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CORRUPTION RISK ASSESSMENT IN THE HEALTH SECTOR IN KOSOVO



UNITED NATIONS DEVELOPMENT PROGRAMME

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**CORRUPTION RISK ASSESSMENT
IN THE HEALTH SECTOR
IN KOSOVO**

FINDINGS AND RECOMMENDATIONS

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ACRONYMS

EDL	Essential Drug List (same as EML)
EML	Essential Medicines List (same as EDL)
EUO	European Union Office in Kosovo
FMC	Family Medicine Centre
GCB	Transparency International's Global Corruption Barometer
GP	General Practitioner
HFA	Health Financing Agency
HIS	Health Information System
CAA	Kosovo Anti-Corruption Agency
KMA	Kosovo Medicines Agency
KUCC	Kosovo University Clinical Centre
KUHCS	Kosovo University Hospital and Clinical Service
MFMC	Main Family Medicine Centre
MOH	Ministry of Health
NGO	Non-Governmental Organization
OAG	Office of the Auditor General
OECD	Organization for Economic Cooperation and Development
OOP	Out-of-Pocket Payment
PHC	Primary Health Care
PPP	Purchasing Power Parity
PPRC	Public Procurement Regulatory Commission
SAEK	Support to Anti-Corruption Efforts in Kosovo program
TI	Transparency International
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
WHO	World Health Organization

I. TERMS OF REFERENCE AND METHODOLOGY

The purpose of this assessment was to conduct an exploratory mission to understand how corruption manifests itself in the health sector in Kosovo¹ and where risks exist. Institutional frameworks for anti-corruption, transparency and accountability in the Ministry of Health (MoH), audit and procurement processes were examined which subsequently identified types of corruption risks.

To accomplish this scope of work, the team has reviewed the available literature and interviewed 36 key institutions representing different levels of health institutions and governance structures. We met with Ministry of Health officials, representatives of the Office of the Auditor General, members of the Parliament, practicing clinicians and managers at the Kosovo University Clinical Centre (KUCC), a hospital and primary health care (PHC) facilities in two municipalities, municipal level health sector managers, representatives of international partner organizations, non-governmental organizations (NGOs), media, and private practitioners [see Annex 1 for list of organizations consulted].

The assessment of risks of corruption in the health sector is based on the World Health Organization (WHO) health systems building blocks framework.² While acknowledging that health systems are highly context specific, WHO notes that most health systems are organized around fundamental “building blocks” including leadership/governance, service delivery, health workforce, information, medical products/vaccines/technology, and financing (Figure 1). This assessment considers the weaknesses in these building blocks and how they may be affected by or facilitates corruption.

Figure 1: WHO Health Systems Building Block Framework



¹ All references to Kosovo are in line with UN Security Council Resolution 1244 (1999)

² World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*. 2007, World Health Organization: Geneva.

Corruption is defined as “abuse of entrusted power for private gain”³. In addition to bribes, this encompasses theft, absenteeism, embezzlement which are sometimes referred to as “quiet corruption,” or the failure of public servants to deliver goods or services paid for by governments.⁴

³ Transparency International, *Global Corruption Report 2006: Special Focus Corruption and Health*. 2006, London: Pluto Press.

⁴ World Bank, *African Development Indicators 2010: Silent and lethal, how quiet corruption undermines Africa's development efforts*. 2010, World Bank: Washington, DC.

II. HEALTH SECTOR ORGANIZATION, REFORMS AND FINANCING

Kosovo is a lower-middle income place with a population of 1.8 million⁵. Kosovo has an estimated €2,700 per capita gross domestic product (GDP), with 29.7% of the population living below the poverty line⁶. The population in Kosovo is young: one third of the population is under the age of 15, and only 6% over age 65⁷. Vital statistics are lower than other Balkan countries, for example, life expectancy in 2007 was 69 years, compared to 76 in Albania and 74 in Serbia; infant mortality was 20.6 deaths per 1,000 live births, compared to 7.8 and 7.1 in Albania and Serbia, respectively⁸.

Kosovo's context affects risks: after the 1999 conflict, health systems and structures needed to be reconstructed and developed, huge influxes of donor aid provided resources (along with coordination challenges) and reform strategies were adopted⁹ also influenced by the donor community. The reform agenda included an emphasis on primary health care/family medicine and attempts to separate payer and provider functions. The Ministry of Health shifted to a regulatory, policy-making, and financing role, while decentralizing operation of health facilities to the municipal level. Yet, due to externally driven reform agendas, compressed timetables for reform, and weak newly established government capacity, reform implementation was slow and incomplete¹⁰.

Problems that the health sector still faced in 2009 included gaps in availability of services, inadequate financial protection, shortcomings in quality of care, and a lack of data to enable health managers to plan or measure progress. The Health Sector Strategy 2010-2014 acknowledged difficulties in planning and allocating resources due to poor information, gaps in accountability due to unclear roles, and major problems in drug supply and health financing.¹¹

A World Bank assessment conducted in 2007 examined accountability in more detail [13]. The study identified flaws that made it difficult to hold managers accountable for performance, including an absence of statistical and management information, inadequately controlled medicine supply, and inflexible, input-based budgeting systems. Budgets did not seem to correspond to actual activity levels or need for spending in

⁵ World Bank. *Kosovo Overview*. 2014 May 15, 2014]; Available from: <http://www.worldbank.org/en/country/kosovo>

⁶ Ibid

⁷ Ministry of Health, *Health Sector Strategy 2010-2014*. 2009, Government of Kosovo Ministry of Health: Prishtina.

⁸ World Bank, *Kosovo Public Expenditure Review. Report No. 53709-XK*. 2010, World Bank: Washington, DC.

⁹ UNDP and USAID, *Action Paper on Healthcare in Kosovo: Satisfaction with Healthcare Services and Perceptions on the Presence of Corruption. Public Pulse Project*. 2013, UNDP, USAID: Prishtina.

¹⁰ Buwa, D. and H. Vuori, *Rebuilding a health care system: war, reconstruction and health care reforms in Kosovo*. *European Journal of Public Health*, 2006. **17**(2): p. 226-230. Also in Percival, V. and E. Sondorp, *A case study of health sector reform in Kosovo*. *Conflict and Health*, 2010. **4**(7): p. 1-14.

¹¹ Ministry of Health, *Health Sector Strategy 2010-2014*. 2009, Government of Kosovo Ministry of Health: Prishtina.

individual facilities. Revenue from patient user fees which was supposed to fund night shift allowances was insufficient and resulted in staff not receiving pay.¹² Such system flaws, combined with a lack of transparency, can raise suspicions of corruption even when the problems are due to overly rigid bureaucracy or poor management.

The Ministry of Health (MoH) has tried to remedy these problems. Table 1 shows the Strategic Objectives of the MoH from 2010-2014. Although the objectives do not specifically mention anti-corruption, they included measures meant to increase accountability and transparency through more clearly defined roles and responsibilities at the institutional and individual level (Objective 2) and better information systems (Objective 4). Improved procurement and drug supply were also targeted (Objectives 1 and 3).

Table 1: Strategic Objectives of the Kosovo MoH, 2010-2014

Objective	Outputs
1. Reduce morbidity and mortality	<ul style="list-style-type: none"> • Health is protected and improved through sustainable public health programs • Capacities strengthened at all levels, with emphasis on Family Medicine & emergency services • Drug supply needs from essential medicines list (EML) are fulfilled. • National disease management plans established
2. Improve resource and quality management	<ul style="list-style-type: none"> • Roles and responsibilities of health institutions, departments/units, and employees are clearly defined, enhancing accountability • Quality standards are implemented • Inappropriate referrals are reduced • Monitoring & evaluation systems are operational
3. Reorganize infrastructure and procurement	<ul style="list-style-type: none"> • Investments are made according to approved Master Plan • Health institutions are supplied with medical equipment which is functional and well maintained, according to EU standards
4. Implement Health Information System	<ul style="list-style-type: none"> • Health information system (HIS) is developed with clearly defined managerial and organizational structures • A phased approach for implementation is designed • Quality of HIS outputs meets WHO and Eurostat standards
5. Develop sustainable funding system for health sector	<ul style="list-style-type: none"> • Health Insurance Law is approved • Lists of basic services, health procedures, norms and standards, and service/procedure costs are established

Source: MoH Strategic Plan 2010-2014

¹² Gaumer, G., *Kosovo Report on Management Accountability in the Health Sector*. 2007, World Bank: Washington, D.C.

Turnover of staff has been a problem, especially in the early years of the strategic plan. According to one key interviewee, between 2009 and 2014 there were three ministers of Health and three General Secretaries, which likely slowed implementation.

The present assessment took place during a period when the Kosovo health sector is embarking on a new phase of reform in the organization, financing and delivery of health care services. The Kosovo Assembly has endorsed five important laws during the past three years including the updated Law on Health (2012/04-L-125), Law on Chambers of Healthcare Professionals (2012/04-L-150), Law on Tobacco Control (2012/04-L-156), Law on Medical Products and Supplies (adopted in March 2014), and Law on Health Insurance (adopted in April 2014). As the laws have now been passed, current activities focus on enabling sub-legal acts and planning for implementation of the reforms. As of April 2013, the MOH approved a regulation which systematizes jobs and clarifies internal organization within the Ministry.

In addition, regulations are being promulgated for the functioning of the Health Financing Agency (HFA) established in Health Law 2012/4-L-125, and for the Kosovo University Hospital and Clinical Service (KUHCS). KUHCS will function as an executive autonomous health care institution comprising secondary and tertiary level healthcare institutions in the public health sector, to be defined by sub-legal act issued by the Ministry. The KUHCS will combine tertiary institutions and regional hospitals along with professional services (organized by service lines), and will be accountable to government through the Ministry of Health.¹³ Ministry personnel are engaged in supporting the development of these institutions and strengthening capacities needed to run them.

An environmental factor which should be considered in light of these plans is the possibility of a change in administration which could result from elections being held in June 2014. This could slow reform as new staff are appointed and need to be brought on board with reform goals.

Health Financing

Most people interviewed for this study believe that the health sector is currently underfunded. Currently all health expenditure is financed from the general budget plus out-of-pocket (OOP) payments by individuals, along with some off-budget donor support. Individuals pay MoH-established user fees for services and non-essential medicines in public facilities.¹⁴ They also seek care in the burgeoning private sector at an array of private pharmacies, diagnostic facilities, private practices and hospitals. In 2009, 7.6% of general government expenditures were on health (compared to 9.6% on average for OECD countries in the same year), total health expenditure was US\$108 (€80), with about 38.5%

¹³ Olofsson, L., *Discussion Paper: The Functionality of the Audit System in the Health Sector and the Needs to Adjust to Reforms*. 2014, Office of the Auditor General: Pristina.

¹⁴ Health Agency for Development, *The evaluation of antibiotic prescription in the primary health care setting of Kosovo*. 2013, World Health Organization, Kosovo: Pristina.

of spending private.¹⁵ The Kosovo Household Budget Survey 2012 found consumption per household of 7,657 €, with 45% spent on food, 30% on housing, and 2% (€153) on health.¹⁶ This is slightly lower than the 2.3% of total consumption expenditure on health reported in 2008.¹⁷

One of the government's goals is to establish universal access to health services. Insurance is expected to help increase the funding available for health, create efficient risk pooling to assure financial protection and equitable access to care, and align incentives through provider payment mechanisms to improve health care delivery. In the past, OOP posed an unfair burden on the poorest populations: the poorest quintile spent 13% of their total expenditures on health, compared to only 4% for the richest quintile, and researchers estimated that OOP health payments increased the incidence of poverty by 15%.¹⁸ Health insurance is also expected to reduce the risk that catastrophic payments¹⁹ for health care will push households into poverty.

¹⁵ World Bank, *Kosovo Public Expenditure Review. Report No. 53709-XK*. 2010, World Bank: Washington, DC. Also in OECD, *Health expenditures in relation to GDP*, in *Health at a Glance 2011: OECD Indicators*, OECD, Editor. 2011, OECD Publishing.

¹⁶ Kosovo, *Results of Household Budget Survey 2012. Series 5: Social Statistics*. 2013, Kosovo Agency of Statistics: Pristina.

¹⁷ World Bank, *Kosovo Public Expenditure Review. Report No. 53709-XK*. 2010, World Bank: Washington, DC.

¹⁸ Bredenkamp, C., M. Mendola, and M. Gagnolati, *Catastrophic and impoverishing effects of health expenditure: new evidence from the Western Balkans*. Health Policy and Planning, 2011. **26**: p. 349-356

¹⁹ Note: catastrophic payments according to the World Health Organization refers to when people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household."

III. CORRUPTION RISKS IN THE HEALTH SECTOR

Table 2 summarizes the areas of vulnerability to corruption according to the WHO Health Systems Building Blocks Framework. The most salient corruption risks are discussed further in the body of the report. These include:

- Informal payments made outside official fees for services or supplies.
- Personnel issues, including private practice by public employees outside allowable bounds;
- Medicines, including corruption in procurement and theft of drugs.

In addition, we discuss the current situation of audit, complaint mechanisms, and citizen engagement, as institutions and processes for prevention.

1. Informal Payments

An informal payment is defined as “a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to”.²⁰ Informal payments include both gifts and bribes; although payments demanded by providers (conditioned payments) are more concerning, even gifts can pose financial barriers to access and may be perceived as obligatory.²¹

Earlier reports identified the problem of informal payments in Kosovo.²² Most of these reports do not provide data on the frequency or magnitude of informal payment; however, Percival and Sondorp (2010) discuss a World Bank study in 2000 which found that 28% of respondents could not access needed care due to financial barriers, and over 95% reported paying OOP, including an average of 5 Euros in ‘gifts’ to healthcare providers. Another report described patients paying informal payments to health staff working in public facilities and for the purchase of drugs which should have been provided but were out of stock [8].

Table 2: Areas of Vulnerability to Corruption in Health in Kosovo

Health System	Activities	Corruption Risks	Assessment data from Kosovo
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²⁰ Gaál, P., M. Jakab, and S. Shishkin, *Strategies to address informal payments for health care*, in *Implementing Health Financing Reforms: Lessons from Countries in Transition*, J. Kutzin, C. Cashin, and M. Jakab, Editors. 2011, World Health Organization: Geneva. p. 327-361.

²¹ Jancsics, D., *Petty corruption in Central and Eastern Europe: the client's perspective*. Crime, Law, and Social Change, 2013. **60**: p. 319-341. Also in Miller, W., A. Grødeland, and T. Koshechkina, *If you pay, we'll operate immediately*. Journal of Medical Ethics, 2000. **26**: p. 301-311.

²² See in Bredenkamp, C., M. Mendola, and M. Gagnolati (2011). Also in Jancsics, D., *Petty corruption in Central and Eastern Europe: the client's perspective*. Crime, Law, and Social Change, 2013. **60**: p. 319-341.

Building Block			
Leadership and Governance	Policy making; legislation; regulatory functions	Regulatory capture; conflict of interest at highest levels; grand corruption; bribes or influence used in drug registration and licensing/control of quality of drugs; lack of standards or regulatory control of public and private facilities	World Governance Indicators suggest that overall governance is weak in Kosovo. In 2012, Kosovo scored -0.39 in government effectiveness and -0.62 in control of corruption on a scale ranging from +2.5 to -2.5. The current Minister of Health has shown skill in getting major health legislation passed supported by national and international stakeholders. Most key interviewees thought the policies were appropriate, but implementation was a problem. Politicization in general including justice and health system affects selection of staff and good governance. Previously, senior staff (including past director of Kosovo Medical Agency, a Secretary General) were arrested for misuse of position.
Service Delivery	Provision of services by frontline health workers; coordination by managers	Informal payments; referring patients to private practice; absenteeism; theft of supplies or equipment	Early articles mentioned the problem of informal payments, but recent data seem to indicate lower rates (between 4-16% depending on the source). We did not talk to patients directly for this study. Much concern is about doctors referring patients to their private practice, and being absent during working hours to work in private clinics. Key interviewees mentioned risk that financial incentives are used to get doctors to refer patients to specific pharmacies or other ancillary services.
Human Resources	Selection, posting, training, promotion, and disciplining of	Favoritism in hiring and promotions; mission inconsistent	Staffing decisions are seen as influenced by politics. No concerns were raised about buying or selling jobs. Impunity is an issue; people are not held accountable for

	staff	posting and transfer practices (i.e. incompatible with professional ethics)	performance.
Medicines and Technologies	Selection, procurement, distribution and use of medicines	Bribes add to selection lists; financial relationships between doctors and private pharmacies; over-treatment for financial gain; procurement corruption (collusion among bidders, kickbacks, sharing of confidential information in favor of certain bidders)	Drugs are in short supply. Facilities may receive <50% of their request. It is not clear if drugs were never bought (due to budget shortfalls) or were diverted for sale in private sector, or both. Past MoH staff have been accused in medicines corruption (hospital pharmacy director). MoH has recently initiated pharmaceuticals procurement reforms (Jan 2014). Economic operators now distribute drugs for secondary and tertiary level directly to facilities based on requests of the hospitals and approval of the Health Financing Agency. Shortages of drug supplies may be due to small quantities requested by the health institutions and weak penalties/safeguards set in contracts for supply delays. In procurement there is high staff turnover, inadequate numbers of staff, and possible lack of capacity for technical oversight (i.e. quantification of need, setting specifications). Irrational use is a problem and there are concerns about financial motivation for prescribing and referrals.
Financing	Resource allocation, collection of user fees, insurance, contracting	Leakage of official fee revenue; embezzlement of budgeted funds; insurance fraud	Newly adopted laws, for example those related to the health insurance fund and KUHCS, mean that systems will be changing. The insurance regulations should consider fraud control measures. Contracts with providers should hold facilities accountable for control on individual providers asking for

			informal payments. Improvement of capacities for cost effective planning, procuring and monitoring and evaluation at the MoH as well as at the Health Financing Agency are needed.
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According to Transparency International (TI)'s Global Corruption Barometer (GCB) 2013, 70% of people surveyed in Kosovo thought that medical and health care institutions were corrupt or very corrupt, while 16% of people who used those services reported having to pay bribes. Kosovo's rate of bribe-paying is lower than Bosnia & Herzegovina, Greece, Romania and Serbia, but higher than Bulgaria, Croatia, and Turkey (Figure 2). Figure 2 also shows that the proportion of people who think the health sector is corrupt is routinely higher than rates of experienced bribe-paying. This may be because other types of misuse of power besides bribes factor into patients' perceptions of corruption at the sector level (e.g. theft of medicines, over-treatment for financial gain, nepotism, etc.).

The 16% bribe-paying rate in Kosovo and high perceptions of corruption are in contrast to *Action Paper on Healthcare in Kosovo: Satisfaction with Healthcare Services and Perceptions on the Presence of Corruption* conducted by UNDP with USAID funding which found that over 70% of patients were satisfied or very satisfied with services, and only 4% of respondents were solicited for a bribe during their most recent visit²³. Demographics may be a factor: older respondents are more likely to be satisfied with services²⁴, and the UNDP study had a sample which was somewhat older than the population average (16% of survey respondents were older than 65, while this category accounts for only 6% of the population). In addition, a large proportion of patients (44%) who sought care at KUCC refused to answer the question on satisfaction, possibly due to fear that appearing critical would have a negative effect on future care. According to one key interviewee who has done survey research on the quality of care in Kosovo, patients sometimes feel reluctant to answer honestly due to fear of disrespecting their doctor. This interviewee noted that while patients initially gave high ratings to quality of care in a survey, later sub-questions revealed that providers were not adhering to quality standards. In other words, patients may lack the knowledge to evaluate quality.

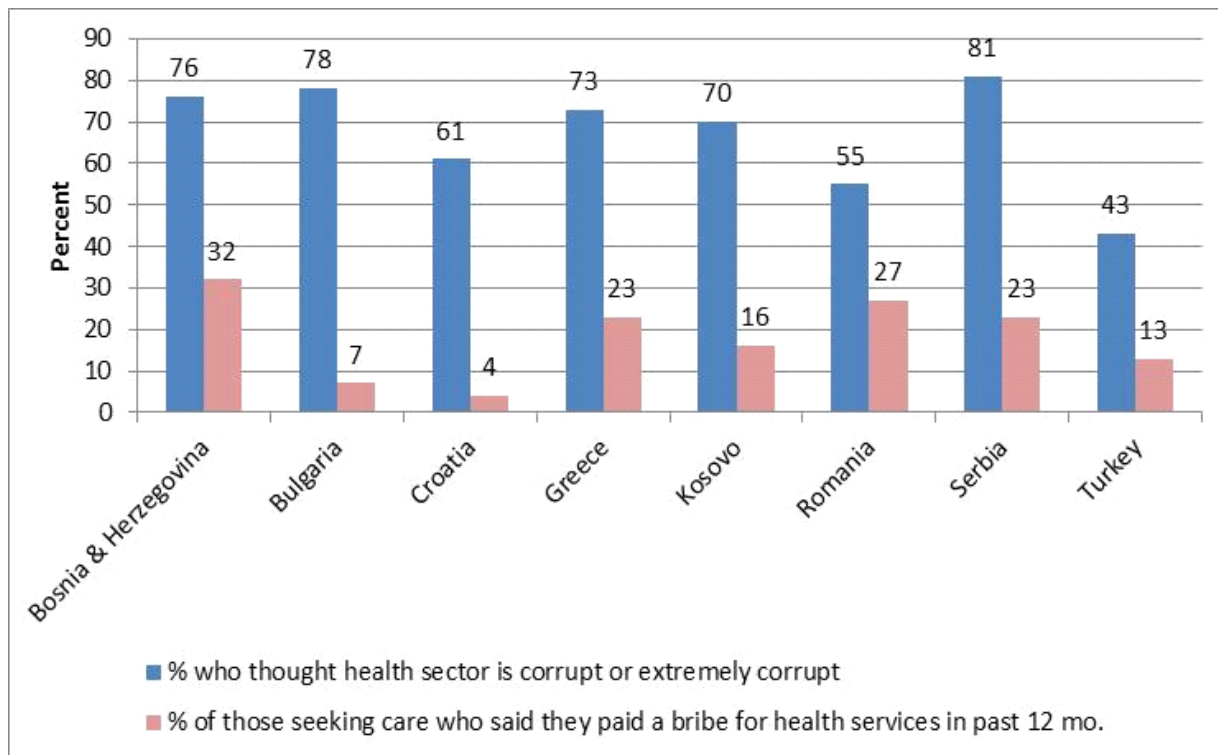
It is also possible that the people who are most dissatisfied with services are opting out of the public system altogether and are now using private services. This leaves those who are poorer, and less able to pay informal payments, as the main users of public services. Analyzing data from Croatia, one study found that citizens' perceptions of corruption can lead to distrust of government's ability to meet their demands and lower perceived quality

²³ UNDP and USAID, *Action Paper on Healthcare in Kosovo: Satisfaction with Healthcare Services and Perceptions on the Presence of Corruption*. Public Pulse Project. 2013, UNDP, USAID: Prishtina.

²⁴ Nikoloski, Z. and E. Mossialos, *Corruption, inequality and population perception of healthcare quality in Europe*. BMC Health Services Research, 2013. 13(472).

of care, which in turn leads patients to avoid seeking care in the public sector if they can find and afford private options.²⁵

Figure 2: Transparency International Global Corruption Barometer 2013 Data on Perception of Corruption in the Health Sector and Bribe-Paying Experience



People may be giving gifts (such as offering lunch to all staff to celebrate a birth), which is considered different from bribes. Examining the specific local language terms used on the two surveys might help probe this issue.

Key interviewees in the Ministry of Health thought that informal payments could be occurring: “In the whole world, they happen. They can happen in Kosovo, too.” Low salaries of medical personnel are thought to be one driver of informal payments²⁶; yet, in Kosovo doctors’ salaries were recently increased by 30% in 2011, and again by 30% in 2012. The average salary of a doctor is now 650 euros/month, though with duty allowances this salary could go up to 900 euros/month (1,233USD/month, or \$14,796/annual), while a nurse makes 340-400 euros/month. The average salary for a general practitioner (GP) in an analysis of six OECD countries was at least \$29,000 per year, suggesting that salaries are still low, although an appropriate comparison would be to examine doctors’ salaries

²⁵ Radin, D., *Does corruption undermine trust in health care? Results from public opinion polls in Croatia*. Soc Sci Med, 2013. **98**: p. 46-53.

²⁶ Lewis, M., *Informal payments and the financing of health care in developing and transition countries*. Health Aff (Millwood), 2007. **26**(4): p. 984-97.

compared to the average wage rate in Kosovo. A 2008 study comparing remuneration of GPs to the average wage in 14 OECD countries found that remuneration of GPs varies from being 2 times greater than average wage in Finland and Czech Republic to 3.5 times greater than average wage in the United States and Iceland.²⁷

Conclusion: Out-of-pocket payments appear high in the health sector, and this is a problem for access to care. The rate of informal payments may be between 4-16%, which is lower than Albania but still could be a cause for concern. The average rate of informal payment may obscure differences in rates of informal payment for different types of services: in many countries, informal payments are more frequent and larger for serious illnesses which require hospitalization and surgery.²⁸ Better data is needed to evaluate whether this is the case in Kosovo. It should be a high priority to conduct a study of the frequency and magnitude of out-of-pocket and informal payments to evaluate whether intervention is needed.

2. Personnel Issues

Besides informal payments, people raised four other important personnel management issues: politicization of appointments and lack of management capacity; inappropriate shifting of patients to private sector because of dual practice by doctors; financial conflicts of interest which may be affecting prescribing of medicine; and absenteeism.

Politics is thought to be an important factor when selecting agency or committee leaders, even when the agency or committee should be apolitical. For example, according to one key interviewee the Kosovo Medicines Agency (KMA) has had five Chief Executive Officers over the past 10 years: *“Just when a leader has gotten to know the organization, he or she is replaced. This is disruptive to development and the effectiveness of the organization.”* Another key interviewee gave an example related to commissions formed to screen job applicants: it appeared that the commission members exercised favoritism, and that rules in place to assure merit were seen as ineffectual. A third key interviewee described how under an MoH-managed project with donor funding, four project management staff were abruptly fired, seemingly without cause, and replaced with less qualified staff. A fourth person observed that each new municipal mayor makes unrealistic promises related to the health sector: a new mayor may promise new facilities and actually build them, but then expects the ministry to pay for running costs and MoH supply them with medicines, when the sector really needs less new facilities and more attention to repairing existing ones.

²⁷ Fujisawa, R. and G. Lafortune, *The remuneration of general practitioners and specialists in 14 OECD countries: what are the factors influencing variation across countries?* Health Working Paper DELSA/HEA/WD/HWP(2008)5. <http://www.oecd.org/health/health-systems/41925333.pdf> 2008, OECD

²⁸ Lewis, M., *Informal payments and the financing of health care in developing and transition countries*. Health Aff (Millwood), 2007. **26**(4): p. 984-97. Also in Vian, T., et al., *Informal payments in government health facilities in Albania: results of a qualitative study*. Soc Sci Med, 2006. **62**(4): p. 877-87.

Due in part to politicization, the cadre of skilled managers may not necessarily be part of the Kosovo health sector. Key interviewees mentioned that reforming institutions is not the same as changing mentality, and a challenge in the health sector is the lack of personal accountability: *“People need a lot of watching and monitoring...they don’t feel responsible for reporting on time,”* said one interviewee. Other interviewees described poor communication skills and a failure to delegate responsibility, which is demotivating for younger staff. One interviewee noted that ministry staff lacks capacity to prepare project proposals and cannot manage teams. These issues contribute to poorly functioning management control systems, which make it less likely that abuses will be detected and sanctioned.²⁹ We did talk to some very motivated hard working senior managers of PHC services at the municipal level, so although depth of management expertise is a problem, there are skilled officers available.

A second personnel issue is physicians who are practicing in both the public and private sector, creating risk of inappropriate referrals to private services. One doctor estimated that 20-30% of doctors in his regional hospital also work in the private sector. The Kosovo Parliament tried to separate public and private practice through the Health Law, which forbade doctors from working in private clinics if they were employed in government service. But a case was brought to the Constitutional Court which ruled that not allowing doctors to practice in the private sector if they wanted to do so outside of normal government working hours was considered against the “rights for work and practicing profession”, and as a result the Health Law was changed to allow dual practice.

Several interviewees noted that this is an area where abuse may be likely, as physicians earn more from private practice, and therefore have an incentive to divert time and resources there. One key interviewee thought that medical staff might even be sabotaging equipment in public facilities, or at least neglecting maintenance and repair, so that patients are forced to go to the private sector to seek care. Another key interviewee mentioned that doctors come late or leave early for their private clinics, and that they encourage public patients to see them in their private practice in order to receive better quality care. This is not allowed under Article 41 of the Health Law (see Table 1).

The third problem is physicians who have financial interest in private ancillary services, including pharmacies. This also is prohibited by the Health Law, but several key interviewees said that they thought there were some cases of financial interest. *“A doctor might tell a patient to go to a certain pharmacy [for personal gain] but a doctor wouldn’t harm a patient,”* said one interviewee. Another key interviewee from the private sector admitted that in the past doctors had asked if they could receive a kickback for referral of patients to his ancillary service.

²⁹ Gaumer, G., *Kosovo Report on Management Accountability in the Health Sector*. 2007, World Bank: Washington, D.C.

Absenteeism

We did not see records and could not establish rates of absenteeism during this assessment, but several people mentioned absences of doctors (as mentioned earlier). The MoH and regional hospitals have electronic monitoring system for daily work attendance, as well as signature sheets. This allows supervisors to know who is not present. In addition, for the first time in 2013 the MoH has allocated money to health institutions to reward the best health workers according to criteria such as productivity and patient satisfaction.

Conclusion. Possible problems related to personnel include politicization of appointments (which may indicate patronage), negative effects of dual practice of medicine (such as over-treatment and increased OOP by patients), financial kickbacks or conflict of interest in ancillary service use and prescribing, and absenteeism. Key interviewee interviews could not provide a lot of data on any of these problems, but the risks of over-treatment and financial conflicts of interest have been identified in other countries, and should be considered risk areas in Kosovo.

3. Medicines

The medicine supply chain includes processes for selection, procurement, distribution, and use of medicines in the treatment process. Government offices and publicly-employed staff are involved in all these activities, as well as in regulating the quality and safety of medicines through licensing of medicines and pharmacies. Corruption can happen at all stages of the supply chain, from bribes to influence the selection of medicines to procure, artificially exaggerated estimates of need in order to maximize kickbacks on orders, bribes in the tendering process which inflate cost, collusion to rig bids, theft of medicine supply during distribution and storage, and improper promotion practices which influence prescribing practices and promote irrational use of medicines.³⁰ Below we make observations about the strength of the public pharmaceutical systems in controlling against corruption. Table 2 (page 13) summarizes key risks.

In 2012, four people in the MoH, including the General Secretary and directors of Quality Assurance, Pharmacy, and Procurement were arrested and charged with abuse of position. The General Secretary and the Chief of the Quality of Care Division were found guilty, and others were acquitted. In addition, the Director of the Central Pharmacy at the KUCC was arrested on 14 April 2014 for misuse of official position. This is important context as previous evidence of illicit activities is an indicator of heightened risk.³¹

³⁰ Cohen, J.C., M. Mrazek, and L. Hawkins, *Tackling corruption in the pharmaceutical systems worldwide with courage and conviction*. Clin Pharmacol Ther, 2007. **81**(3): p. 445-9. Also in World Health Organization, *Measuring transparency in the public pharmaceutical sector: Assessment instrument*. 2009, World Health Organization: Geneva.

³¹ Klitgaard, R., *Controlling Corruption*. 1988, Berkeley, CA: University of California Press.

Selection and Procurement Processes

Selection

Health Law No. 2004/4 establishes that the government budget should be used to purchase drugs from the essential drug list (EDL) determined in the official register, and that this list of medicines will be provided to all health care levels (S. 27.5). In Health Law No. 2012/04-L-125, Article 3 definition 1.16 refers to the “List of drugs and medical consumables” as a list of medical products and medical consumables covered by the Government and by co-payments. It is likely that these two names refer to the same list. Over- and under-inclusion are indicators of possible corruption. Over-inclusion relates to the inclusion of expensive “me-too” medicines on the list (an excessive number of statins, for example), or under-inclusion of effective, inexpensive drug options. Pharmaceutical companies may pay bribes to have their drug added to the list or to exclude inexpensive competitor medicines.³² To our knowledge, no specific analysis of the list has been conducted. The director of the central pharmacy was accused of having inappropriately changed the list of medicines to include a more expensive medicine (see note 14, referred to as the “Palonosetron case”).

According to one study, guidelines for how to establish necessary drugs were lacking prior to 2013, resulting in the procurement of some drugs that were non-essential and costly.³³ The HFA has conducted analyses VEN/ABC to try to rationalize the selection of medicines, and prescribing restrictions are being put in place to reduce the prescribing of non-essential medicines.

Procurement

Law on Public Procurement in Kosovo No. 04/L-042 establishes the Public Procurement Regulatory Commission (PPRC) as having primary responsibility for overall functioning of public procurement rules and system in Kosovo, with 173 contracting authorities (including the MoH, KUCC, and the municipalities) performing procurement activities [33]. The PPRC assures transparency and provides an internal mechanism for accountability in procurement. It produces an annual report analyzing activities of public procurement in Kosovo, available in 3 languages - Albanian, Serbian, and English. The web site publishes all tenders and related procurement documents, and had 8,400 unique visitors per day in 2013. According to the PPRC, health related procurements (MoH, hospitals, and other health related agencies such as the Institutes of Public Health, but not counting municipalities) numbered 1,185 in 2013, or 9.4% of the total number, with a value of €25.3 million, or about 5.7% the overall total value of procurements for Kosovo.

In 2013, the PPRC gave a total of 35 written interpretations of rules, 368 interpretations through email, and 1,073 interpretations of rules over the phone, and offered training for 648 officers. According to key interviewees, the Ministry of Health is a contracting agency

³² Meagher, P., O. Azfar, and D. Rutherford, *Governance in Bulgaria's Pharmaceutical System: A Synthesis of Research Findings. A report to USAID*. 2005, IRIS Center, University of Maryland: Maryland.

³³ Health Agency for Development, *The evaluation of antibiotic prescription in the primary health care setting of Kosovo*. 2013, World Health Organization, Kosovo: Pristina.

that frequently requests advice in order to follow the rules correctly. This may be due to recent problems which resulted in the removal of some staff and charges of corruption which are still being adjudicated.

The PPRC annual report tracks detected violations of the law by article. The report cites many types of violations, from not honoring tender time limits for price quotation, to mistakes in statement of need, failure to publicize procurement properly on the web site of PPRC, evaluation of a bid more than 96 hours after public opening of bid, or use of an improperly formed evaluation committee. The report does not distinguish the motivation of these violations, so it is not possible to distinguish corruption from mismanagement, nor are violations tabulated by contracting agency so we cannot compare the health sector to other sectors.

One key interviewee from the MoH noted that the review process for procurement has improved over time, observing that in 2013 there had been 4-5 complaints, compared to tens of complaints in past years. However, another key interviewee thought procurement oversight did not function well, and that procurement officers sometimes feel “pressure to accept bad procedures.” A key interviewee mentioned that setting specifications for tender is a place where corruption can happen in Kosovo, and that diversity in working group membership is needed to provide checks and balances.

A study sponsored by WHO found that the quantities of medicines procured by the MoH were not calculated in a systematic way prior to 2013.³⁴

Decentralization of health procurement

Until December 2013, procurement was centralized at the MoH. Since January 2014, the MoH continues to procure essential medicines for distribution to the Main Family Medicine Centers (MFMC) and service delivery points below. These medicines are procured from the EDL and distributed by the economic operators on a monthly or bimonthly basis. For hospitals, procurement procedures are still initiated at the central level, but contract management functions and ordering through framework contracts has been **decentralized** to facilities. The MoH Pharmaceutical Division now requires less warehouse space, as medicines are delivered directly to hospitals, though storage capacity is still needed for the medicines and vaccines procured at the central level and going to MFMCs.

Hospital facilities estimate the quantities and types of medicines needed, and submit their requests to the Health Financing Agency (HFA), whereas the facilities at the primary health care level submit their needs through the MoH Pharmaceuticals Division, which sends the request to HFA. The HFA consolidates requests, makes sure that the medicines are registered and on the EDL, assures that financial resources are available, and then initiates procurement procedures through the MoH Procurement Division in accordance with the Public Procurement Law.

³⁴Ibid

Decentralization of procurement is often intended to increase accountability and flexibility.³⁵ As this reform is being implemented as of January 2014, the results in practice are unclear. Some key interviewees thought that decentralization may prevent the MoH from being able to reallocate medicines easily between facilities. Others noted that in the short run, the move to decentralization has reduced the average quantities being ordered and resulted in stock-outs.

A major problem in procurement of medicines according to all key interviewees we interviewed is that the budget is inadequate for needs. According to one key interviewee, in 2008 the government was able to procure 87% of the medicines requested by facilities, but in recent years the shortfall has grown. Key interviewees told us that budget was enough to procure only 13% of requested materials and 21% of requested essential medicines in the first quarter of 2014 at KUCC; only 50% of medicines requested in one regional hospital visited; and only 30-35% of PHC medicines in a municipality. One key interviewee indicated that this may be due to initial difficulties in the reform process, but a major cause is inadequate funding. According to the HFA, government is spending € 21.7 million for medicines, not including cancer medicines. The aforementioned VEN/ABC analysis results are being used to rationalize procurement of medicines and reduce mismanagement. But patients must purchase most of the medicines used for treatment. According to another key interviewee, 85% of total OOP spending is on medicines.

Other problems mentioned which may increase procurement risks are 1) low numbers of procurement officers and high staff turnover, and 2) procurement oversight agencies do not really understand health. First, a key interviewee at the Public Procurement Regulatory Commission noted that the MoH has the highest turnover of procurement staff of all the Ministries, which has had an impact on institutional development. According to the key interviewee, people leave to accept better jobs, open private agencies to help economic operators to prepare tendering documents, or they change their working position because they are being investigated. Ministry of Health corruption cases related to procurement have made current staff more cautious, and since the MoH budget is smaller now due to decentralization, the number of procurement problems has also declined.

The second procurement risk is that PPRC staff are not health experts, which makes some oversight tasks more difficult. One key interviewee complained that the Government of Kosovo treats all procurement alike, whereas medicines and medical device procurement has special needs and risks. Delaying procurement for bureaucratic reasons can mean that life-saving drugs are unavailable, or that they are delivered late and have a shorter shelf-life and expire before they can be used. The PPRC cannot easily determine whether the quantities being procured are reasonable, or evaluate the technical specifications of medicines and medical devices to determine if procurement is being targeted to particular vendors.

³⁵ Dickens, T., *The World Medicines Situation 2011: Procurement of Medicines*. 2011, World Health Organization: Geneva. Also in Shaw, A., *Corruption and decentralized public governance. World Bank Policy Research Working Paper 3824*. 2006, World Bank: Washington, DC.

Distribution

Under decentralization of pharmaceutical supply, more of the distribution function will be outsourced to suppliers. Yet the MoH will still need to keep records and use proper stock taking procedures at the individual facility level, and, in the case of medicines for primary care facilities and vaccines, in the MoH central warehouse. The World Bank assessment of management accountability in 2007 noted the absence of good control systems for medicine supply,³⁶ and one key interviewee with expertise in procurement said that “Supply is not going well, in my opinion; there are obstacles in all parts of the supply chain.”

Several key interviewees mentioned concern about diversion of supply for sale in the private sector. An article in the local *Gazeta Tribuna* newspaper highlighted this problem. The article reports on diverted supplies of contraceptives funded by UNFPA which were being offered for sale in private pharmacies [36]. On investigation, it appeared that the main warehouse was eight months behind in record keeping, which created vulnerability for theft. Little action appears to have been taken since the article appeared, showing a lack of follow-up once a problem is detected. Another key interviewee thought that other hospital products might also have been leaked including oxytocin (used to induce labor and control bleeding after delivery).

Use

WHO estimates that worldwide, more than half of all medicines are inappropriately prescribed, dispensed or sold [37], and Kosovo is among the top 10 countries with highest antibiotic use in Europe resulting in bacterial resistance 2.5 times higher than in other European countries [15]. Improper promotional activities by the pharmaceutical and medical device industries can promote irrational use of medicines, through referral or prescribing kickbacks, biased continuing medical education, and speaking fees, gifts or other benefits (foreign travel, meals) to providers [38]. Some key interviewees thought that clinical guidelines and audit mechanisms are currently lacking in Kosovo; however, the HFA has been developing treatment standards as part of the move to implement contracting under the National Insurance Program, so this may change in the future.

Conclusion: Regulatory controls on procurement seem to be in place and working (as measured by violations and complaints recorded), although many people still complained about problems with procurement rules and delays. Lack of staff and staff turnover are a problem, and oversight bodies do not have health expertise. Problems in the drug supply and distribution system result in stock-outs and it is not easy to distinguish the reasons for the stock-outs. Theft of drugs may be a problem, but it is hard to know for sure. Some measures are in place to promote transparency in procurement (e.g. annual procurement report made public in the PPRC web site), but more efforts could be made to promote transparency specifically in medicines supply. Kosovo should conduct a national assessment of transparency in medicines using a more in-depth methodology (see for example the WHO transparency assessment instrument <http://www.who.int/medicines/areas/policy/goodgovernance/phase1/en/>)

³⁶ See in Gaumer, G. (2007)

4. Audit and Complaint Mechanisms, and Citizen Engagement

Audit and complaint mechanisms are important anti-corruption strategies. This section describes the audit process and complaint mechanisms in place currently, as well as media and civil society transparency initiatives meant to promote citizen engagement.

Internal audit

The Internal Audit function is intended to increase value for money and conserve resources by identifying internal control deficiencies, improving risk management and regulatory compliance, and improving governance. The KUCC, the MOH, and municipalities all have separate internal audit offices. The MOH internal audit division includes three auditors working under a director who reports to the Minister. In the past year, audit reports have produced findings including: 1) accounts payable delays (rent owed by the contractor responsible for catering services) at Gjilan/Gnjilane Hospital which meant that funds were not available to pay on call duty and night shift staff³⁷; 2) bottlenecks in contracting a repair company to repair the CT scanner at Mitrovica Hospital, which resulted in patients having to seek care in the private sector or at KUCC; and 3) stock-outs of psychotropic medicines needed to treat patients at the Mental Health Centre in Gjilan. The audit staff document and analyze problems and propose solutions to managers.

The Auditor General of Kosovo conducted an assessment of the MoH's audit system in 2014 and found that the internal audit system in the health sector was not sufficient to assure that internal controls are being implemented in line with goals and that risk is being adequately managed [14]. Issues raised in the assessment included:

- Lack of human resources (quantity and capacity);
- Little or no cooperation between the different internal audit units (Ministry, KUCC, municipalities);
- A dysfunctional Audit Committee with continuously changing membership and irregular meetings;
- Inadequate coverage of statutory external audit over the different levels of the health care system.

In summary, the Auditor General (AG) did not think that the current audit system was robust enough to handle the further delegation of responsibilities envisioned by the health reforms now taking place. The AG recommended two options for reorganizing the audit function. The first alternative is to establish a single Audit Unit within the Ministry responsible for audits in the entire health sector and reporting to the Minister. The single unit would be supported by three separate Audit Committees (in the MoH, KUCC, and HFA). The second alternative is to establish and strengthen 3 separate Audit Units (MoH, KUCC,

³⁷ Hospital used the income from the rent of premises for catering services to pay the on call duty and night shift staff.

and HFA) with additional personnel of higher qualifications. In this case, two of the units would not report to the MoH. These alternatives are now being considered. The AG also recommended statutory external audits of all four main actors in the health system, including MoH, HFA, KUHCS, and the municipalities (for primary health care). Currently there are no legal obligations specified for external audit in HFA.³⁸

Health inspectors

Inspectorate staff (currently 11, with 5 staff added in 2013) conducts regular inspections to assure the quality of care, monitor the behavior of doctors and assure adequate treatment of patients. They also receive and act on complaints from patients. Most complaints are about long waiting times or absenteeism (patients arrive at a facility but the doctor is not present); others are about inadequate quality (for example prescribing of diagnostic tests without actually seeing the patient at the admission in hospital, poor outcome of surgery, etc.). If a patient has a complaint about corruption, he or she will generally go to the police, who may contact the Inspectorate staff for help in investigating. The Inspectorate staff generally does not deal with problems of drug supply, as there are Pharmaceutical Inspectors who are responsible for this.

Complaint boxes and hotline

There are complaint boxes in all health facilities. The content of the complaint boxes is reviewed at the facility level. In addition, the MOH has established a 24/7 telephone line where patients can complain. Currently the MOH receives about 30-40 complaints per month. These complaints are reviewed daily by the Human Rights officer at the MOH and referred to the appropriate unit, e.g. Health Inspectorate, Ethics Committee of MOH, disciplinary commission at facility level, etc. If a complaint is sent to the Health Inspectorate, they will often visit the facility to discuss the complaint with the manager. A report is created which is sent to the Deputy Minister and Minister of Health. A summary analysis of activities of the Inspectorate is provided on a quarterly and annual basis, including information on complaints.

Media and transparency initiatives

www.kallxo.com, is an online platform managed by Internews Kosova (NGO), UNDP SAEK's implementing partner, where citizens can report corruption. Categories include crime, fraud, and abuse of position, negligence, and public endangerment. Since 2004 there have been 3,168 cases reported, out of which 167 were related to health care (5.3%). The kallxo.com team checks facts and, if verified, they produce a TV segment or an article about the incident, or will lodge a formal complaint with the concerned institution. A link to www.kallxo.com appears on municipal government web sites. Central ministry web sites are seen as less dynamic, but kallxo.com would be willing to work with the Ministry of Health to host a link. Examples of some health-related cases include a Family Medicine center that was inexplicably closed for a month (after the complaint was investigated, the center re-opened), and special needs children who were not receiving educational

³⁸ See in Olofsson, L. (2014)

services to which they were entitled due to coordination issues between the Ministry of Health, Ministry of Education, and municipalities.

We also met with the developers of a searchable public database of public and private providers <http://kerkomjekun.com/>, to assist patients in choosing a licensed doctor or other service provider based on information like location, office hours, services offered, gender, languages spoken, etc. The website launched in November 2013, lists more than 150 providers, and has about 150 visitors a day. The developers hope to incorporate an institutional rating scheme to record patient feedback on dimensions such as waiting time, cleanliness, and other dimensions. This information could be shared with policy makers. The idea is to foster competition among providers, which will result in better service for patients, and to enhance accountability and transparency. Kosovo has high internet penetration: the number of homes with internet increased from 72% in 2012 to 77% in 2013.

Although media plays an important role as external watchdog, many key interviewees felt that media were distorting citizen perceptions by exaggerating problems or reporting unevenly. Media also produce shows on police and the courts which not only expose possible malfeasance, but also try to educate citizens about positive things done by police officers in an effort to build public trust in government. It would be interesting to consider a similar effort to strengthen the trust in the health sector.

IV. CONCLUSION AND RECOMMENDATIONS

This assessment focuses on risks of corruption in the health sector based on key interviewee interviews and review of literature. We have used the WHO building blocks framework as a way to structure our analysis and assess vulnerabilities to abuse of power in the functional areas of service delivery, human resources, medicines, financing and information.

Our analysis revealed that health systems are rapidly changing due to current health reform efforts. This provides both risks and opportunities. Corruption thrives when procedures and expectations are unclear, therefore a strong communication strategy promoting the reforms to the public is required. In addition, new reforms such as the health insurance fund will create opportunities for new types of corruption, such as reimbursement system fraud. Yet, the new reforms also hold promise of increased financing, access to care, and more accountability for performance on the part of health providers contracted by the Health Insurance Fund. Installing an internal audit system at the municipal and central level would be of a paramount importance for the success of the reforms.

The media has an important role in educating citizens about the consequences of corruption, raising awareness of patient rights and channels for redress of grievances, and in promoting active debate on health policy issues. The media should play a watchdog role, and other groups that created web sites to promote health sector transparency (e.g. www.kerkomjekun.com, www.kallxo.com). Yet, health officials complain that media play too adversarial a role and are sensationalizing corruption. This may be making citizens lose faith in government and could make public engagement less likely. Citizens should become involved in efforts to hold government accountable, and more collaborative citizen participation could be helpful.

Our report observes areas where there are suspicions of corruption, but often what is perceived as corruption can also be mismanagement, ineptitude, or lack of resources. For example, OOP seem high in the health sector, in part due to the failure of public systems to provide adequate drug supply or quality services. Patients who should be able to access care in government facilities are therefore compelled to seek care in the private sector. This is not corruption, but providers who practice in both the public and the private sector may take advantage of this situation by actively recruiting patients to their private practice. Between 4-16% of patients paid a bribe when seeking care in a public facility. This rate is an average for outpatient and inpatient care settings, and the rate is probably higher for illnesses requiring surgery or hospitalization.³⁹

³⁹ Lewis, M., *Informal payments and the financing of health care in developing and transition countries*. Health Aff (Millwood), 2007. **26**(4): p. 984-97. Also in Vian, T., et al., *Informal payments in government health facilities in Albania: results of a qualitative study*. Soc Sci Med, 2006. **62**(4): p. 877-87.

Politicized appointments, inappropriate shifting of patients to the private sector, financial conflicts which affect treatment decisions and absenteeism are corrupt practices which were raised by key interviewees. It is difficult to measure the scope and consequences of these problems with precision, but interventions to mitigate risk are needed.

Medicines are a key area of concern for corruption. Stock-outs of essential medicines appear to be common, as we have discussed in the previous section, and theft may be a contributing factor. The institutional framework for oversight of procurement seems designed to address many of the OECD standards for integrity (See Annex 2) such as access to information and complaint mechanisms, although a report by the Auditor General suggests that internal audit capacity in the health sector is inadequate. The procurement oversight office doesn't have special expertise in medicines, the registration process takes a long time and is cumbersome (a risk factor for bribes), and record keeping in warehouses is months behind. More in-depth analysis of transparency in medicines is needed to determine specific action steps which could improve medicines registration, licensing of establishments, inspection, and regulation of drug promotion.

Recommendations:

1. Strengthening and consolidating internal audit structures within main three pillars of the health sector reform (MoH, HFA and KHUCS) as well as municipalities is of paramount importance for achieving health sector goals. The Ministry of Health should consider the Auditor General's two proposed options for strengthening the internal audit function in light of ongoing reforms, and should choose the best option to implement. The strengthening should include investment in additional human resources and greater cooperation among the different audit units and committees.
2. The implementation of national health insurance will create new corruption risks. The HFA should begin to consider how corruption could undermine the health insurance fund, and make plans for active transparency and mitigation of risk. Activities could include:
 - Developing a consumer-friendly web site with clear listing of essential drugs, entitlements to services, and co-payments, to avoid the problem of individual clinicians informing patients that a given service is not covered when it is really an entitlement.
 - Creating a subdivision for beneficiary protection which includes outreach education on entitlements, a call center for complaints, and a rating system for institutions which includes complaints or rule violations as a factor.
 - Collaborating with the Anti-Corruption Agency (ACA) on detection strategies, a process for consultation and communication on specific cases, and how to incorporate sanctions into contracting (e.g. assess penalties on facilities which do not take actions to assure that providers are not accepting informal

payments, or who do not install closed circuit cameras in fee collection areas).

3. The creation of KUHCS as an executive autonomous health care institution or parastatal organization creates an opportunity to control abuses of dual practice while staying within the parameters of constitutional law. As new human resource management systems are being developed, the HFA should consider implementing term contracts with doctors which include provisions so that if doctors do not show up for work, they are not paid, and that they could be dismissed for breach of contract. Assistance may be needed to write professional contracts.
4. For other health sector personnel, the MoH should conduct a separate legal review to create sub-laws which could control absenteeism. The Russia Legal Health Reform Project has developed laws and guidance that may be helpful for reference. Inspectors must follow-up and monitor health institutions in cases of absenteeism to assure that regulations are being followed. Performance award programs and monitoring can help reduce absenteeism and increase accountability; however, action must be taken to reduce impunity. Results monitoring should result in disciplinary actions for staff that are abusing their position or not respecting working hours.
5. Holding individual clinical staff accountable for performance is an important step in creating accountable care organizations, and this cannot happen without treatment guidelines and performance audit mechanisms. The HFA, in close collaboration with other relevant stakeholders, should develop a clinical audit process to accompany the clinical treatment guideline development which is now ongoing. The clinical audit process could be based on a peer evaluation mechanism with the goal of assessing quality of service provision. Clinical guidelines could help to detect and control the practice of unnecessary referrals to private practice. The process needs to be transparent while protecting personal information, and issues of information access need to be considered (i.e. when/how can patients access information on complaints filed against providers, etc.).
6. In designing the new insurance claims payment process, the HFA should develop a computerized routine to check for movement of patients from a public to private facility. While there could be legitimate reasons for transfer, such a check could help detect cases where patients are being inappropriately referred to private facilities for diagnostic tests in order to increase financial gain to the referring clinician.
7. The MoH and development partners should support further development of management control systems and performance measurement in the drug distribution system. In designing the new health management information systems, drug management indicators should be given priority so that managers can monitor and be held accountable for reducing preventable drug stock-outs.

8. UNDP, MoH, and other development partners should consider ways to facilitate increased dialogue between media and government on health sector issues, and to increase public engagement in the health sector. Currently citizen engagement is limited to complaints, and media coverage focuses on negative perceptions of corruption in the health sector. Although media has a legitimate watchdog function, there may be ways to increase coverage of other issues where public information is also critical and useful, including health reform implementation progress and procedural transparency (e.g. what to do if a medicine is unavailable in a facility, how the quality assurance process works, etc.). Other mechanisms of engagement, such as citizen participation on facility advisory or governance boards, should be explored for feasibility. Citizen health board activism was significantly associated with lower informal payments and lower prices paid for pharmaceuticals in Bolivian hospitals.⁴⁰
9. UNDP and other international partners should support further analyses which help determine the scope and consequences of corruption in the health sector, and establish baselines against which interventions could be measured. This might include: 1) a medicines transparency assessment using the WHO tool; 2) a mixed methods study of informal payments which would determine frequency and magnitude of payments in inpatient facilities compared to outpatient, and which would gather qualitative information from patients and providers about attitudes and practices; 3) baseline study on absenteeism of doctors in order to determine the seriousness of the problem. If baseline data indicate a significant problem, a combination of hierarchical controls, better information systems and personnel management systems, and community monitoring are interventions which could reduce absenteeism.⁴¹

⁴⁰ Gray-Molina, G., E. Perez de Rada, and E. Yanez, *Does voice matter? Participation and controlling corruption in Bolivian hospitals*, in *Diagnosis Corruption: Fraud in Latin America's Public Hospitals*, R. Di Tella and W.D. Savedoff, Editors. 2001, Inter-American Development Bank: Washington, DC. p. 27-55.

⁴¹ Garcia-Prado, A. and M. Chawla, *The impact of hospital management reforms on absenteeism in Costa Rica*. Health Policy Plan, 2006. **21**(2): p. 91-100. Also in Banerjee, A. and E. Duflo, *Addressing Absence*. Journal of Economic Perspectives, 2006. **20**(1): p. 117-132.

Annex 1

LIST OF INSTITUTIONS CONSULTED

Ministry of Health

- Office of the Minister
- Procurement Division
- Internal Audit
- Health Financing Agency
- Budget and Finance Division
- Health Inspectorate
- Kosovo Medicines Agency
- National Institute of Public Health

Other Central Government Agencies

- Public Procurement Regulatory Body
- Office of the Auditor General

Kosovo University Clinical Centre

- Central Pharmacy
- Procurement Office
- Medical Faculty

Municipalities and Facilities

- Gjakova/Djakovica Regional Hospital
- Gjakova/Djakovica Municipality
- Gjakova/Djakovica Main Centre of Family Medicine
- Department of Health and Social Welfare, Pristina Municipality
- Pristina Main Centre of Family Medicine

International and Civil Society Organizations

- World Health Organization
- UNDP
- UNFPA
- Kosovo-Luxembourg Cooperation
- Community Development Fund
- *Internews* Kosova and Balkan Investigative Reporting Network

Private Facilities and Organizations

- Two private hospitals
- A private diagnostic testing laboratory
- Private developers of health-related web application

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