health priorities in Kosovo/a,

identifying the determinants to ensure access to health care across all communities, and developing a financial strategy to implement this. Specific topics to be addressed include: examining the degree and extent of government involvement in health care provision, and the degree to which public and private health care provision should be mixed.

In the light of these deliberations, the working groups will consolidate their findings and develop the draft recommendations generated through the activities of the STWG. Again, the revised recommendations will be disseminated to the appropriate offices of the implementation agencies and members of the Group. They will also be distributed to a number of specialist NGOs and donors, who are interested in exploring avenues for increasing political and public participation in generating health projects. Moreover, the recommendations will help the members of the Group to track developments in the health sector over time.

A full Report of this training workshop, including the recommendations generated, will be available soon after the conclusion of the event.

IV. RECOMMENDATIONS

The following recommendations are of a provisional nature and will consequently be revised to take account of the strategies and policies formulated by the participants of the training workshop on health (see above):

RECOMMENDATIONS

On the Functioning of the Kosovo/a Health system
as an Overall System of Health

- To facilitate the expeditious and effective reconstruction of the health system in Kosovo/a and to establish a fully functioning system based on equity and non-discrimination, the central goal of policy-makers should be a policy of integration.
- For integration to be realised, a long-term overarching policy framework of reconstruction and reform should be developed, which is fully informed by the needs and concerns of all communities of Kosovo/a.
- The efficacy, equity and sustainability of this policy framework depends on the uniform regulation of all levels of health service provision in Kosovo/a.
- The common goal of rebuilding an integrated health system should be based on the principles of equity and non-discrimination and should recognise the existence of common values and common needs across ethnic divides.
- Recognising the limit on public funds to support a comprehensive public health system, provision should be made for private health care services.
- Where such private provision exists, it should be regulated according to transparent, binding and uniform regulations which comply to an acceptable minimum standard and extend to the regulation of public employees in private practice. This should be done by the granting and revocation of licences.
- To ensure the continued provision of adequate and comprehensive health care services in Kosovo/a, including the provision of acceptable levels of payment for medical personnel, a sustainable method of funding must be found. This needs to include provision for social insurance and benefits.
    - For the short-term, options for providing alternative payment schemes, such as co-payment and user fees should be explored; in the long term, concrete measures need to be taken to establish and implement a comprehensive and equitable health insurance scheme.
    - Effective reform in the health care sector and the development of effective strategies to changes this will remain limited without the existence of reliable demographic statistics and information.

On the Provision of Primary Health Care

- To bring about the rational and efficient utilisation of primary health care resources, a detailed plan should be adopted to assist in identifying existing areas of overlap, duplication and geographical distribution as well as the rational allocation of manpower to facilities.
- To support this process, the role and competences of qualified nurses should be re-evaluated. Their duties should in future be extended to cover:
    - The provision of maternity services: ante- and postnatal care;
    - Their increased deployment of to peripheral regions;
    - The adoption of an educative role in matters of hygiene and reproductive health.
- Effective consultation and cooperation of doctors should be sought to facilitate possible areas for the better allocation of resources and personnel.
- Equal consideration should be given to the training requirements of nurses, not only as a means of improving services by addressing gaps in skills and knowledge but also as a means of creating incentives to remain within the health sector.
- To prevent the potential for imbalances in service provision, measures should also be taken to encourage medical personnel to remain employed in more peripheral structures.
- As a further measure to preclude the inequitable provision of health services and improve resource allocation, efforts should be focused on further decentralising the health care system.

On Equal Access to Health Care

- To guarantee the development of an integrated and equitable health service in Kosovo/a as well as to develop trust in the system amongst all communities of Kosovo/a, the principles of equity and non-discrimination must be strictly adhered to throughout all levels of health services, encompassing consumers, providers and employees.

- Particular attention should be paid to especially vulnerable groups, such as the poor and the disabled, and the level of awareness of their attendant medical problems should be raised.
- Urgent steps should therefore be taken to eliminate the provision and consumption of separate services as well as to ensure the equal distribution of resources between urban and rural areas.
- To guarantee access to health care provisions for endangered groups, efforts must be redoubled to ensure the safe passage of patients to and from medical facilities.
- The provision of reliable access to safe transport and channels of communication, particularly in the case of emergencies, is crucial.
- Concrete measures must be put in place to ensure that safe corridors be created to ensure the unhindered transport of vulnerable patients.
- The provision of emergency treatment in cases of evacuation must also be clarified and clear guidelines should be adopted to govern the entitlement to medical evacuation facilities.

On the Provision of Secondary and Tertiary Health Care

- In view of the pressing need to improve access to secondary and tertiary health care, particularly in remote areas, urgent steps should be taken to address the shortage of facilities and specialist personnel outside Pristina.
- Steps should also be taken to improve the provision of outpatient services so as to bring them into line with hospital standards.
- To ensure the adequate provision of qualified medical personnel across all levels of health care provision, a comprehensive programme of targeted and ongoing training should be implemented.
- Attention should also be paid to widening the skills base of existing medical personnel while seeking to fill the gaps in existing knowledge and specialist provision.
- An integrated policy of training should be adopted with built-in mechanisms to optimise the transfer of knowledge.
- This programme should also be extended to cover the training of health services personnel such as laboratory assistants and technicians.

- To address the urgent need for the effective allocation of resources and planning of personnel, there is also a clear need to adopt and implement a training programme to supply skilled personnel in health systems management.
- The nurturing of cooperative practices between ethnic groups should be pursued through the organization of cross-ethnic doctors associations and interest groups.
- In order to increase specialist knowledge of medical personnel within Kosovo/a 'Twinning programmes' should be explored with centres of expertise in neighbouring countries. This should also be extended to exploring the rational sharing of specialists facilities across border.

On the Supply and Abuse of Drugs

- Clear and effective steps need to be taken to adopt and implement an essential drugs programme that also places emphasis on the issues of supply and prevention of illegal substances.
- The provision of community-based support for drug addicts through existing familial structures should be supported.
- To provide long-term support to drug addicts and facilitate their reintegration into society, consideration should be given to the construction of a drug rehabilitation centre.
- A wide-reaching media campaign should be initiated to increase public awareness of the knock-on effects of drugs and related diseases, such as AIDs and hepatitis.
- The regulation of pharmacies through the granting of licences should be introduced as a means of stemming the expansion of private practices and for setting strict guidelines for the legitimate prescription of essential drugs.

On Health Education

- The implementation of a comprehensive and overarching policy of health education is an essential element in the establishment of a fully functional and effective health system.
- Education on health matters should be incorporated into all levels of the school curriculum.

- Particular attention should be paid to raising the level of awareness of diseases and ill-health amongst the most susceptible sectors of society.

Appendix

1. Programme of the Second Meeting

Saturday, 26 May 2001

TIME	ACTIVITY
9.00-9.45	**Introductory Remarks**
	Coffee Break
10.00-11.30	**First Plenary Session:** o The functioning of the Kosovo/a health system as an overall health system o Primary health care provision o Equal access to health care
	Coffee Break
11.45-13.15	**Second Plenary Session**: o Secondary and tertiary health care o Issues of drug abuse o Health education
13.15-14.30	*Lunch*
14.30-16.00	**Working Groups 1 and 2:** o Working Group 1: First plenary topics o Working Group 2: Second plenary topics
	Coffee Break
16.15-17.30	**Plenary Briefing**
17.30-19.30	**Dialogue with UNMIK & JIAS**
19.30-20.30	*Closing Dinner*

2. Implementation agency representatives

Name	Agency	Status
Hannu Vuori	Co-Head of Health and Welfare Department, JIAS	Attended
Pleurat Sejdiu	Co-Head of Health and Welfare Department, JIAS	Unable to attend due to travel
Erik Schouten	Head of Mission, WHO, Pristina	Attended
Arben Cami	Primary Health Care Officer, Department of Health and Social Welfare	Attended
Peter Schuman	Co-Director, Department of Public Services	Attended

Two further UNMIK officials were invited to participate in the meeting but failed to attend.

3. Background Paper

The contemporary state of health and the health system in Kosovo/a

MICHAEL WATERS

Cambridge, 8 May 2001

This brief on the contemporary state of health and the health system in Kosovo/a is based on interviews conducted with the Department of Health and Social Welfare, UNMIK, the Institute for Public Health, WHO and other UN bodies, international donors, and a wide range of NGOs. It makes use of extensive background materials and publications, some of which are not yet available for public circulation, in order to provide a broad but current introduction to the subject. It does not claim to be authoritative on any particular issue, nor can it claim to summarise all aspects of health or the health system in Kosovo. Rather, it attempts to convey basic information about the issues which were deemed particularly pressing by one or more of the stakeholders consulted in connection with the drafting of this document.

Introduction

Until June 1999 the Federal Republic of Yugoslavia (FRY) administered the province of Kosovo. As a result of political policies this resulted in a 'parallel system' with Kosovar Albanians creating their won education and health structures in the period 1991-1999.

The Department for Health and Social Welfare (DHSW) was formed on the 2nd February 2000 with national and international Co-Directors. It is likely to be one of the first in 2001 to undertake a process of "Kosovarisation", whereby a national Director will assume full self-government responsibility supported by international advisors.

Service delivery is through 64 recognised facilities, including 6 regional hospitals, 34 health centres (including Health Houses and 3 Family Medicine Centres), 8 Public Health Institutes and 12 Pharmacies. Private facilities do exist by to date are not formally registered with the DHSW and have no service provision contracts.

The DHSW has also established a number of groups and commissions to provide policy recommendations and regulation across its service structure and delivery.

These include: tuberculosis; laboratory; central specialisation board; licensing board; and the drug regulation authority.

Key Health and Demographic Indicators

Due to the significant societal and demographic changes since the conflict in Kosovo/a there is no confirmed population data available, figures ranging from 1.8 - 2.5 million. However, the Department of Local Administration (DLA) of the Joint Interim Administrative Structure (JIAS) has based the distribution of its 2001 financial resources on a population estimate of 2.082 million. The UNHCR/OSCE estimate in Feb 2000 was that Kosovar Albanians comprise >90% and that Serbs, Muslim Slavs, Roma, Gorani and Turks account for <10% (approx. 197,000).

Because of Kosovo/a's historical reporting to a centralised structure and the collapse in structures during the conflict there are no 'government' indicators available. Recent studies and papers present conflicting information on key indicators, with reference to 1990-91 and 1999-2000 surveys. The Institute for Public Health (IPH) has lead responsibility under the DHSW to manage health information and considerable progress towards the production of key indicators has occurred. With the support of WHO and other agencies, an Annual Report 2000 is expected to be released in May 2001.

All studies confer that over 50% of the population is >25 years old, with a mean age of 24.6 years and only 8% is over 60. Women of childbearing age (15-45) constitute 56% of the female population. The average number of people per household is 7.

UNFPA reports an infant mortality rate of 25/1000 live births, placing Kosovo/a only marginally above the European average of 21/1000, at a similar level to its neighbour Macedonia (23/1000) and below that of Albanian (30/1000). This disputes the previous association of Kosovo/a having the worst European levels of infant mortality. However, given the very young population structure and a very young female population as a percentage of total population, service improvements in reproductive health could result in significant decreases below the European average.

A study of hospital mortality showed that 12% was due to communicable diseases, 53% to non-communicable diseases, 3% to maternal conditions, 29% to neonatal conditions (0-28 days) and 3% to injuries.

The most common adult chronic conditions are cardiovascular, renal and lung diseases, and chronic back pain and ulcer/gastritis. Cancer is an increasing problem. Tobacco is a major contributor to morbidity and mortality.

Communicable diseases are endemic in the region, including Hepatitis A and tularaemia, but there have been no major outbreaks during the UNMIK administration. High tuberculosis incidence is particularly worrisome.

The most frequently used health facilities are health houses (35%), ambulantas (31%), hospital outpatient departments (20%), and inpatient departments (4%). The utilisation rate is 5.6 contacts with the health care system per person per year.

Primary Health Care

According to the DHSW, primary health care will play the gatekeeper role by hoping to cover 80-90% of demand on the health service delivery structure. Currently in urban areas, there may be a health house and several ambulantas within easy reach. Rural facilities are sparser and the level of varies between them. Many small ambulantas have just a nurse or a doctor with a stethoscope providing minimal services. Initiatives underway to train an initial cohort of family medicine specialists (General Practitioners) to support this structure will meet only a fraction of Kosovo/a's long-term needs and hence training to develop the service will be a key element of health policy, if supported by international funds, for at least another 5 years.

Regulation 2000/45 on the Self-Government of Municipalities in Kosovo/a envisages the devolution of responsibility for a number of activities from central to municipal level. Amongst these activities is listed responsibility for the provision of primary health care. In anticipation of a transfer of responsibility on January 1, 2001, the DHSW drafted an overview document by way of guidance that aimed to answer the

questions of municipal administrators and health authorities with regard to the organisation of primary health care services at municipal level. The aim of the DHSW was that this document would serve as a helpful tool for the municipal authorities rather than a definitive instruction as to how to organise their services. Within the existing legal framework and with reference to the relevant guidelines issues by the Department of Local Administration, each municipality is free to establish their own system.

The assumption of responsibility by municipal authorities has not been uniform across the province and is affected by a number of factors. After October 28 when the municipal elections occurred, the establishment of municipal structures took place at varying speeds depending in many cases on the degree of consensus or lack thereof in each location. As a result it cannot be said that there was a uniform and simultaneous act of decentralisation.

The DHSW originally envisaged a comprehensive hand-over of the responsibility for primary health care to the municipalities as and from January 1, 2001. However, in recognition of the difficulties faces by some municipalities in fully assuming their responsibilities, this target date was pushed back to March 1. In reality the process of transition is likely to be gradual and ongoing and ultimately will vary from one location to another according to local circumstances. This is particularly true in the case of services provided to minority populations as the practice in each municipality can vary considerably according to the actors involved and the specific needs of the beneficiary populations.

A comprehensive review of the impact of devolution on minority access to health care is currently being undertaken by WHO. Work on this review is quite advanced, with information gathered from most municipalities. Some of the issues under consideration include: access to primary care within the immediate community; quality of the primary health care; availability of laboratory equipment; water and sanitation; availability of emergency transport; immunisation; access to ante natal care; and access to secondary and tertiary health care.

However, tensions over devolution span beyond ethnic lines and include problems between competing Albanian political parties. Municipalities were primarily awarded to LDK representatives, while centralised DHSW posts tend to have been filled with individuals loyal to the PDK. Negotiations over the technical implementation of the devolution mechanisms has an added level of difficulty when the devolution of administrative power is taken to be synonymous with the devolution of political power.

NGOs have pointed out that within the political context of the health care system, it is control of the regulatory framework, rather than access that concerns locals and minorities alike. Devolution according to this view will not run smoothly until individuals feel that they not only have a stake, but also have a say in how their health care is managed. Some medical professionals disagree and argue that control of the resources of health care, both between municipalities and between the DHSW, will be the source of future impasses, rather than regulatory concerns.

Secondary and Tertiary Health Care

Secondary and limited tertiary care is available through the six hospitals with approximately 4,390 beds available. WHO equate this to a n overall bed per 1000 population of 2/1000 when set against provisional population data. Over 50% of the total beds are in the Pristina University Hospital (2,400) and access to the 470 beds in the northern town of Mitrovica is restricted due to political and safety issues. Any utilisation of hospital statistics for majority planning purposes must therefore consider the singular environment.

Access to tertiary health care for Kosovars involves both the delivery of those services and meeting the expectations of the population. Currently ad hoc arrangements are made with Belgrade, Skopje, Tetovo, Switzerland, etc to accommodate patients requiring advanced care, such as certain cancer treatments, renal problems and heart operations. It is important to note that access to tertiary care may be determined not only by ethnicity, but also by geography. Treatment for oncology, for example, may be easier to obtain in Belgrade for a Serb from Northern Mitrovica, than an Albanian from Southern Mitrovica.

One means of ensuring access to tertiary care in Kosovo/a would be to improve and institutionalise these regional relationships, perhaps by way of negotiating the expansion of the regional catchment areas. Expectations that Kosovo/a will ever have a fully functioning and sustainable tertiary health care system are not realisable given its size and wealth. Popular expectations will have to be tempered by this reality.

Human and Physical Resource Reform

The DHSW has central staff of over 80 officers and is a prominent employer in the public sector with a payroll of 13, 516 as of February 7. The staff is predominantly Kosovar Albanians, who have returned to the jobs they lost in the parallel years whereas Serbian staff have been ousted to the minority and parallel facilities supported UNMIK out of political necessity. The number of non-specialist doctors is low, reflecting the previous emphasis on service delivery via speciality.

In the overall economy 4.7% of employed males and 18% of employed females earn their living from the health sector, according to a UNFPA / IOM 2000 report.

The financial cost of this number of specialised medical staff and number of hospital beds cannot be sustained in view of the DHSW's emphasis on primary health care. Job cuts will increasingly be resorted to and met by resistance, as will bed cuts in a working culture that often still equates the number of beds with the health of the hospital.

The human and physical resource reform being undertaken also requires management reform. One NGO stressed that Pristina University Hospital after the conflict was not so much in need of paramedics as accountants. Staff training and infrastructure can be put in place through cooperation between local and international actors, but the sustainability of the system will not be ensured until it is properly managed and maintained.

Access to Employment

The level of involvement of minority health care workers is generally low, with the exception of the Kosovo/a Serb community. Several institutions that service the Kosovo/a Serb community continue to be overstaffed as health care workers have been concentrated in a limited number of geographic locations as a direct result of displacement. This can result in small locations being staffed by over 100 nurses and four doctors on a rotational basis. The UNMIK effort to incorporate Serb health workers into the overall health system is complicated by the workers themselves, who are afraid to lose seniority and pension entitlements accrued through their years in the state health care system. Some workers continue to receive their contractual status and salary directly form the central authorities in Belgrade, which has been referred to in resistance to full cooperation with UNMIK. Serb health care workers may also find themselves under pressure from their community who see collaboration with UNMIK as a betrayal.

Access to Medical Services

Access to health care services remains a persistent problem for minority populations, especially with respect to secondary and tertiary health care. In comparison, the provision of primary health care was less problematic given the broad network of ambulantas at the local level. However, it was equally noted that primary health care for minority patients was often dependent on the existence of a minority specific ambulanta within their own community or in other cases, particularly for isolated rural minority communities, on the provision of mobile health services supported by NGOs.

The same is true for isolated minorities in urban locations who are reliant on house calls in order to access health care. Concerns have been expressed about the sustainability of such complementary services, which are not fully incorporated into the long-term plans for health care provision. Such worries were echoed loudly by several of the specialist health NGOs highlighting the fact that such services are ultimately unsustainable. More recently doubts have been expressed even for the

short to medium term sustainability of such services given that a number of NGOs are phasing down their activities and planning their departure from Kosovo/a.

Kosovo/a Serbs continue to experience the most acute problems in accessing health care at all levels. In almost all cases this is directly related to their security and freedom of movement problems. However, it can be argued that Kosovo/a Serbs have benefited from the most intensive efforts on the part of the international community provide complementary services, such as the installation and equipping of a medial facility in Ulpiana/Gracanica, Prishtine/Pristina.

Roma, Ashkaelia and Egyptian (RAE) communities, by comparison, are generally assumed to enjoy access to facilities servicing the needs of Kosovo Albanians. Field staff, however, observe that this is not always the case and limitations on their freedom of movement coupled with incidents of intimidation and harassment at clinics can adversely affect the ability of these communities to effectively access health care. In several areas it was noted that where physically separated ambulanta exist and are clearly identifies as benefiting Kosovo/a Albanians or Kosovo/a Serbs, RAE and other minority communities are left stuck in the middle. Services are available but the act of availing oneself of these services can be interpreted as a statement of loyalty or allegiance, with the consequent security implications that apparent support may entail.

These issues raise the immediate question of how the current health care needs of minorities should be addressed, and the more long-term goal of how minorities can be integrated into the health system. Some NGOs are increasingly favouring measures to facilitate minority access to advanced care, including the establishment of more robust primary health care clinics that encompass blood and urine testing facilities, or make use of specialised minority medical staff not currently employed by the wider health system. Such practices juxtapose the immediate need for minority health care against the slow progress towards a fully integrated health care system.

Maternity Care

As mentioned in the key health factors, given the very young population structure and a very young female population as a percentage of total population, service improvements in reproductive health could result in significant decreases below the European average for infant mortality.

Improvements could take the form of better pre-natal education and preparation, improved infrastructure linking villages to hospitals, and the training of midwives to assist with home births. Early mortality health could further be improved by instituting a system whereby all new mothers are visited by one or two nurses who then assist and instruct on the basics of childcare. This could also play into the larger DHSW goal of ameliorating the quality of health education and awareness in Kosovo/a.

Access to maternal care and child health care is variable from one location to another, and depending on the minority group in question. Access becomes a particularly acute problem for all minority communities in the case of complicated births where the expectant mother needs to be transferred to a hospital facility. Minority communities indicate that this was due to a combination of factors. In some cases the problem centred on security concerns and/or discrimination at the hospital. Most frequently, however, the challenge was posed simply by the logistics of reaching a hospital safely given the general context of sever limitations on the freedom of movement of may minority communities.

In the case of RAE communities, who often do not have the same access to emergency transport as is available to Kosovo/a Serbs closely guarded by KFOR, there appears to be more recourse to home births. In more routine cases, without any aspect of emergency complications, most communities report satisfactory access to maternal services by note that like other medical services, these are frequently provided in a segregated manner.

Mental Health

Community based mental health services are hardly existent beyond the realm of those provided by international NGOs. This gap in health care affects majority and minority populations alike. The DH intends to develop a community based mental health care scheme, which will ultimately fall to municipal authorities to implement. The severe lack of trained psychiatrists and psychologists has been and continues to be an obstacle. It is clear that the stressful conditions faced by the Albanian population in past, and the problematic circumstances of minority populations in the present, generate a range of mental health problems, which make services of this type all the more necessary.

Public and Environmental Health

Sporadic water supply and sub-standard sanitation are problems that affect many communities throughout Kosovo/a. This is the net result of years of neglect, poor maintenance and war damage. The UNHCR argues that while many minority communities have complained of scant or irregular attention to these issues, it is something that they often share in common with their Albanian neighbours. Although the water is often faecally contaminated, only 2.5% of households chlorinate it. Up to 90% of urban households have flush toilets attached to sewage systems, while the large majority of rural households use latrines.

As alluded to earlier with respect to the devolution of responsibilities to the municipalities, there is further work that needs to be completed on working out sustainable arrangements for regulations and resources necessary at the municipal level to deal with the issues and problems at the local level. It does not appear that the 2000/45 framework specifies the means by which certain standards and levels of service will be assured at the local level, or how the local level may help to control the resources to which they have access. This is an issue that gives rise particular concern amongst minority groups.

Drug Use

The incidence of narcomania has been subject to much speculation since the conflict, with most hypothesising a great increase in its prevalence. However, to date no conclusive studies have been undertaken that might help inform a policy stance on the issue. The World Health Organisation has commissioned a Rapid Assessment and Response (RAR) study in collaboration with UNICEF to examine the use of drugs by youth and prisoners, to be released May 11. The first of a wider regional study on the subject, the RAR will address the supply-side issues (police, customs, law enforcement) and the demand-side issues (prevention, cessation, and harm-reduction). Furthermore, it will call for a newly informed policy response, as there is currently no integrated policy framework to deal with these issues.

If the RAR does confirm high levels of drug use, the health of the community in the widest sense will require a multifold response. Intravenous drug use could contribute to higher levels of AIDS and Hepatitis, delinquency and crime, as well as the accompanying physical health associated with drug abuse.

First Aid

The prevalence of traffic accidents in Kosovo/a inflicts lost productive capacity and high health care costs on Kosovo/a. Besides improvements in licensing and infrastructure, a mandatory first aid course for all individuals wishing to obtain their licence has been proposed by a number of NGOs. This system was in place prior to the conflict, and succeeded in curbing fatalities and injuries, in part because of the techniques themselves, and in part because it helped to instil a more responsible driving culture.

Disease Control

Immunization and vaccination services continue to rely heavily on the involvement of NGO actors, especially where minorities are concerned. Under current arrangements, it would appear that no sector of the population has been left unattended by the

vaccination campaigns carried out to date. However, the DH recognises that mobile services dependent on international support is an expensive way of running this service and in future should be completely in the hands of the municipality as part of normal primary health care services.

Hepatitis A is not a problem with a prevalence of 2%, whereas Hepatitis B with a prevalence of 4% warrants a national immunization plan according to the WHO. Resistant strains of typhoid have not yet been detected, but there is extensive monitoring being carried out through the WHO DOT programme.

An AIDS committee has been established to monitor and help stem the progress of the disease. Kosovo/a currently is an environment replete with the vectors necessary to produce a sudden and dramatic rise in number of AIDS cases: large migratory international population; changing cultural attitudes and norms; increased prevalence of drug abuse; etc. However, the incidence of AIDS cases at the moment does not pose a serious health risk to individuals at the moment according to the IPH.

Information Systems

Currently in Kosovo/a there is no integrated health information service that allows for the regular and institutionalised transmission of management and patient information between the municipalities and the DHSW. While measures have started to be taken to put such a system in place, its absence has wide ranging implications for the current health system. Patient records are not kept or transferred in a standardised format so their health care is compromised.

Epidemiological data and evidence is difficult if not impossible to compile, making conclusion about the health of the nation difficult to ascertain. Without this health intelligence, no informed policies can be formulated or implemented to help address gaps or problems in the health care system. Some professionals have suggested combining the need for increased registration within the UNMIK structure with health education and immunization awareness campaign.

Health Education

The DHSW intends to initiate Kosovo/a-wide health education activities as a part of their long-term strategic plan. Many stakeholders have observed that individuals from rural areas are frequently unaware of basic health considerations and symptoms. As such, they often do not recognise instances when it is time to make use of the local medical facilities at their disposal. Moreover, improvements in person hygiene, reproductive education, water and sanitation education could go a long way to increasing the quality of public health in Kosovo/a.

According to the DHSW education objective, the IPH would assume responsibility for the manner and materials of health education, which would then be communicated to the municipalities via the District Health Authority (DHA) who would supervise their implementation. At present, however, practical problems such as the maintenance of ambulantas has kept the DHSW from pushing overall health education forward, and progress does not appear likely to improve dramatically in the short term. The provision of health education to minority communities has been variable and in large part depended largely on the activities of NGOs who are now increasingly reducing their operations.

Prevention and Rehabilitation of Disability

A survey by Handikos suggests that 2.5% of the population have some type of physical disability. Community and home-care for these individuals is virtually non-existent. Many are relegated to the home and receive what non-professional assistance might be rendered to them by their family. This is an area of pressing concern to the DHSW and many NGOs, but it remains to be seen whether financial resources and specially trained medical practitioners will be made available to address the problem.

It was found that some physically disabled were not able to access resources that have been made available for them. A child wounded by a mine, for example, will automatically be delivered a wheelchair. The same is not true for an automobile accident or someone cripple from birth. In these instances the family may never be

aware that a programme exists for their child, they may be confused as to how to complete the application, or lack the resources to travel to another location to collect the wheelchair.

Injuries caused by mines and unexploded ordnance will continue, particularly among young males. Through November 2000 there had been 466 register incidents with 103 deaths and 413 wounded.

Drugs and Medical Supplies

Of the 2001 Goods and Services budget (approximately DM 49 million) pharmaceuticals will consume around DM 35 million. They are centrally procured through international tenders and managed by the Pharmaceutical Procurement Unit (PPU). Hospitals receive supplies direct from the PPU. The supply of basic drugs was previously overseen by the international NGO, Pharmaciens Sans Frontières, but it has been effecting its withdrawal from Kosovo/a since January 2001. The responsibility for handling and distributing has been passed to the state pharmacies of Kosovo/a, *Korporata Farmaceutike e Kosoves* (KFK), who supply primary health locations such as state pharmacies, ambulantas and health houses. The state pharmacies are licensed to carry out commercial activities (for other than essential drugs) to enable them to be self-financing.

Pharmaceutical regulation is being developed in recognition of the large quantities of poor quality drugs and illegal drug shops that have opened in Kosovo/a from June 1999 to date. From November 2000, the Kosovo/a Drug Regulatory Authority (KDRA) is charged with ensuring that drugs in Kosovo/a are of good quality and are stored and distributed in a safe manner. KDRA requires presentation of quality certificates for all imported products and is licensing and inspecting all distribution outlets.

The KFK currently faces practical and logistical difficulties in ensuring a supply to minority areas and relies on international NGOs to ensure an adequate distribution of drugs. This arrangement will end in June 2001, when the KFK will be obliged to ensure that their services cover minority needs. The difficulty in negotiating a

workable solution between the KFK and minority groups illustrates the larger problem of 'Kosovarisation' for the health service.

Health Sector Financing

The DHSW initiated a co-payment strategy at point of service in 2000 and continues to develop its collection process, with the exception of some vulnerable groups and limited treatments. The Estimated 2001 budget assumes revenue of DM 12 million from this strategy. The DHSW estimates that an average household spends about 70 DM for drugs, 17 DM for transport, 6 DM for dental care, and 3 DM on inpatient care per year.

Capital investment is restricted to less than 5% of total available resources but it is hoped that international assistance will continue to support essential and DH approved needs through the Public Reconstruction and Investment Programme (PRIP), calculated as DM 170.6 million in 2001-2003.

In addition the DHSW has contracted a Health care financing development study supported by World Bank funds to investigate and then initiate a pre-payment scheme for Kosovo/a. This project will commence in Marc 2001 for a period of 24 months. A second study by the International Labour Organisation (ILO) is investigating the feasibility of developing community insurance schemes. Sis groups, including the Teachers Union and the Mother Theresa Society, are involved in this study and ILO hope to present findings by June 2001.

The two above studies will hopefully allow further analysis of out-of-pocket expenditure. Widespread assumption would indicate a significant proportion of total health expenditure by individuals and households with the DHSW estimating that the figure is higher than public expenditure. Sent against the average income the studies may verity and quantify inequitable access.

Key Health Policies

In February 2001, the DHSW launched their "Health Policy for Kosovo" publication,

the result of considerable inputs from the department and a WHO working group as a follow-up to the "Interim Health Policy Guidelines" of September 1999. Key objectives, based on principles of equity & non-discrimination are:

- Development of Primary Care through 'family health teams'
- Prioritisation of maternal, child and reproductive health care
- Development of referral services
- Reduction of bed capacity and improved efficiency in secondary care
- Development of community based mental care
- Development of IPH capacity in public health
- Introduction of pre-payment scheme
- Development of Human Resources and reallocation of staffing levels
- Regulation of private practice
- Development of bio-medical engineering capacity

The publication does not expand on detailed implementation arrangements or deadlines, but will be progressively formulated throughout 2001 in partnership with the many stakeholders.

Many of its objectives are dependent upon improved capacity within primary and community care, which as already discussed require considerable training inputs and resources in personnel. In the interim any development or rationalisation of services will be affected by the weakness of this sector. The publication does not appear to consider the financial cost of rationalisation and organisational change. Given that government funding is unable to offer these resources there is an expectation that the PRIP initiative to target international assistance for these areas.