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HEALTH REFORM IN POST-CONFLICT KOSOVO

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ABSTRACT

The international community undertakes complex interventions in states emerging from war. These interventions include broad efforts to reform the political and institutional structures of the state. After the United Nations took political control of Kosovo in June 1999, it embarked on such a reform program, extremely ambitious in nature. This thesis examines the efforts to rehabilitate and reform the health sector.

The immediate post-conflict environment in Kosovo was extremely chaotic. Hundreds of millions of dollars poured into the province, funding the operations of several hundred non-governmental organisations. The initial efforts of the international community in the health sector were focused on coordinating resources and the activities of these organisations.

However, Kosovo's health system was in clear need of widespread reform. The system had been devastated by years of neglect and months of conflict. A reform program was undertaken, with the objectives of establishing a primary care based system, increasing the quality of secondary and tertiary care, modernizing the public health system, and ensuring a cost-effective, equitable health system. By 2004, the reform program had largely failed to meet these objectives.

This study examines the reasons that health reform was so difficult utilizing a combination of methods, i.e. a review of literature on peacebuilding, health and conflict, and health reform; analysis of the implementation of reform utilizing primary evidence such as policy documents and health data; and interviews with key stakeholders.

Results show two important lessons for other post-conflict interventions. First, the reform program neglected building the capacity of government institutions. If the state does not have the capacity to implement reforms, the sustainability of the health reform process will be undermined. And second, the Kosovo reform program failed to build the foundation for reform before initiating ambitious projects to modernize the health sector.

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LIST OF ABBREVIATIONS

DDR:	Demilitarisation, Demobilisation and Reintegration
DOT:	Directly Observed Treatment for Tuberculosis
EAR:	European Agency for Reconstruction
FRY:	Federal Republic of Yugoslavia
GDP:	Gross Domestic Product
HCCA:	Health Care Commissioning Agency
HIF:	Health Insurance Fund
HIS:	Health Information Systems
HIV:	Human Immunodeficiency Virus
IDPs:	Internally Displaced Persons
ICRC:	International Committee of the Red Cross
IMC:	International Medical Corps
IPH:	Institute of Public Health
IRC:	International Rescue Committee
JIAS:	Joint Interim Administrative Structure
KLA:	Kosovo Liberation Army
LDK:	Democratic League of Kosovo
MDM:	Medicins du Monde
MSF:	Medicins sans Frontieres
NATO:	North Atlantic Treaty Organization
NGO:	Non-Governmental Organisation
OSCE:	Organization for Security and Cooperation in Europe
PISF:	Provisional Institutions of Self-Government
SIZ:	Self Managing Community of Interest
STDs:	Sexually Transmitted Diseases
UNHCR:	United Nations High Commissioner for Refugees
UNICEF:	United Nations Children's Fund
UNMIK:	United Nations Interim Administrative Mission in Kosovo
UNSCR:	United Nations Security Council Resolution
USAID:	United States Agency for International Development
USD:	United States Dollars
WFP:	World Food Program
WHO:	World Health Organization

INTRODUCTION: THE PUBLIC HEALTH CHALLENGE OF POST-CONFLICT HEALTH REFORM

This thesis was sparked by a puzzle encountered when the author worked in Kosovo. The author was one of the thousands of internationals who flocked to the province after the war ended in June 1999. The author initially worked for the Canadian Department of Foreign Affairs, following humanitarian developments in Kosovo from Ottawa. Then the author moved to the province in March 2000 to work for the Canadian International Development Agency, coordinating Canadian initiatives in the health sector.

The author's previous field experience had been in Africa, working on the borders of Guinea, Liberia and Sierra Leone as a field officer for the United Nations High Commissioner for Refugees. The situation was tragic: hundreds of thousands of refugees had fled brutal fighting in Sierra Leone. They arrived in Guinea, physically weakened from months spent fleeing the violence and hiding from rebels in the bush. Many individuals had been subjected to egregious human rights violations. Guinea offered them little refuge. The security situation was precarious, as Sierra Leonean rebels conducted cross-border raids. The natural environment also posed challenges, with the long rainy season making many roads impassable. The refugee population was largely unskilled, characterized by high levels of illiteracy. Non-governmental organisations and multilateral agencies working in the area lacked sufficient funds and skilled personnel. It was an extremely difficult and frustrating implementing environment, and because of these constraints, many objectives of international humanitarian actors were not met.

Kosovo was a stark contrast to Guinea, and most other previous humanitarian and post-conflict environments. The international community poured hundreds of millions of dollars into the province. As a result, Kosovo did not suffer from the shortages of funds that plagued other humanitarian emergencies. While it was a post-conflict situation, the implementing environment was relatively secure with forty thousand NATO troops (for a population of roughly two million). Although these troops were largely unable to prevent revenge killings and stem the exodus of Serbs from the province, the forces were generally able to stabilize the province, and organisations operated freely and easily in most areas. The province was governed on an interim basis by the United Nations, which meant that multilateral agencies and NGOs did not have to negotiate access with local political authorities. The population

was educated, and largely welcomed the involvement of the international community, with Kosovo's Albanians heralding the arrival of the international community as the birth of Kosovo's independence.¹ Non-governmental organisations and multilateral agencies employed seasoned professionals, and were able to hire skilled individuals from Kosovo. In the health sector, organisations applied the lessons learned from previous international engagements in post-conflict environments, taking advantage of the presence of international money and human resources to initiate an ambitious project to reform the health sector. In short, Kosovo provided an extremely enabling implementing environment, one in which organisations should have been able to operate effectively and achieve their objectives. However, as this thesis demonstrates, the ambitious initiative to reform the health sector has been slow to achieve results, and reform objectives are far from being met.

The problematic health reform process in Kosovo presents us with a puzzle, which this thesis investigates. Despite the advantages of Kosovo—the skilled international and local human resources, the financial resources, the fact that the United Nations was the administrative authority, the safe and secure operating environment, and the application of lessons learned from other post-conflict settings—the progress of health reform has been painful and slow, and by 2005, key reform objectives had not been met.

I. RESEARCH CHALLENGES

There have been few in-depth case studies of post-conflict health reform which analyse the process of implementation of that reform, evaluate the reform measures assess the success of those reforms, and situate the health reforms within the larger context of peacebuilding efforts in post-conflict settings. Therefore, this thesis analyses uncharted territory.

Analysing the health reform effort in Kosovo posed several challenges. Literature examining health interventions in conflict and post-conflict situations provided useful information on the pitfalls of health interventions as part of the overall humanitarian effort, focusing on questions of coordination and sustainability, but gave

¹ The issue of Kosovo's final status was left deliberately ambiguous by the international community. While Yugoslavia (which was succeeded first by Serbia-Montenegro, and second, with the independence of Montenegro, Serbia) still held *de facto* sovereignty over the province, the Security Council Resolution that established the United Nations Interim Administrative Mission in Kosovo stated that the issue of final status would be decided at a later date through a political process, and until a final political settlement was reached, the United Nations would have authority in Kosovo and be charged with developing autonomous institutions of self-government.

little guidance on factors that facilitate or impede the reform of the health system. No framework existed to examine post-conflict health reform efforts. The existing research on health reform assumed a functioning government and a pre-existing health system complete with equipment, human resources, and financial and information management structures. Much of the analysis on health reform focused on the reform measures themselves, rather than the context within which the reforms are implemented.

The nature of the international engagement in Kosovo was also novel. As part of its efforts to consolidate the peace in post-conflict settings, such as Kosovo, the international community promotes wide-ranging and ambitious reforms to state institutions, including the health sector. At the time, Kosovo was one of the first and most ambitious of these international interventions. With international political control and significant international investment, the international community saw post-conflict engagement in Kosovo as a key window of opportunity to promote dramatic reforms to build liberal democratic institutions, reform the state, and build the prerequisites for peace.

Therefore key knowledge gaps exist. First, how should post-conflict health reform efforts be analysed? And second, what are the factors that impede the progress of reform in a post-conflict environment such as Kosovo, with its massive influx of resources, and the intervention governed by a strong political agenda?

II. RESEARCH SIGNIFICANCE AND OBJECTIVES

In many ways, Kosovo represented the beginning of a new form of international engagement in countries emerging from armed conflict.² The international community's objective in these states is to ensure that these countries do not slip back into widespread violence. Therefore the international community engages in sweeping reform of the institutions of government. The objective of these "peacebuilding" reforms is to make post-conflict governments more stable, more accountable, and ultimately more peaceful.

The term "post-conflict" does not mean that all potential sources of conflict have been addressed, or that low levels of violence do not remain, or that the situation

² The formal definition of armed conflict in the international relations literature is 1 000 battle deaths per year. But as the 2005 Human Security Report notes: "Measuring armed conflict is a complex and often contested business. Definitions of what constitutes a conflict vary widely, as do data collection methods, accuracy and coding rules." THE HUMAN SECURITY CENTRE (2005) *The Human Security Report 2005*, New York, Oxford University Press.

may not at some point return to ‘conflict’ levels. In this thesis, the post conflict period refers to the time period following the cessation of violent hostilities, when there is a formal ceasefire or a peace agreement between previously warring factions and significant international engagement is in place to sustain this ceasefire. In some cases, such as Kosovo and East Timor, the international community in the form of the United Nations has been granted the authority by the United Nations Security Council to administer the territory in question.³ Reform efforts undertaken as part of these peacebuilding activities are implemented at the prodding and behest of the international community, and they have the objective of building liberal democratic institutions of self government. (Paris, 2004, pp.18-19)

The health sector is part of this overall reform effort. The focus of health reform is to change the manner in which health care is delivered to make it more efficient, effective, and equitable. A common set of health reform measures are typically implemented in post-conflict settings—a heightened focus on primary care, an emphasis on the health of women and children, financing reforms including the separation of purchaser and provider functions, and human-resource planning. Millions of dollars are typically invested in such reform efforts, with short time horizons for the dispersal of these funds, typically two to five years. As a result of this short time span, rehabilitation programs often become contiguous with reform.

Despite the millions of dollars invested in reform efforts, few comprehensive assessments have been undertaken of the health reform efforts undertaken by the international community in post-conflict settings. Much of the literature on health and conflict focuses on humanitarian and rehabilitation interventions, and focuses on the need to plan the reform process, rather than the successes and failures of reform outcomes.

This thesis has two main *objectives*. First, new theories or frameworks are needed to explain the challenges of health reform in post conflict settings. Therefore, the thesis establishes a conceptual framework to examine post-conflict health reform, integrating an understanding of health reform efforts, the unique nature of the

³ There is a debate regarding the appropriateness of the term “post-conflict” given that the underlying root causes of violence have often not been addressed with the formal cessation of hostilities, and often criminal violence and/or insurgency continues. This debate, while important, is outside the scope of this dissertation. Note that the issue of a positive peace was raised by Galtung in his seminal work GALTUNG, J. (1975) *Three Approaches to Peace: Peacekeeping, Peacemaking and Peacebuilding*. IN GALTUNG, J. (Ed.) *Peace, War and Defence: Essays in Peace Research*. Copenhagen, Christian Ejlert.

international engagement in the province, and an identification of the key factors that could impede reform. And second, the thesis tests this framework by applying it to Kosovo's health reform effort.

III. THE FORMAT

First, the methodological approach is established. The research questions underpinning the analysis are outlined, and the range of methods to address these research questions is identified. Through an examination of the strengths and weaknesses of these approaches, the methods most appropriate for answering these research questions in the Kosovo context are identified. Both social science and public health approaches are utilized, and the advantages of each approach are highlighted. The key themes from the literature review are also summarized with explanations given for the inclusion and exclusion of relevant literature.

Part One of the thesis then establishes the conceptual framework for analysing health reform in post conflict settings in three steps. The foundation for this conceptual framework is built by examining the impact of conflict on population health and health systems, and outlining the key elements of health reform in Chapter One. Chapter Two proceeds to examine key lessons learned from health reform in Central and Eastern Europe to identify the impediments to the reform process. Chapter Three examines the context of a post-conflict peacebuilding mission and analyses the impact of this unique context on the health reform process. The conceptual framework, as outlined in Figure One, is then presented in Chapter Four.

This conceptual framework highlights the factors internal to the health reform process as well as those social, political and economic factors external to the reforms, which need to be integrated into the analysis of health reform. Utilizing the literature review, the thesis then builds a hypothesis on the key impediments to health reform in post-conflict states. In Part Two of this thesis, this conceptual framework is applied and the hypothesis tested using the case of Kosovo. Chapter Five outlines the socio-economic and political context in Kosovo after the war; Chapter Six reviews the pre-reform population health and health system; while Chapter Seven reviews the progress of health reform, testing and proving the hypothesis that three key factors impeded the reforms: the externally driven reform agenda; the post-war social and political context wherein health was extremely politicized and impacted on government capacity; and the compressed nature of the reform timetable.

The thesis concludes with an overview of the lessons of this health reform program for other post-conflict health reform efforts. While a window of opportunity exists for reform in post-conflict settings, it is a window of opportunity for incremental change, not for dramatic socio-economic and political development compressed into a tight timeframe. Much can be learned from development experiences in building health systems: the rebuilding and reforming of health systems is development work, requiring a strong foundation for success. The timeframe required for development cannot easily be compressed.

THE METHODS

This thesis is a case study examining the factors impacting on the outcome of the health reform process in Kosovo. As such, it relies on a combination of social science methodology and public health methods. Social science methodology identifies how to effectively study causation in complex socio-political systems and outlines the advantages and disadvantages of undertaking case study research. Public health methods provide guidance on how to study and gather data on health related events.

Below, this section outlines the relevant methodological approaches of both disciplines, and the range of methods that could be utilized to answer the research question. Second, it outlines the methods chosen to analyse post-conflict health reform, and provides a rationale for these methods. Third, it discusses the selection of the literature analysed to build the conceptual framework. It concludes with a description of what factors will not be incorporated into the study and the reasons for their exclusion.

I. SOCIAL SCIENCE METHODS

This thesis presents an in-depth examination of one case study. Below, this section outlines the methodological principles underlying single case studies including the advantages and pitfalls of case study research, and reviews the five tasks of research design. Here, the thesis relies on the authoritative work by Alexander George on the methodology of case study research.⁴

A. Case Study Research: The Methodological Principles

Case studies allow for “high levels of conceptual validity” when examining difficult to measure variables that are not suitable for large statistical analysis.⁵ Case studies allow for the identification of new variables and hypothesis, enable the detailed examination of causal mechanisms, and provide a detailed consideration of contextual factors.

⁴ Alexander George is a Professor Emeritus of International Relations at Stanford University, and has written extensively on case study methodology in social science.

⁵ George and Bennett argue that “Case studies allow a researcher to achieve high levels of conceptual validity, or to identify and measure the indicators that best represent the theoretical concepts the researcher intends to measure.” GEORGE, A. & BENNETT, A. (2005) *Case Studies and Theory Development in the Social Sciences*, Cambridge, MIT Press.

1. *The Utility of Focusing on One Case Study*

In the social sciences, most case studies are comparative case studies, involving the testing of hypothesis across several cases, a technique known as ‘structured focused comparison.’ Single case studies are relatively rare, as social scientists argue that their generalizability outside that specific case setting can be limited.

However, in *Case Studies and Theory Development in the Social Sciences*, Alexander George and Andrew Bennett argue for the utility of single case studies: the detailed examination of one historical episode with the objective of developing and testing explanations generalizable to similar episodes in future research exercises. (George and Bennett, 2005, p. 5) The objective of case study research is to find “the conditions under which specified outcomes occur, and the mechanisms through which they occur, rather than uncovering the frequency with which those conditions and their outcomes arise.” (George and Bennett, 2005, p.31) George and Bennett point out that an analysis of an individual case can contribute to theory development and testing, if the case focuses on “deviant” cases or if the case contributes to building new theories. (George and Bennett, 2005, p. 32) As they argue:

Theory development via case studies is primarily an inductive process. The outcome in a deviant case may prove to have been caused by variable that had been previously overlooked but whose effects are well known from other research . . . An inductively derived explanation of a case can also involve more novel theories and variables. (George and Bennett, 2005, p. 111.)

Application in the Thesis: This thesis utilizes a case study approach to examine post conflict health reform. As noted above, a single case study, such as the Kosovo case, is methodologically valid in the theory development stage.

2. *Development of the Framework*

When inductively developing and testing theories, researchers cannot utilize the same case study to develop the theoretical frameworks or propositions as they use to test the theory. Such an approach would bias the findings, and thus jeopardize the generalizability of the theory – its applicability to other case studies.

. . . researchers are frequently advised not to develop a theory from evidence and then test it against the same evidence; facts cannot test or contradict a theory that is constructed around them. In addition, using the same evidence to create and test a theory also exacerbates risks of confirmation bias, a cognitive bias toward affirming one’s own theories . . .” (George and Bennett, 2005, p. 111.)

Application in the Thesis: To avoid the prospect of developing a theory from evidence and then testing it against the same evidence, the conceptual or theoretical

framework developed for the analysis of post-conflict health reform in Kosovo was derived from a literature review that did not include the Kosovo case. This literature review is described in detail below.

3. *Tracing Causality*

Case studies allow for “process tracing” to disentangle and document complex causal interactions.⁶ (George and Bennett, 2005, p. 19-22) Process tracing identifies the linkages between independent, intervening variables and the dependent or outcome variable. (George and Bennett, 2005, p. 6) It is a critical tool for establishing causality in single case studies.

In process tracing, the investigator explores the chain of events or the decision-making process by which initial case conditions are translated into case outcomes. The cause-effect link that connects independent variable and outcome is unwrapped and divided into smaller steps; then the investigator looks for observable evidence of each step. (Evera, 1997, p. 64)

Application in the Thesis: Process tracing was utilized in this thesis to first build the conceptual framework and then to test it in the case of Kosovo. Process tracing diagrams - tracing the pattern of causality by identifying the relevant intervening variables between the independent and dependent variables - were created for the development of the framework. These diagrams were also utilized to test the framework against the Kosovo case.

B. **The Five Tasks of Research Design**

George and Bennett outline the five tasks of research design in case study research. Below these tasks are described, and then their application to this thesis is explained.

1. *Specification of the Problem and Research Objectives*

Methodological Principles: George and Bennett argue that the researcher should articulate an important research problem or ‘*puzzle*’, and make the case that the proposed research will make a significant contribution to the field. The research *objective* should also identify if there is a need for testing a theory or competing theories, or if new theories are required.

⁶ These complex interactions include equifinality (in open systems that the same end state can be achieved through a variety of means), complex interactions effects (non-linear results from the interaction of different levels of variables often as a result of threshold effects) and path dependency (when once a path is selected, there is little deviation or variation from that path). Ibid.

They specify six types of theory building case studies:⁷ atheoretical case studies (descriptive which contribute only marginally to theory building), disciplined configurative case studies (utilize established theories to explain a case), heuristic case studies (identifying new variables, hypothesis, causal mechanisms and causal paths), theory testing (assess the validity and scope conditions of single or competing theories), plausibility probes (preliminary studies on untested theories), and building block studies (cases that pose tough tests for theories or identifying alternative pathways to similar outcomes). (George and Bennett, 2005, p. 74)

Application in the Thesis: As outlined above, this thesis addresses a puzzle: despite the many advantages of Kosovo and the application of ‘lessons learned,’ the health reform effort stumbled. As such, the thesis investigates an under-researched area that is a key component of international engagement in conflict-affected societies.

As outlined above, this thesis has two main **objectives**. First, the thesis establishes a conceptual framework to examine post-conflict health reform, integrating an understanding of health reform efforts, the unique nature of the international engagement in the province, and an identification of the key factors that could impede reform. And second, the thesis tests this framework by applying it to Kosovo’s health reform effort.

In terms of its **typology**, this study is heuristic, where new variables are identified, hypothesis built and tested, and causal mechanisms charted.

2. **Specification of Variables**

Methodological Principles: Researchers should identify the dependent (outcome) variable, as well as the independent and potentially intervening variables in the study. In single cases (such as this study of post-conflict health reform in Kosovo), George and Bennett argue that alternative hypotheses should be considered, to ensure that “left out” variables do not threaten the validity of the research design.

Application in the Thesis: In this case study of Kosovo, as outlined below, the dependent and independent variables are the degree to which health reforms have been implemented (dependent variable), the reform measures (independent variable) as well as social, political and economic factors, the nature of the implementation process -

⁷ Five of these theory building case studies were identified earlier by Arend Lijphart and Harry Eckstein, see Footnote 3 Ibid. [See Arend Lijphart, “Comparative Politics and the Comparative Method,” *American Political Science Review* Vol 65, No 3 (September 1971), pp. 682-693; and Harry Eckstein, “Case Studies and Theory in Political Science, in Fred Greenstein and Nelson Polsby, eds. *Handbook of Political Science*. Vol 7 (Reading Mass, Addison-Wesley, 1975), pp. 79-138].

compressed and externally driven (intervening variables) identified through the literature review and integrated into the conceptual framework (outlined below). Alternative explanations for this failure are considered – specifically the evidence base for the reforms, the possibility of funding shortfalls, and coordination problems.⁸

3. *Selection of Cases*

Methodological Principles: Case study selection should be an integral component of the research design to achieve the objectives of the study. As outlined above, many social scientists argue strongly that the findings of comparative case studies have more validity and reliability, and are thus more relevant for both testing and building theory. Therefore, one methodological approach for analysing post-conflict health reform would include comparative methods – for example, a ‘structured focused comparison’ where two or more case studies of post-conflict health reform would be assessed. The case studies would have to be of the same ‘class of events’ – i.e. post-conflict health reform, where the international community has initiated overarching efforts to reform, has extensive political control, and one such reform initiative includes efforts to transform the health sector. The reforms in the health sector would have to be comparable – i.e. the effort to build a primary care based health system. The focus should be on assessing similar independent and dependent variables, to enhance the comparability across cases. (George and Bennett, 2005, pp. 69-70, Evera, 1997, pp. 56-58.)

The analysis of case studies conventionally begins with defining the issue rather than a specific case. George and Bennett argue that starting with a case study in search of a theory is a viable approach, particularly in the early phases of theory development. (George and Bennett, 2005, p. 84)

Application in the Thesis: Given that there has been little examination of post-conflict health reform, as outlined above, a single case study focus is a useful starting point. Once a conceptual framework has been built through a heuristic case study, further research comparing cases (plausibility probes) can be undertaken. In the case of Kosovo, the author began with a case study, searched for a relevant theory, and then inductively developed a conceptual framework to apply to the case study.

4. *Description of the Variance in the Variables*

Methodological Principles: The manner in which variance is described is critical to further the development of new theories or the assessment and refinement of

⁸ See the Conclusion for the explanation of why competing explanations failed to convince.

existing theories. The variance may be described in quantitative or qualitative terms. (George and Bennett, 2005, p. 84-85)

Application in the Thesis: In the Kosovo case study, variance is described utilizing primarily qualitative data, but quantitative data is employed where it is available. (See section below on triangulation.)

5. **Formulation of Data Requirements**

Methodological Principles: The specific data to be obtained from the case study should be specified, and data requirements determined by the research strategy. (George and Bennett, 2005, pp.86-87)

Application in the Thesis: The data requirements - specifically the triangulation approach - are outlined in more detail in the section below outlining public health methods.

II. **PUBLIC HEALTH METHODS**

While social science methods provide useful guidelines for case study research and outline how to identify causality in complex social, political and economic systems, they provide less specificity on gathering data and measuring variance of health related variables. The thesis now addresses the methodological principles of such a case study from a public health perspective.

Patricia Ulin *et al*, outline the following research questions to guide the research process, from the perspective of qualitative public health research:

- What is the general area of inquiry and how is the research problem defined;
- What are the objectives of the research;
- What questions will address the research problem;
- What methods will best address the research question; and,
- Who should participate, what ethical standards assure the participation of study participants, and how should the data be collected and analysed. (Ulin et al., 2005, p. 33)

Below the thesis addresses each of these research design issues, outlining how these issues were addressed.

A. **The Area of Inquiry: The Public Health Problem**

Health reform in post conflict settings poses a challenge to public health professionals. The health needs of the population are significant, the health sector requires rehabilitation, there is often a shortage of health professionals, and the capacity of the government is often weak. In addition, health reforms form an important component of international engagement to rebuild and reform government institutions. In the complex economic, social and political environment that

characterizes post conflict environments, a key question remains unanswered: how should health reform be undertaken so that it builds an effective, efficient and equitable health system?

B. Research Objectives

As outlined above, this thesis has two main objectives: establish a conceptual framework to examine post-conflict health reform and test this framework by applying it to Kosovo's health reform effort.

C. Research Questions

This thesis asks the following research question: Was health reform successful in Kosovo? To answer this research question, the thesis also explored several other questions.

- What exactly is health reform, and how should health reform progress be measured?
- How do factors internal to the reforms themselves impede implementation i.e. are the reform measures themselves appropriate, and based on solid public health evidence of what works?
- And how do factors external to the reform process—the social, political, and economic context, as well as international pressure to implement particular health interventions—affect the progress of reform? Specifically, how does government capacity – or the lack thereof - impact on the health reform process?

D. Methods to Address These Research Questions

Several methodological approaches would have been appropriate to assess the success of health reform in Kosovo. Below, the thesis provides an overview of these methodologies, and assesses their strengths and weaknesses.

1. Quantitative Data with Qualitative Input: Assessing Health Data

One methodological approach which could answer these research questions would utilize quantitative health data. To determine if health reform was successful, this method would correlate the implementation of health reform and positive (or negative) health outcomes. The independent variable would be the health reform measures, and the dependent variable would be health outcomes. This quantitative analysis would be complemented with an analysis of the health reform measures and how they are implemented.⁹

⁹ For more information on this method, please see BOWLING, A. (2000) *Research Methods in Health: Investigating Health and Health Services*, Buckingham, Open University Press.. The utilization of health data is common in evaluation of humanitarian interventions, where these interventions are specifically targeted to improve dramatically the health of the population. See CHECCHI, F. & ROBERTS, L. (September 2005) *Interpreting and Using Mortality Data in Humanitarian Emergencies*. London, Overseas Development Institute., SALAMA, P., SPIEGEL, P., TALLEY, L. & WALDMAN,

As outlined in Chapter Five, the International Rescue Committee (IRC) undertook a survey in 1999 to identify health priorities in the immediate post-war period. This data would be utilized as the 'baseline.' New health data could be gathered in one of two ways: first through routine surveillance – health data gathered by the Kosovo health information system. And if that data was not available, the data could be gathered through a repetition of the cluster survey method employed by the IRC in 1999.¹⁰

The advantages of this approach are in its parsimony – the independent variables and the dependent variables are clear. The weaknesses of this approach are three-fold. First, the linkage between health reform and health outcomes is indirect. It could take a significant period of time for the health reform process to impact on health indicators. (Bowling, 2000, p. 181) Second, the objective of reform is broader than just to influence health outcomes. As outlined in Chapter One, health reform also has the objectives of improving efficiency and equity. And third, the health information system was not operating in Kosovo at the time the thesis was researched, so therefore such health data was unavailable.

Given that this health data was not available utilizing the health information system, the only option would be to repeat the cluster survey – a very expensive undertaking.¹¹ The author had neither the financial means nor the epidemiological expertise to conduct such a survey.

2. *Assessing Management Data*

Another approach to assessing the success of health reforms would utilize health sector management and performance data instead of health data. Such management data would provide information on the performance of the health system – for example, the amount of resources allocated to support reform measures, data on consultations with family physicians, and referrals to the secondary and tertiary level comparing them to utilization of these services without such a referral. In such a study, the independent variable would be the health reform measures, while the

R. (November 13, 2004) Lessons Learned from Complex Emergencies over the Past Decade. *The Lancet*, 364, 1801-1813.

¹⁰ This would be a form of longitudinal study utilizing health data. Ann Bowling warns against over-reliance on longitudinal data for the analysis of change, as underlying changes could be masked.

BOWLING, A. (2000) *Research Methods in Health: Investigating Health and Health Services*, Buckingham, Open University Press.

¹¹ Such surveys typically cost in the hundreds of thousands of dollars, depending on the complexity of the environment, the number of samples selected, and the number of teams deployed.

dependent variable would be the implementation of these reforms measured by this management and performance data.¹²

The advantages of this approach are that its focus on performance data can measure the degree of implementation of reforms. It avoids some of the difficulties (the presence of confounding variables) associated with utilizing health data to evaluate health reforms. However, management data needed to evaluate health reform implementation is available only in health systems with fully functioning management information systems. And these information systems were not functioning in Kosovo.

3. *Qualitative: Analyse a Specific Element of the Reform Program*

Another possible approach to assess the success of the health reform program would focus on one reform measure and undertake an in-depth examination of that particular measure. Examples would include health financing, creation of the family medicine program, or efforts to revamp the epidemiological monitoring system. The independent variable would be that particular reform measure. The dependent variable would be the ability of that reform measure to achieve its stated objectives – for example, increase cost effectiveness and efficiency, introduce a family medicine system, and produce evidence from public health surveillance.

This approach is commonly adopted to assess particular donor funded initiatives. With the focus on one reform measure, it is easier to identify specific indicators of the success or failure of that reform and to identify the factors impacting on that success. While parsimonious, it misses the important question of the overall context of reforms. What internal (population health and economic efficiency) or external (social, economic and political) factors are driving the reform measures? How do the specific elements of the reform program interact? And what factors intrinsic to the reform process as well as social, political, and economic factors external to the reforms are impacting on the reform implementation and success? These are important issues impacting on the success of reforms that could be missed in a limited analysis of one particular reform measure.

4. *Triangulation Utilizing Mixed Methods - Broad Examination of Reform*

With this method, the dependent variable would be the ability of the reform program as a whole to meet its objectives. The independent variable would be the reform measures. Key intervening variables – the social, economic and political

¹² See for example BRINKERHOFF, D. (2003) *Accountability and Health Systems: Overview, Framework and Strategies*. Bethesda, PHR Plus.

factors impacting on the dependent variable would be identified either by utilizing existing theories and conceptual frameworks of post-conflict health reform, or by undertaking a review of relevant literature to build that conceptual framework. Data would be gathered through the use of triangulated methods, such as interviews, document analysis, and the use of the sporadic health quantitative data that existed to ensure validity and reliability of research findings. (Bowling, 2000, pp. 361-2)

The advantage of this approach is that it enables a focus on the broader reform process and program – and encapsulates the social, political and economic factors impacting on reform. The disadvantage of this approach is its complexity – the lack of parsimony.¹³ As outlined below, this is the approach adopted in this study.

E. Who Should Participate, Ethical Standards, Data Collection and Analysis

Participation in Study: Given the nature of the subject matter – an understanding of health reform requires specialized knowledge – “intensity sampling” (also known as stakeholder methods) would be most appropriate. Participants should be aware of their objectives of the study, and provide consent for participation and attribution purposes.

Data Collection: Data generated through interviews provide key information on perceptions of the success or failure of health reform and the reasons for that outcome. To ensure comparability of responses, either a standardized open-ended interview or a closed, fixed response interview is appropriate. The responses should be coded for analysis, with a focus on informing the variables identified in the conceptual framework. As outlined below, these principles were followed in this thesis.

III. SUMMARY: METHODS CHOSEN TO ANALYSE POST-CONFLICT HEALTH REFORM

Case Study Approach: This thesis builds a framework for analyzing health reform, and tests that framework in a single case study. In the analysis of the case study, process tracing was employed to assess and analyse the relationship among the various variables. Triangulated methods – interviews with key stakeholders, document analysis, and the use of quantitative data - are utilized to provide information and values for these variables.

Theory Building: The Conceptual Framework: A conceptual framework for health reform was built from a literature review. Through this literature review,

¹³ To address this complexity, the author utilized process tracing to map the relationships among the independent, intervening and dependent variables.

independent and intervening variables were identified, which include the health reform measures, and additional factors (political, economic and social context, the external pressure and resources for reform, the pre-reform health system and health status, the capacity of the government, and the implementation process for reform). The dependent variable is the outcome of the reform process, the degree to which the reform program met its objectives. This literature review also identified a hypothesis to test.

Theory Testing -The Kosovo Case Study: This conceptual framework and the hypothesis were tested on the case of Kosovo. Process tracing was utilized to trace the causal pathway between the independent variable (the health reform measures) and the dependent variable (the outcomes of the health reforms). To gather data on variables, the triangulation method (primary sources, interviews, and the sporadic health data that does exist) was utilized to determine variance.

IV. THE LITERATURE REVIEW

The conceptual framework was built through a review of several sets of literature: an examination of the impact of conflict on health, the general literature on health reform, the specific health reform experience in Central and Eastern Europe after the fall of the Berlin Wall, and the literature on post-conflict peacebuilding interventions. These sets of literature are analysed in detail in Chapters One, Two and Three.

Ulin *et al* describe the purpose of a literature review:

A literature review helps to make a case for the importance of the problem, to build it into a conceptual framework, and to avoid duplication of effort. When you state the problem and purpose of your research, you usually are describing a gap in scientific knowledge, a puzzle to put together, or a mystery to solve. (Ulin et al., 2005, p.35)

Below the thesis outlines why the various sets of literature were targeted for review, the process of identifying relevant literature, the potential biases that the literature review may have caused, and the main themes that emerged in this literature.

A. Selection Criteria

This thesis asked the research question: “Was health reform successful in Kosovo?” To address this research question, the thesis also explored several other questions, including: what exactly is health reform, and how should health reform progress be measured? How do factors internal to the reforms themselves impede implementation i.e. are the reform measures themselves appropriate, and based on

solid public health evidence of what works? And how do factors external to the reform process—the social, political, and economic context, as well as international pressure to implement particular health interventions—affect the progress of reform?

Specifically, how does the post-conflict environment and the lack of government capacity impact on the health reform process?

Process: Initially, the author searched for an existing framework that would enable the examination of the case study of Kosovo and answer these questions. However, as no such framework existed, the author searched specific groups of literature to answer these questions. The literature selected included the examination of conflict and health, health reform, health reform in Central and Eastern Europe, and post-conflict peacebuilding. The review focused on these four sets of literature to understand the nature of contemporary health reform processes; the impediments to reform; and the particular nature of post-conflict environments and international interventions within those environments.

As the thesis was written over several years, the literature review was an iterative process, focused on answering the key research questions and informing the development of the conceptual framework. Table One below summarizes the inclusion and exclusion criteria for the four sets of literature, as well as the literature that informs the analysis of the case study.

Potential Bias: The inclusion and exclusion criteria presented in Table One focus on answering the research questions posed in this thesis. However, some biases may result.

First, the exclusion of an analysis of developed country reforms, as well as the implementation of specific reform measures could have resulted in the exclusion of literature that provided details on the pitfalls of the implementation process. Second, literature that analysed and assessed peacebuilding in contexts without a significant international engagement and mandate was excluded. This literature could potentially have provided further insight into the difficulties of the transition from conflict (without the influence of the international community).

Third, if the review had been undertaken in a systematic fashion at one point in time, rather than in an iterative fashion, these four sets of literature could have been more systematically assessed and evaluated. This would have provided a heightened guarantee that relevant literature was not inadvertently excluded.

Table One: Literature Review: Inclusion and Exclusion Criteria

	<u>Inclusion</u>	<u>Exclusion</u>
Language	English	Non-English
Time Frame	Published since 1991 until 2005 Post-conflict peacebuilding literature - literature published after 1999 ¹⁴	Published before 1991
Topics of Interest	Health policy in immediate post-conflict environment; Transition from relief to development in health sector; Health reform definition and frameworks for analysis; Health reforms in post-conflict environments; Post-conflict international engagement – mandate and objectives; <i>Case study literature:</i> Impact of the conflict on health in Kosovo; Health policy post-conflict Kosovo.	Health reforms in developed countries Analysis of specific reform interventions (i.e. health insurance, health financing, health information systems, health management systems) Conflict prevention and peacebuilding; Ethnic conflict; Health as a bridge to peace.
Study Type	Peer reviewed journal articles; Books; Grey literature including reports from research organizations, NGO reports, and reports from multilateral organizations; Key documents such as speeches, United Nations reports and resolutions; Key government documents.	Reports from Serbian government 1990 to 1999; Editorials, letters to the editor.
Summary of Searches		
Databases Utilized	Pub-Med/Medline Health Star HMIC Google Scholar Google Search Engine British Library	
Subject Headings	Conflict and Health Health Policy and Conflict Health reform and Eastern Europe Health reform and Central Europe Health reform and Balkans Post-conflict peacebuilding Post conflict reform	

¹⁴ Note that the 1999 time frame was chosen for the post-conflict peacebuilding literature as Kosovo was the first in a series of international interventions where the international community had significant international administrative and political control.

B. Evaluation of Literature

Key themes emerged within these four sets of literature. These themes are described, and the rationale for focusing on particular analytical works presented below.

1. *Post Conflict Health Reform: Conflict and Health Literature*

An important external factor shaping health reform was the post-conflict environment. To assess how the literature on health interventions in conflict affected states addressed the issue of health system reform in post-conflict environments, the literature review included health interventions in post-conflict environments.

Much of the literature focused on the impact of conflict on health, examining humanitarian challenges, and analyzing the key obstacles facing non-governmental and multilateral organizations responding to health needs. The dominant theme in the conflict and health literature was the need to enhance the health impact of humanitarian assistance (reducing mortality and morbidity) through various mechanisms: enhanced coordination mechanisms, ensuring evidence based interventions, and establishing minimum standards in humanitarian delivery.¹⁵

The specific findings of the literature are outlined in Chapter One. Few articles focused on the specific challenges of the post-conflict environment, and the effort to reform the health sector.¹⁶ And the literature that did analyse the post-conflict reform

¹⁵ See for example SALAMA, P., SPIEGEL, P., TALLEY, L. & WALDMAN, R. (November 13, 2004) Lessons Learned from Complex Emergencies over the Past Decade. *The Lancet*, 364, 1801-1813., LEVY, B. S. & SIDEL, V. W. (1997) *War and Public Health*, New York, Oxford University Press., NOJI, E. K. (1997) *The Public Health Consequences of Disasters*, Oxford, Oxford University Press., SCHOOR, V. V. (2005) Reviving Health Care. IN JUNNE, G. & VERKOREN, W. (Eds.) *Postconflict Development: Meeting New Challenges*. Boulder, Lynne Rienner, CHECCHI, F. & ROBERTS, L. (September 2005) Interpreting and Using Mortality Data in Humanitarian Emergencies. London, Overseas Development Institute., MURRAY, C. L. G., KING, G., LOPEZ, A. D., TOMIJIMA, N. & KRUG, E. G. (2002) Armed Conflict as a Public Health Problem. *British Medical Journal*, 324, 346-349.. See also the Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Relief, <http://www.sphereproject.org/>, as well as the Good Humanitarian Donorship Initiative: <http://www.goodhumanitarianandonorship.org/>.

¹⁶ See for example JUNNE, G. & VERKOREN, W. (2005) The Challenges of Postconflict Development. IN JUNNE, G. & VERKORN, W. (Eds.) *Postconflict Development*. Boulder, Lynne Rienner., MACRAE, J. (1995) Dilemmas of 'Post'-Conflict Transition: Lessons from the Health Sector. London, Relief and Rehabilitation Network., MACRAE, J. & ZWI, A. (1994) *War and Hunger: Rethinking International Responses to Complex Emergencies*, London, Zed Books., SCHOOR, V. V. (2005) Reviving Health Care. IN JUNNE, G. & VERKOREN, W. (Eds.) *Postconflict Development: Meeting New Challenges*. Boulder, Lynne Rienner., SONDORP, E., KAISER, T. & ZWI, A. (2001) Beyond Emergency Care: Challenges to Health Planning in Complex Emergencies. *Tropical Medicine and International Health*, 6, 965-970., and WATERS, H., GARRETT, B. & BURNHAM, G. (June 2004) Rehabilitating Health Systems in Post-Conflict Situations. IN (UNU), W. I. F. D. E. R. W. A. T. U. N. U. (Ed.) *Making Peace Work*. Helsinki, Finland..

process did not place the health intervention into the broader political, social and economic context, nor did it evaluate the success of reform efforts. While the literature broadly advocated for health interventions in post-conflict settings to develop a policy framework for health reform, no theoretical or conceptual frameworks are utilized, comparative cases are not studied, and there have been few evaluations of the success of these efforts.¹⁷

2. *Health Reform Literature*

Recall one of the research questions of this thesis: What exactly is health reform, and how should health reform progress be measured? To address this question, the health reform literature was examined to establish a definition of health reform, assess the process of health reform, outline the nature of health reform measures, to assess the internal and external pressures on health reform, impediments to reform, and how to assess the outcomes of health reform.

Much of the literature focused on the economics of health reform, focusing on how to reform the system to improve efficiency.¹⁸ Very few analyses provided a definition for health reform, there were few cross case examinations of health reform implementation, and only one piece attempted to provide an overarching framework for analyzing and assessing reform efforts.¹⁹ None of the literature reviewed investigated the role of the state in overseeing the health reform process: all authors assumed a functioning state.

The specific findings of the literature survey are outlined in Chapter One. The works selected to inform the conceptual framework defined health reform, and assessed the various components of health reform.

¹⁷ The one exception was TULLOCH, J., SAADAH, F., ARAUJO, R. M. D., JESUS, R. P. D., LOBO, S., HEMMING, I., NASSIM, J. & MORRIS, I. (2003) *Initial Steps in Rebuilding the Health Sector in East Timor*, Washington, The National Academies Press..

¹⁸ See for example BENNETT, S. (2000) Reforming state capacity: the demands of health sector reform in developing countries. IN MILLS, A. (Ed.) *Reforming Health Sectors*. London, Kegan Paul International Ltd., DIXON, A., LANGENBRUNNER, J. & MOSSIALOS, E. (2004) Facing the Challenges of Health Care Financing. IN FIGUERAS, J., MCKEE, M., CAIN, J. & LESSOF, S. (Eds.) *Health Systems in Transition: Learning from Experience*. Copenhagen, European Observatory on Health Systems., FIGUERAS, J., MENABDE, N. & BUSSE, R. (2005) The Road to Reform. *British Medical Journal*, 331, 170-171., FIGUERAS, J., SALTMAN, R., RATHWELL, T. & WALT, G. (2000) Implementing successful health care reforms: minding the process. IN MILLS, A. (Ed.) *Reforming Health Sectors*. London, Kegan Paul International., FRENK, J. (2000) Changing the role of the state. IN MILLS, A. (Ed.) *Reforming Health Sectors*. London, Kegan Paul International Ltd., MILLS, A. (2000) Reforming health sectors: fashions, pashions and common sense. IN MILLS, A. (Ed.) *Reforming Health Sectors*. London, Kegan Paul International Ltd., and, MILLS, A., BENNETT, S. & RUSSELL, S. (2001) *The Challenge of Health Sector Reform: What Must Governments Do?*, Houndmills, Palgrave..

¹⁹ See ROBERTS, M., HSIAO, W., BERMAN, P. & REICH, M. (2004) *Getting Health Reform Right: A Guide to Improving Performance and Equity*, Oxford, Oxford University Press..

3. *Health Reform in Central and Eastern Europe:*

Other key research questions included how do factors internal to the reforms themselves impede implementation i.e. are the reform measures themselves appropriate, and based on solid public health evidence of what works? And how do factors external to the reform process—the social, political, and economic context, as well as international pressure to implement particular health interventions—affect the progress of reform?

The lack of case studies in the reform literature created a knowledge gap regarding these factors that impact on the implementation of these reforms. Moreover, very little systematic analysis had been done of the effort to implement primary care based reforms, particularly the transition from a Semashko based system to a primary care based system.

The objective of the review of health reform in Central and Eastern Europe (CEE) was to identify the key factors/variables impacting on reform progress to inform the conceptual framework through a structured focused comparison of reform in CEE.²⁰ Cases were selected because they a) had the same pre-reform health system as Kosovo; b) implemented the same type of reforms and c) all the cases were undertaking this reform process at roughly the same time – after the fall of the Berlin Wall.

Examining the health reform effort in Central and Eastern Europe also avoids ‘selection bias’ – which can occur when researchers select cases on the dependent variable, or among the relevant population of cases. (George and Bennett, 2005, p. 23) The specific advantage to the Central and Eastern European cases studies is that they did not undergo conflict – so the internal and external factors that have impeded reform could be identified, free of the potentially confounding variable of conflict.

Much of the literature on Central and Eastern Health Reform processes focused on the factors internal to the reform process, as well as those social, political, and economic factors external to reforms, which affected the progress of reform and impacted on reform outcomes.

²⁰ Recall that George and Bennett argued theory cannot be built (inductively) from the same case study to which it is applied. They also argued that structured focused comparisons are important for identifying key variables which are reliable and generalizable. Therefore, to identify key variables to build the conceptual framework, it was important to examine cases of health reform outside of the Kosovo case study.

The author assessed the factors across the case studies in Central and Eastern Europe to identify the factors internal to the reform process and factors external to the reforms that impacted on the ability of the reform program to achieve its outcome. This analysis is described in detail in Chapter Two and Appendix One.

4. ***Post-Conflict Peacebuilding:***

An important element driving the reform agenda in Kosovo was the fact that Kosovo was subjected to an international peacebuilding intervention. Therefore, to further investigate how factors external to health interventions—the social, political, and economic context—affect the progress of reform, the literature examining post-conflict political interventions was reviewed to understand the broader political context driving the reform process.

The extensive literature on peacebuilding focuses on how to prevent the occurrence of violent conflict in countries emerging from war.²¹ Several themes dominate, including demobilization of armed combatants, policing and peacekeeping mandates, the appropriateness of international political mandates, coordination (or lack thereof) among international organizations, the interface between international organizations and the local population, the role of the local media, the need to build political parties, and the interface between peacebuilding and development.²²

²¹ Another strand of peacebuilding literature focuses on preventing the outbreak of deadly conflict.

²² See for example BRAHIMI, L. (2000) Report of the Panel on United Nations Peace Operations. New York, United Nations., CALL, C. (2005) Institutionalizing Peace: A Review of Post-Conflict Peacebuilding Concepts and Issues for DPA. New York, Department of Political Affairs, United Nations., CARLSSON, I., SUNG-JOO, H. & KUPOLATI, R. (1999) Report of the Independent Inquiry into the Actions of the United Nations during the 1994 Genocide in Rwanda. New York, United Nations. PRESIDENT OF THE SECURITY COUNCIL (2001) Peacebuilding: Towards a Comprehensive Approach. New York, United Nations, DOYLE, M. W. (January 2001) The New Interventionism. *Metaphilosophy*, Volume 32, 212-235, GALTUNG, J. (1975) Three Approaches to Peace: Peacekeeping, Peacemaking and Peacebuilding. IN GALTUNG, J. (Ed.) *Peace, War and Defence: Essays in Peace Research*. Copenhagen, Christian Ejlertsen, UNITED NATIONS OFFICE OF THE SECRETARY GENERAL (1992) An Agenda for Peace: Preventive Diplomacy, Peacemaking and Peacekeeping. New York, United Nations, UNITED NATIONS SECRETARY GENERAL (1999) The Fall of Srebrenica. New York, United Nations, UNITED NATIONS OFFICE OF THE SECRETARY GENERAL (2005) In Larger Freedom: Towards Development, Security and Human Rights for All. New York, United Nations, GHOBARAH, H., HUTH, P. & RUSSETT, B. (2003) Civil Wars Kill and Maim People - Long After the Shooting Stops. *American Political Science Review*, 97, 189-202, GLEDITSCH, N. P. (1992) Democracy and Peace. *Journal of Peace Research*, 29, 369-376, JEONG, H.-W. (2005) *Peacebuilding in Postconflict Societies*, Boulder, Lynne Rienner, JUNNE, G. & VERKORN, W. (2005) The Challenges of Postconflict Development. IN JUNNE, G. & VERKORN, W. (Eds.) *Postconflict Development*. Boulder, Lynne Rienner, ORR, R. C. (2004a) Constructing a Cohesive Strategic International Response. IN ORR, R. C. (Ed.) *Winning the Peace: An American Strategy for Post-Conflict Reconstruction*. Washington, Centre for Strategic and International Studies, ORR, R. C. (2004b) Governing when Chaos Rules: Enhancing Governance and Participation. IN ORR, R. C. (Ed.) *Winning the Peace: An American Strategy for Post-Conflict Reconstruction*. Washington, The Center for Strategic and International Studies, ORR, R. C. (2004c) Joint CSIS/AUSA Post-conflict Reconstruction Task Framework. IN ORR, R. C. (Ed.) *Winning the Peace: An American Strategy for*

Given that the United Nations exercised complete administrative authority in Kosovo and had an ambitious reform agenda, this thesis analysed literature focusing on cases where the international community held significant decision-making authority, and used this control to promote a dramatic reform agenda.

C. Literature Excluded from the Review

Two sets of literature – health reform in Bosnia and policy analysis - were excluded from the literature review, and therefore not fully integrated into the conceptual framework. The reasons for this exclusion are outlined below.

1. Literature on the Reform Process in Bosnia

Bosnia appears like the perfect case study to inform the study of health reform in Kosovo. Both Kosovo and Bosnia were part of Yugoslavia (although Bosnia was its own republic, while Kosovo was an autonomous province of the republic of Serbia), largely sharing the same pre-war health system and enduring an international peacekeeping presence, an influx of international resources, and significant international engagement in the administration of the country.

But on closer examination, the only commonalities that Bosnia shared with Kosovo were the pre-war health system and the influx of donor resources.

Duration of the Conflict: The Bosnian conflict was of a much longer duration, inflicted significantly more casualties and resulted in more damage to infrastructure than the Kosovo conflict.

Ethnic Minorities with a Strong Voice: The Bosnian state emerged from the war ethnically divided. While significantly swathes of its territory were ethnically homogenous, the total population was more heterogeneous than that of Kosovo, with approximately 48% Bosnians and 37% Serb, and 14% Croatian. Kosovo was over 90% Albanian; while ethnic politics were omnipresent, it did not have the stranglehold on legislative reform that it had in Bosnia.

Degree of International Political Control: While the international community was represented by the “High Representative” who had some oversight powers under

Post Conflict Reconstruction. Washington, Centre for Strategic and International Studies, ORR, R. C. (2004d) *The United States as Nation Builder: Facing the Challenge of Post-Conflict Reconstruction.* IN ORR, R. C. (Ed.) *Winning the Peace: An American Strategy for Post-Conflict Reconstruction.* Washington, Center for Strategic and International Studies, THE UN SECRETARY GENERAL'S HIGH-LEVEL PANEL (2004) *A More Secure World: Our Shared Responsibility.* New York, United Nations, PARIS, R. (2004) *At War's End: Building Peace After Civil Conflict.* Cambridge, Cambridge University Press, SMITH, D. (2003) *The Penguin Atlas of War and Peace,* New York, Penguin Putnam Inc., COUSENS, E. & KUMAR, C. (Eds.) (2001) *Peacebuilding as Politics,* Boulder, Lynne Rienner Publishers. REYCHLER, L. & PAFFENHOLZ, T. (Eds.) (2000) *Peacebuilding: A Field Guide,* Boulder, Lynne Rienner.

the Dayton Peace Agreement and the subsequent Bonn Agreement of the Peace Implementation Council, the international community lacked the total administrative control that they had in Kosovo.

The Two Entity Structure: The Bosnian state was a federated structure with two entities. The Republika Srpska was Serbian dominated and had a more centralized structure, while the Federation of Bosnia and Herzegovina was dominated by Bosnians and Croats, with significant power decentralized to the canton level.

Differing Health Reform Process and Measures: The health reform process in Bosnia was different than that conducted in Kosovo: there was no national mandate for health – it was the purview of the two entities. Moreover, the administration of health care differed significantly between the Federation (decentralized) and the Republika Srpska (centralized); the reform process was not as defined or ambitious, nor was it initiated at an early stage; and the reform program differed in the two entities. And most critically, under the Dayton Accord the international community had no jurisdiction in the health sector. Therefore, the High Representative could not impose reforms as the United Nations had done in Kosovo. The international community maintained its traditional role of coordinator and donor.

In summary, the Bosnian reform process is not similar on the independent variable of health reform measures, the intervening variables of international political control, impact of the conflict, political structure, and the implementation of the reform measures. Because the health reform program was so different in Bosnia, it is also not similar on the dependent variable of the outcome of the health reform program.²³ A review of Bosnia could not inform the analysis of health reform (given that the lack of coherency of the reform program), the peacebuilding context (due to the differing mandate of the international community in Bosnia), and the health and conflict literature (due to the lack of planning for health reform).

After the conceptual framework is tested on Kosovo and other similar cases (such as East Timor and Afghanistan), Bosnia could form part of a “plausibility probe”, where the same framework is applied on a small number of cases. To control

²³ The other cases of health reform in Central and Eastern Europe examined through the literature review were actually more comparable to the Kosovo case. They had roughly the same pre-war health system and the same reform measures implemented.

for the confounding variables identified above, the congruence method could be utilized.²⁴

2. *Literature on Health Policy*

Many analysts examining the health reform programs have utilized theories of the policy making process.²⁵ Such theories focus on the process of policy design and policy making: how policy initiatives are selected against the backdrop of powerful vested interests, the voices of advocates, and competing policy priorities; what issues are included and excluded in these initiatives; the major actors both within and outside of government who influence this process; and the context within which those policy choices are made.²⁶

This body of literature has contributed to our understanding of policy agenda-setting. It provides crucial insight into the complex world of policy making, illuminating why certain policy initiatives are feasible and why others are not. The tools of policy analysis, such as political mapping, multiple streams analysis, and analysis of coalition building, have been analytically useful to examine policy choices in complex systems such as health care.

While strong on the analysis of policy choice, the policy analysis literature focuses less on the assessment of policy outcomes.²⁷ While some health policy literature does discuss implementation, it tends to focus on the *conditions* for

²⁴ The congruence method compares cases assessing congruence or incongruence in the independent and intervening variables to determine which variables are significant in shaping the dependent variable. EVERA, S. V. (1997) *Guide to Methods for Students of Political Science*, Cornell, Cornell University Press.

²⁵ See for example COLLINS, C., GREEN, A. & HUNTER, D. (1999) Health Sector Reform and the Interpretation of Policy Context. *Health Policy*, 47, 69-83, FRENK, J. (1995) Comprehensive Policy Analysis for Health System Reform. *Health Policy*, 32, 257-277, GLASSMAN, A., REICH, M., LASERSON, K. & ROJAS, F. (1999) Political Analysis of Health Reform in the Dominican Republic. *Health Policy and Planning*, 14, 115-126, OKUONZI, S. A. & MACRAE, J. (1995) Whose Policy is it Anyway? International and National Influences on Health Policy Development in Uganda. *Health Policy and Planning*, 10, 122-132, REICH, M. (1996) Applied Political Analysis for Health Policy Reform. *Current Issues in Public Health*, 2, 186-191, WALT, G. & GILSON, L. (1994) Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis. *Health Policy and Planning*, 9, 353-370, WALT, G. (1994) *Health Policy: An Introduction to Process and Power*, London, Zed..

²⁶ See for example KINGDON, J. (2003) *Agendas, Alternatives, and Public Policies*, New York, Longman, SABATIER, P. (Ed.) (1999) *Theories of the Policy Process*, Boulder, Westview Press, WALT, G. (1994) *Health Policy: An Introduction to Process and Power*, London, Zed..

²⁷ Much of the literature assumes that once policies are selected, the implementation process is a given. KINGDON, J. (2003) *Agendas, Alternatives, and Public Policies*, New York, Longman. is particular guilty of this. Walt and Gilson discuss implementation, but focus on the actors involved in the implementation process, and highlight the importance of the existence or absence of an implementation process, not external or internal factors which delay or derail implementation. See WALT, G. (1994) *Health Policy: An Introduction to Process and Power*, London, Zed, WALT, G. & GILSON, L. (1994) Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis. *Health Policy and Planning*, 9, 353-370.

implementation (the ideal conditions for implementation, the potential impact of top-down implementation), rather than assessing outcomes.²⁸ The literature also assumes a functioning government and a relatively stable society. And critically, it does not provide a framework to enable a systematic examination of the external and internal factors impacting on reform.

The direct question of this thesis is: why did the reforms fail to meet their objectives? This thesis did not focus on the process of policy agenda setting – i.e. why certain policies were selected.²⁹ Instead, given the tremendously favourable implementation environment, it asked why the health reform program was so problematic to implement. Specifically what were the factors internal and external to the health reform process which caused it to fail? Was there something particular about the post-conflict environment that affected its failure? A review of the health policy literature did not answer such questions, nor did it provide a conceptual framework to illuminate these issues within the case study.

V. THE CONCEPTUAL FRAMEWORK AND THE HYPOTHESIS

A. The Conceptual Framework

The conceptual framework developed through the analysis of the above literature is outlined below in Figure One, and further detail is provided in Chapter Four.

“A conceptual framework is a set of related ideas behind the research design. It may be a simple list of concepts and their possible associations or a more elaborate schematic diagram of key influences, presumed relations and possible outcomes of the research problem . . . Literature reviews can identify findings from previous research that will suggest ways of conceptualizing the current problem.” (Ulin et al., 2005, p. 36)

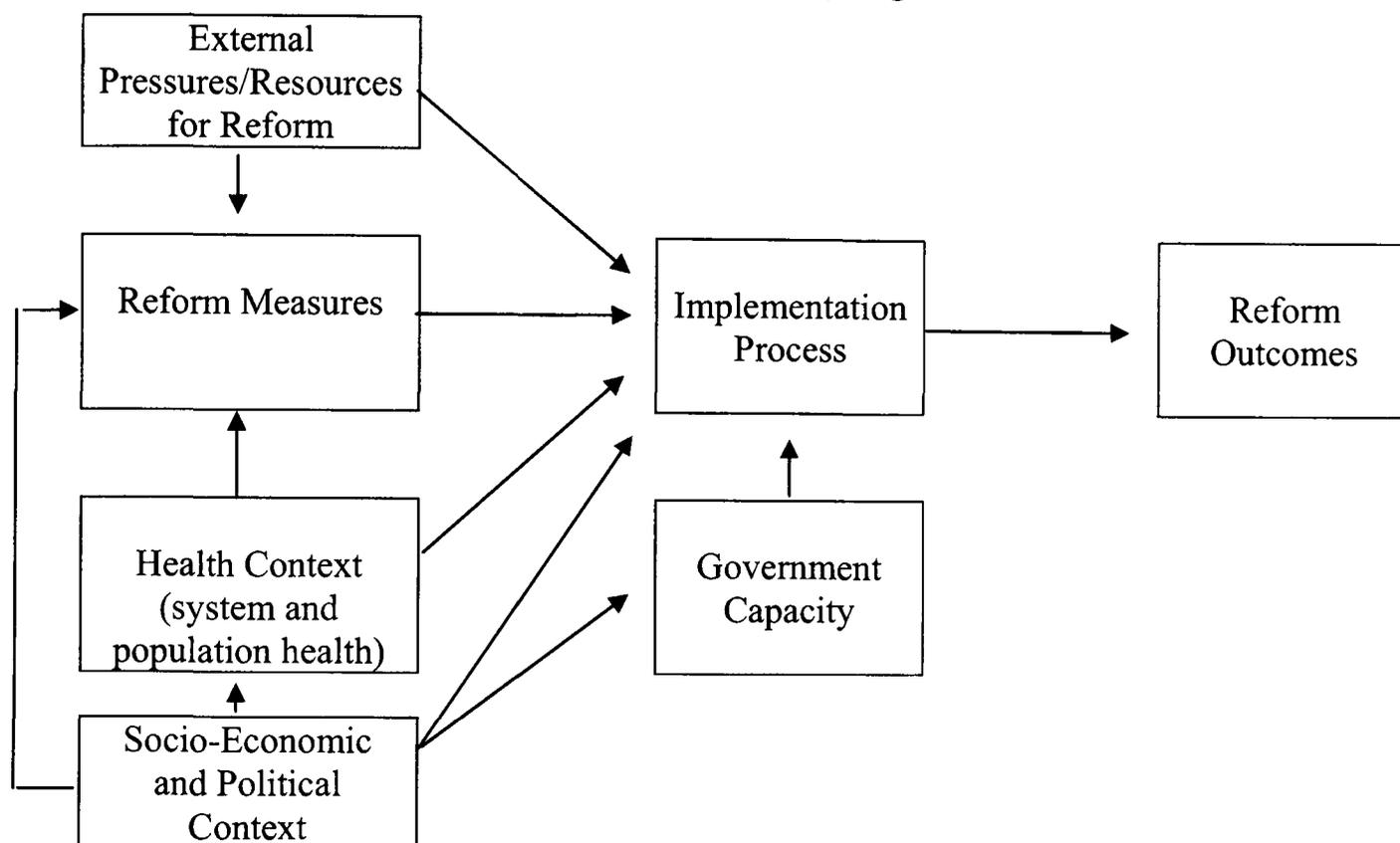
The framework outlines the process through which health reforms are developed and implemented in post-conflict settings, and how the results should be measured. Reform measures are shaped by external pressures, available resources for reform, the local health context (both the efficiency and efficacy of the existing system

²⁸ Walt does discuss implementation, particularly the disconnect between those that have to implement policy and those that make policy choices, particularly when decision makers are members of the international community – donors and multilateral organizations. She also highlights the political resources as well as the financial, managerial and technical resources needed for the implementation process. Of particular interest is her assertion that shorter time frames for implementation may lead to better outcomes. See WALT, G. (1994) *Health Policy: An Introduction to Process and Power*. London, Zed.

²⁹ Such a research question would be valid in the case of Kosovo given the tremendous influence of the international community on the programs and policies selected.

and population health), and by the socio-economic and political context. The implementation of health reforms is affected by government capacity for reform, as well as the socio-economic and political context of the post conflict environment. The success of the reform process should be measured through the degree to which health reforms have been implemented.

Figure One: Conceptual Framework for Analysing Health Reform



B. The Hypothesis

The conceptual framework outlined above highlights several factors that impacted on the reform process. First, the socio-economic and political environment in post-conflict states impacted on the capacity of the state to oversee and implement the reform process. Second, reforms were often externally driven, which undermined their legitimacy. And third, the timeframe for reforms was quite compressed, with ambitious reform agendas implemented within relatively short time horizons.

Therefore, the hypothesis to be tested in Kosovo was that the post-conflict social, economic and political context and its impact on state capacity, the externally driven nature of the health reform process, and the compressed timeframe for reforms all impacted on the ability of the health reform program to achieve its objectives.

C. Applying the Conceptual Framework and Testing the Hypothesis:

Health data and health system performance data on the health system in Kosovo were difficult to obtain, and peer-reviewed literature was largely unavailable.

Therefore, as outlined above, a process of triangulation was utilized through document analysis, stakeholder interviews and the use of the health data that was available.

Document Analysis: To assess the progress of health reform in Kosovo and test my hypothesis, I utilized data from primary sources, such as reports from the Kosovo Ministry of Health, as well as information from grey literature—primarily the reports of consultants hired to review the reform process and report on the work of particular projects. These documents were analysed to understand the social, political and economic context of Kosovo, the process of health reform, and forces driving the health reform process. These reports were obtained from donors and from the Kosovo Ministry of Health. Convenience sampling was used to obtain these reports; the author asked all major donors and the Ministry of Health to share reports they had commissioned or received analysing the various elements of the reform system. The exclusion criteria were the availability of these documents in English.³⁰

Stakeholder Interviews: In an effort to better understand the complex and evolving policy environment, to test my hypothesis on the key impediments to health reform, and to better understand the administrative capacity of the state, the author undertook a stakeholder analysis, interviewing 26 key actors active in the health sector to understand the key impediments to reform and evaluate the reform process. Local stakeholders were chosen based on their familiarity with the health reform process—most occupied positions within the Kosovo health system. While the majority of stakeholders were from Pristina, care was also taken to incorporate a regional perspective, with stakeholders from two of Kosovo’s municipalities also interviewed.

The objective of the stakeholder interviews was to gather and examine data to test the hypothesis that the following three factors would impact on the reform process:

- **External pressures** for reform, and the extent to which this impacts on the **legitimacy** of the health-reform process;
- The socio-economic and political environment that weakened the **capacity** of the state to oversee reforms;
- Compressed nature of the reform process, which impacted on the **progress** and **sustainability** of reform.

Stakeholder questions were designed to assess the following factors:

- **External pressures** for reform, which impact on the **legitimacy** of the reform process;

³⁰ This was not a significant impediment as the vast majority of analysis was written in English.

- The *capacity* of the state to oversee and implement the reform process, including the ability of the government to communicate its vision for reform and respond to concerns;
- The *compressed time frame for reform*, impacting on the progress of reform and perceived sustainability of the reform process;
- Information on the *progress of health reform* was also gathered.

Stakeholders were selected based on the following criteria:

- Active involvement in the health sector;
- Senior positions in the health sector; and
- Impacted by the reform process.

The structured interviews with stakeholders used a questionnaire developed by the author, with the focus primarily on the reform process. Closed questions were developed, with an open question at the end to provide for clarification of response and explanations of position. The questionnaire was tested on three people prior to interviewing stakeholders: one British citizen, one German citizen, and one Albanian. Closed questions were selected, with an open question at the end to provide for clarification of response and explanations of position. The questionnaire was translated into Albanian, then back-translated for verification. Stakeholders provided consent³¹ for the interviews and were interviewed in Albanian by one physician without the author present, to reduce bias. The author met with the physician conducting the interview regularly during the interview process to ensure that the interviews were going smoothly. The results of these interviews were translated into English. The complete listing of stakeholders and the positions that they occupied at the time of the interview is contained in Annex Three. This Annex also includes a summary of the relevant findings from the data-collection exercise.

Stakeholder questions were divided into categories, and responses were coded accordingly. The results of this analysis are outlined in detail in Annex Three. These findings were incorporated into the analysis of the health reform process in Chapters Six and Seven, with the objective of complementing and triangulating data and information gleaned from grey literature, official documents from the Department of Health and the existing health and management data available to ascertain the degree to which health reform had been implemented, the capacity of the state to oversee the health sector and implement the reform process, and the degree to which key stakeholders agreed with the reform process.

³¹ See Appendix Three for a copy of the Information Sheet and Consent Form.

One of the initial objectives of data gathering was to undertake a comparative analysis among municipalities. However, no clear difference of opinion existed between municipal and central level stakeholders. Moreover, the lack of performance and health data made comparisons between the implementation of reform measures in different regions difficult.

VI. RESEARCH TIMEFRAME

The research was undertaken over several years. The initial review of the health reform literature (including reform in Central and Eastern Europe) was conducted from September 2000 to March 2001. A supplemental search on literature published after this date was conducted from September 2003 to June 2005. Documents on the health reform process in Kosovo were gathered from May 2001 until the author's departure from Kosovo in August 2003. Some official documents from the Kosovo Ministry of Health were received after that date. The questionnaire was developed from September until December 2001. The selection of stakeholders and interviews took place from February until March 2003. The data was analysed in March 2004. The thesis was written in sections, beginning in March 2001 and concluding in August 2005.

VII. WHAT THIS THESIS DID NOT INVESTIGATE

The thesis describes the ethnic tensions that characterized the Kosovo health system and the subsequent establishment of the parallel Albanian "Mother Theresa" health network during the 1990s. However, as part of its analysis of health reform in Kosovo, the thesis does not analyse the emergence of a parallel Serbian health system, the efforts by the international community to integrate Serbs within the health system, and the rejection of the Belgrade government of Kosovo reform initiatives or integration into the larger health sector within Kosovo. Because of intransigence from Belgrade, the Albanian community, the Albanian staff within the health sector, Albanian officials in both the 'co-governing phase' and in the provisional institutions of self-government were the primary actors in the health reform effort. The thesis also does not investigate or examine the potential for utilizing health interventions as a tool for peacebuilding to bridge the differences between the majority and minority populations. While both are worthy subjects, the investigation of these subjects was outside the scope of the dissertation – a focus specifically on the efforts of the international community to reform the health system.

which became (unfortunately) almost the exclusive domain of the Albanian community.

VIII. POTENTIAL SOURCES OF BIAS

The author worked as a donor (for the Canadian International Development Agency) and undertook the professional attachment within the Department of Health in Kosovo. In both capacities, the author worked closely with representatives of multilateral organisations and Kosovo health officials shaping the reform process. The author also worked as the head of the office of the International Crisis Group in Kosovo, where she followed political developments and wrote a report on the Kosovo Department of Health. While this firsthand experience provided the author with extremely valuable insight into both the political environment and the health reform process, this involvement may have biased this analysis.

PART ONE: BUILDING A CONCEPTUAL FRAMEWORK

CHAPTER ONE: CONFLICT AND HEALTH REFORM

As the first step in building a conceptual framework to examine post-conflict health reform, this chapter briefly describes the general impact of conflict on population health and health systems. The chapter then focuses on efforts to rebuild health systems. Health is a critical component of post-conflict interventions. International engagement in the health sector ranges from humanitarian assistance, to rehabilitation, to full-scale reform of the health system. Although dramatic health reforms are attempted, most analysts have focused on the humanitarian and rehabilitation elements of post-conflict health assistance. Health reform in post-conflict settings needs further examination.

I. THE IMPACT OF CONFLICT ON HEALTH

Civil wars have a devastating impact on the civilian population: civilians are deliberate targets, social institutions are undermined or destroyed, and the fabric of society collapses. Deaths of non-combatants in wars have increased dramatically, and millions of refugees and internally displaced persons (IDPs) struggle to flee violence. Approximately 5.5 million people died in wars during the first half of the 1990s, with deaths falling to approximately three million between 1997 and 2002. Seventy-five percent of those killed were civilians—some killed directly, but many more dying from disease and malnutrition.³² Currently there are 25 million IDPs (one-third of whom do not receive international assistance) and a global refugee population of eleven to twelve million (United Nations Office of the Secretary General, 2005).

Wars do not just result in heightened civilian deaths and casualties; they also undermine the capacity of societies to function. Infrastructure is destroyed, devastating livelihoods and increasing impoverishment. Governments disintegrate, public services collapse, and a climate of lawlessness and inequity becomes pervasive.

The impact of conflict on population health is extensive, and includes direct casualties from warfare; heightened impoverishment and food shortages leading to malnutrition; increased violence against women; heightened incidence of communicable diseases, including sexually transmitted infections; an increase in mental-health conditions; and a higher level of physical disabilities (Macrae and Zwi,

³² In the Democratic Republic of Congo, eighty-six percent of civilian deaths were a consequence of disease and malnutrition. SONDORP, E. & PATEL, P. (2004) The Role of Health Services in Conflict Ridden Countries. *Journal of Health Services Research and Policy*, 9, 4-5.

1994, Levy and Sidel, 1997, Noji, 1997, International Rescue Committee, 2003, Ghobarah et al., 2003, Sondorp and Zwi, 2002, Macrae, 1995).

As a result, there is an increased demand for health services, at the same time as the capacity of health systems is being systematically undermined. National health systems often suffer extensive damage, which compromises their ability to cope with the heightened demand for their services. Health facilities are damaged and looted, limited resources are available for the provision of public health services, the training of health professionals is disrupted, national health programs such as immunisation are interrupted, and health clinics have difficulty attracting and retaining staff. Many health personnel emigrate or seek higher salaries working for non-governmental organisations in the region. Disease surveillance suffers, as data availability is limited and institutional capacity to assess existing data is severely weakened (Macrae, 1995, Sondorp et al., 2001, Waters et al., June 2004).

Due to the impact of conflict on population health, health interventions are central to the effort to stabilize and reform post-conflict states. First, population health is one of the first casualties of contemporary conflict, and humanitarian assistance in the immediate period following the cessation of hostilities is critical to limiting the loss of life. And second, functioning health systems are crucial for human development: to protect against the threat of infectious diseases, to provide a basis for economic growth, and to ensure that all have the opportunity to contribute to society (Sachs, 2005). The importance of health is reflected in the fact that three of the eight Millennium Development Goals are related to the health sector.³³

Health interventions are an important component of peacebuilding missions. In Kosovo, approximately 80 million Euro was spent on health between 1999 and 2002, which represented the second-largest portion of the Kosovo Consolidated Budget (UNMIK, 2000, United Nations Interim Administrative Mission in Kosovo, 2000). In Afghanistan, the government requested donors provide one billion USD to rebuild the health sector (Waters et al., June 2004). In the first two years of the intervention in Iraq, USAID committed more than 152 million USD to health care initiatives (USAID, 2005). And in East Timor, the World Bank and WHO planned for 38 million USD to be spent on health in four years (Schoor, 2005). These recent interventions

³³ Health related Millennium Development Goals are Goal 4, Reduce Child Mortality, Goal 5, Improve Maternal Health, and Goal 6, Combat HIV/AIDS, malaria and other diseases.

demonstrate that health programs have become an integral part of the international community's post-conflict interventions.

A. Three Phases of Post-Conflict Health Programs

In the post-conflict period, demands on the health system are high. Post-conflict environments are characterized by a proliferation of donors, multilateral organisations, and non-governmental organisations with their own sets of priorities and project objectives. There is a significant risk that in the absence of policy planning and donor coordination resources will be wasted (Macrae, 1995).

There are roughly three phases, outlined in Table Two, in the rebuilding of health systems at the end of a conflict: humanitarian, rehabilitation, and reform (adapted from (Macrae, 1995, Waters et al., June 2004)). Humanitarian and rehabilitation assistance have long been an important component of post-conflict peacebuilding missions. The third phase, the effort to reform and modernize the health care system, evolved as a result of reflection on the need to take advantage of the post-conflict environment to improve health systems. Each of these stages is discussed in detail below.

Table Two: Typical Post-Conflict Health Interventions

<p><i>Immediate</i> Addressing threats to population health</p>	<p><i>Humanitarian/emergency services</i></p> <ul style="list-style-type: none"> • provision of medical treatment • ensuring provision of food, clean water, and shelter • ensuring that humanitarian projects do not undermine health system capacity • coordination of donor and NGO activity to ensure assistance is channelled effectively and is appropriate
<p><i>Medium-term</i> Ensuring that the health system can function at a basic level</p>	<p><i>Rehabilitation</i></p> <ul style="list-style-type: none"> • repair of infrastructure • short-term training programs • gathering preliminary data on population health • development of a longer-term health sector strategy to guide rehabilitation and reform efforts
<p><i>Long-term</i> Modernizing the health system</p>	<p><i>Reform</i></p> <ul style="list-style-type: none"> • further development of health care strategy and implementation of reform goals • transition to a system focused on primary care • reform of system of financing • human-resource planning

1. *Focus on Humanitarian Needs*

In the immediate post-conflict environment, refugees and internally displaced people rush to return home, often to find their sources of livelihood shattered and homes destroyed. Population health is precarious, as supplies of food and potable water are often limited, sanitation systems destroyed, and shelter scarce. The priority is ensuring that humanitarian needs—food, clean water, sanitation, and shelter—are met, and medical services are available. Therefore, the international community typically focuses on meeting the humanitarian needs of the population—access to food and drinking water, ensuring proper sanitation, and providing shelter. In regions where the national health system is not functional, international organisations often provide medical care. Careful coordination is necessary to ensure that humanitarian needs are covered and the role of key actors involved in humanitarian assistance carefully defined (Shuey et al., 2003).

While such projects are critically important to reduce threats to population health, humanitarian agencies have been criticized for their failure to ensure that humanitarian assistance strengthens, rather than undermines, local capacities.³⁴ Too often, humanitarian agencies siphon human resources from the local health care system. International assistance can work to build parallel structures rather than buttressing local ones.

2. *Rehabilitation of Health Systems*

In the medium term, after the situation has stabilized and immediate threats to population health have been addressed, efforts turn to the basic rehabilitation of the health care system.³⁵ Post-conflict environments are characterized by a multitude of donors. Identifying, coordinating, and ultimately regulating the myriad of health care providers—international organisations, the national public system, as well as private providers—that emerge during a conflict makes this phase particularly challenging.

As part of the effort to restore essential health services, projects to repair infrastructure, train local medical staff, and gather basic data on population health are undertaken. Coordination and planning become crucial to ensure the sustainability of the international community's efforts. As agencies prepare to rebuild health care

³⁴ See the Good Humanitarian Donorship Initiative <http://www.reliefweb.int/ghd/>

³⁵ The ability of the international community to undertake rehabilitation projects depends on the stability of the post-conflict environment, which often varies regionally.

infrastructure, they must be careful to ensure that the infrastructure in place prior to the conflict was appropriate (Macrae, 1995). Facility planning must take into consideration population movements after the conflict, including the influx of individuals to cities (Schoor, 2005). Extraordinary resources are required to refurbish and reequip health care facilities, and train health care workers. Unless the local government assumes as much of these expenditures as possible, sustainability and ownership are undermined (Macrae, 1995, Waters et al., June 2004, Sondorp and Zwi, 2002).

Recovery after extensive destruction may offer a unique chance to reconsider the whole health sector and plan it on a comprehensive, rational basis. In many instances, large amounts of capital become frequently available to address major allocative distortions; the atmosphere of change may reduce resistance aimed at preserving the status quo; massive destruction and dilapidation make the abandonment of unwanted facilities easier. Thus building an equitable and sustainable (in the long-term) health system may become a realistic target. A country emerging from a prolonged crisis cannot afford to miss that chance (Pavignani, 2005).

To help ensure that agencies build, rather than undermine, long-term sustainability, analysts recommend that the local government and international organisations develop an articulated national health policy strategy to better manage and coordinate donor and national level resources (Waters et al., June 2004, Macrae, 1995). Such a strategy should be based on rudimentary assessments of health status as well as available levels of financing to ensure that health investments address key determinants of population health, and that available resources are efficiently allocated. This policy process would promote an evidence-based policy debate, even at a rudimentary level, and would help build consensus for rehabilitation goals (Waters et al., June 2004, Macrae, 1995, Pavignani, 2005, Sondorp and Zwi, 2002).

When undertaking rehabilitation projects, a tension exists between the need for quick results and the limitations to the capacity of post-conflict governments. One analyst described the rebuilding of the health sector in East Timor: “It took time for those assisting to understand that the post-conflict development process needed to be slowed down so that the East Timorese could grasp the basics in setting up and running a country” (Schoor, 2005). Some argue undertaking longer-term policy planning in the rehabilitation phase would ensure that the government is strengthened rather than undermined by international organisations undertaking vertical programs (Waters et al., June 2004).

In order to increase capacity for planning and management in the health sector in the long-term it will therefore be important to work with national civil servants and health professionals in order to increase the skills base in the country. In the transitional period, it will be important to work with civil servants, health professionals and community representatives to develop consensus on directions for health policy for the future (Macrae, 1995).

3. *Pressure for Reform of Health Systems*

Humanitarian projects and basic rehabilitation of the health sector are characteristic of many post-conflict settings. Health programs in post-conflict Uganda, Mozambique, and Cambodia focused on the primary care system – the reconstruction of health facilities including right-sizing facility numbers, expanding health service provision, and upgrading the skills of health professionals (Pavignani, 2005).

However, as the peacebuilding objectives of the international community have become more ambitious, so have the goals of the international community in the health sector. As outlined below, post-conflict interventions are seen as a window of opportunity to reform public institutions so as to build the foundation for a more peaceful society. This reform effort includes the health system.

One examination of health projects in post-conflict East Timor makes the observation that the activities in the health sector were really development activities, implemented in an environment with an emergency mindset. The key personnel working on health projects had their main experience in humanitarian response, rather than health sector reform; donors dispensed large sums of money, had short time horizons, and demanded quick results; and a series of independent projects risked undermining a sector-wide approach (Tulloch et al., 2003).

In the post-conflict period, the demands on health systems are staggering. They must meet the health care needs of the population, while undertaking rehabilitation and planning for reform. Unfortunately, these demands come at a time when the capacity for policy development and the ability of the health system to implement reform efforts is low. Moreover, the legitimacy of transitional governments may be questioned by some segments of society—a legacy of years of conflict—and their ability to undertake reform undermined (Macrae, 1995, Waters et al., June 2004, Schoor, 2005).

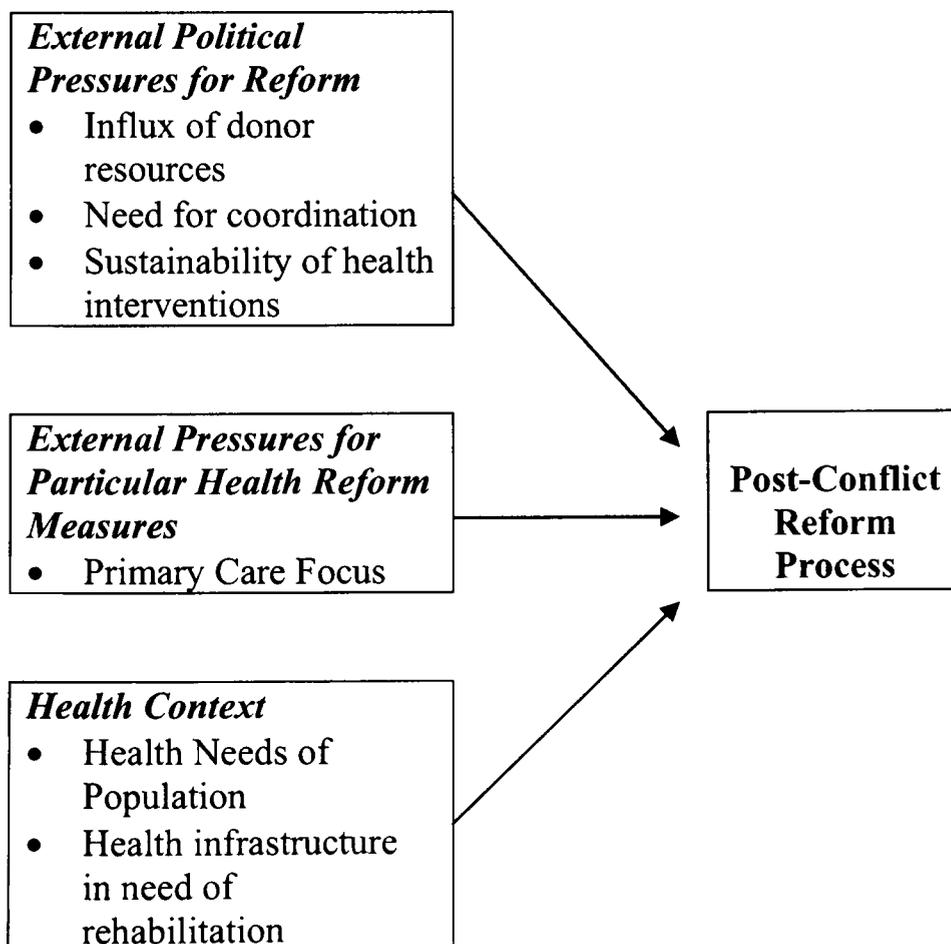
II. SUMMARY: KEY FACTORS EMERGING FROM LITERATURE

Analysis of health programs in these environments has largely been limited to assessments of humanitarian and rehabilitation efforts, and prescriptions for planning reform initiatives. Analysts have emphasized the importance of coordination, ensuring

local capacities are built rather than undermined, and developing a longer-term health strategy in the humanitarian and rehabilitation phases to ensure that critical resources are channelled to build the capacity of a more efficient and effective health system (Sondorp and Zwi, 2002). While analysis of the post-conflict period emphasises the need for a clear health policy framework to be developed, the potential difficulties and pitfalls of the health policy process have not been highlighted.

Figure Two highlights the three forces impacting on the health reform process in a post-conflict setting (where the international community has a significant degree of input and control) which will inform the development of the conceptual framework for the analysis of health reform. First, the tremendous influx of donor resources, the need for careful coordination of the activities of donors and non-governmental organisations, and the need for these interventions to be sustainable creates pressure to have a blueprint outlining how health systems should be developed. Second, specific health interventions are favoured, particularly the movement towards a primary care based system. And third, the health needs of the population and the state of the health infrastructure shape international interventions and the scope of reforms.

Figure Two: Forces Leading to Post-Conflict Health Reform



III. WHAT IS HEALTH REFORM?

The pressures in a post-conflict environment that lead to health reform—poor health status, disrupted health care delivery, and neglected and debilitated infrastructure—are clear. Health sector reform is a broad concept that can include many different initiatives to change the way that health systems operate. Health reform is best described as “sustained, purposive change to improve the efficiency, equity, and effectiveness of the health sector with the goal of improving health status, obtaining greater equity, and obtaining greater cost-effectiveness for services provided” (Basch, 1999). Other authors echo this definition (Mills et al., 2001, Roberts et al., 2004). Reforms differ in two fundamental ways: the number of aspects of the health system that are changed, and how radically the changes depart from past practise. For reforms to be successful, interdependent and mutually supporting interventions must be introduced (Roberts et al., 2004).

For states that are not emerging from conflict, there are three distinct sets of pressures to undertake health sector reform (Figueras et al., 1998). First, reforms often have the objective of targeting health interventions to *improve population health*. Second, *problems within the health sector*—such as escalating costs or poor quality of services—force governments and health service providers to rethink the way in which health services are delivered. International comparisons have demonstrated that in some countries population health is lower than anticipated given available resources and technologies. To understand the reasons for this discrepancy, analysts have examined the organisation of health care services, the cost-effectiveness of health care interventions, the appropriateness of clinical procedures, the quality of services delivered, and equitable access to those services (Figueras et al., 1998, Basch, 1999). Reform measures are based on this analysis.

And third, *economic and political forces outside the health sector* also contribute to health sector reform. Popular expectations for health care provision fuelled by technological advances are often incongruent with available financial resources for health care. The resulting economic pressure to control exploding health care costs prompts health reform initiatives (Figueras et al., 1998). Policy transference can also be a factor in the reform process, with pressures to implement health measures successful in other countries. Countries hoping to accede to the European Union are encouraged to reduce public spending, and implement primary care based systems (Figueras et al., 1998). Reforms also have resulted from efforts by the International Monetary Fund to address acute financial crises in Africa, Latin America, and Asia.

Regional or multilateral agencies such as the World Health Organization (WHO) can also exert influence in the health reform process. In particular, WHO's emphasis on primary care has influenced reform agendas throughout the world.

The goal of health reform is to improve health status and improve the performance of the health system by increasing access to health care, enhancing the quality of that care, and improving the efficiency of the system (Roberts et al., 2004). Public health experts argue that to achieve these objectives the reform program requires clear goals; an accurate diagnosis of problems within the health sector; a reform plan developed with the participation of key stakeholders and focused on the problems of implementation; and evaluation systems built into the reform process to learn from and correct mistakes (Roberts et al., 2004). To achieve the objectives of health reform, reformers have five mechanisms (or 'control knobs') through which they can enact change.

- alterations to the design of financing systems;
- the adjustment of payments to health care providers and facilities to create incentives for change;
- the organisation of the system—i.e. the mix of providers and their roles and functions;
- the implementation of regulations to support the reform process; and
- influencing individual behaviour (Roberts et al., 2004).

These various reform elements are briefly outlined below.

A. The Design of Financing Systems

Financing systems mobilize funds and direct them to particular health-sector activities. There are five basic funding mechanisms to support financing systems: general revenue, social insurance systems, private insurance, direct payments by patients, and community financing. The type of funding mechanism that is employed determines the origins of that money, the amount of money that is available, the entity that controls the funds (private versus public), the ability of the system to manage health care costs, how risks are shared, and the inclusiveness of the system—who receives health care coverage and for what services. Financing systems often employ a combination of these mechanisms. Once funds are mobilized, decisions then should be made about how resources are allocated (Roberts et al., 2004).

B. Adjusting Payments

The payment system comprises the methods through which mobilized funds are dispersed. The entity that controls the funds makes decisions about the type of health care activities to fund, the organisations that will receive funding for these activities,

how much they will be paid, and how those payments will be made. Adjusting the manner in which organisations receive payments can introduce financial incentives for organisational and behavioural change, critical to support reform objectives and improve the efficiency and efficacy of the system (Roberts et al., 2004).

C. The Organisation of the Health System

Health reform activities can focus on four characteristics of the health care system: the organisations that provide health care, the division of health care services among these organisations, the interactions among these organisations, and the administrative structure of these organisations. Reforms can focus on all of these elements, and common reform initiatives include decentralisation and the transition to a primary care based system (Roberts et al., 2004).

D. Regulations to Support the Reform Process

Regulations refer to the full range of legal instruments set and implemented by governments to support other elements of the reform agenda. Both the health care sector and the health insurance system are the subjects of legal and regulatory frameworks, ensuring that the basic conditions are in place for health care systems to operate, that the regulatory environment supports the objectives of the health care system (ensuring equitable access), corrects for market failures, and provides protection from poor quality (Roberts et al., 2004).

E. Influencing Individual Behaviour

Changes in human behaviour can have a profound impact on health system performance. Interventions can focus on addressing lifestyle and prevention behaviour, treatment-seeking and patient compliance behaviours, as well as the behaviour of health professionals (i.e. to be more client-oriented) (Roberts et al., 2004).

F. Evaluating Health Care Reform

While the objectives of health reform are clear—improving population health and the efficacy of health systems—reform analysts have spent less time on how to measure and evaluate the success of reform. Roberts et al. recommend three approaches: measuring changes in health status, determining the level of citizen satisfaction, and the level of financial risk protection provided to the public (Roberts et al., 2004).

In post-conflict environments, these evaluation tools may not be effective. Evaluating health reform based on changes in population health can be problematic.

Valid and reliable data is difficult to obtain in post-conflict environments, and many external socio-economic and political factors impact on health status. Moreover, depending on the key health problems facing a society, an improvement in the health system may not immediately impact and improve health status.³⁶ Measurements of the satisfaction of the public with the health system may be confounded by the difficult social and economic conditions characteristic of post-conflict environments. The level of financial risk protection would also be impacted by the post-conflict social and economic conditions.

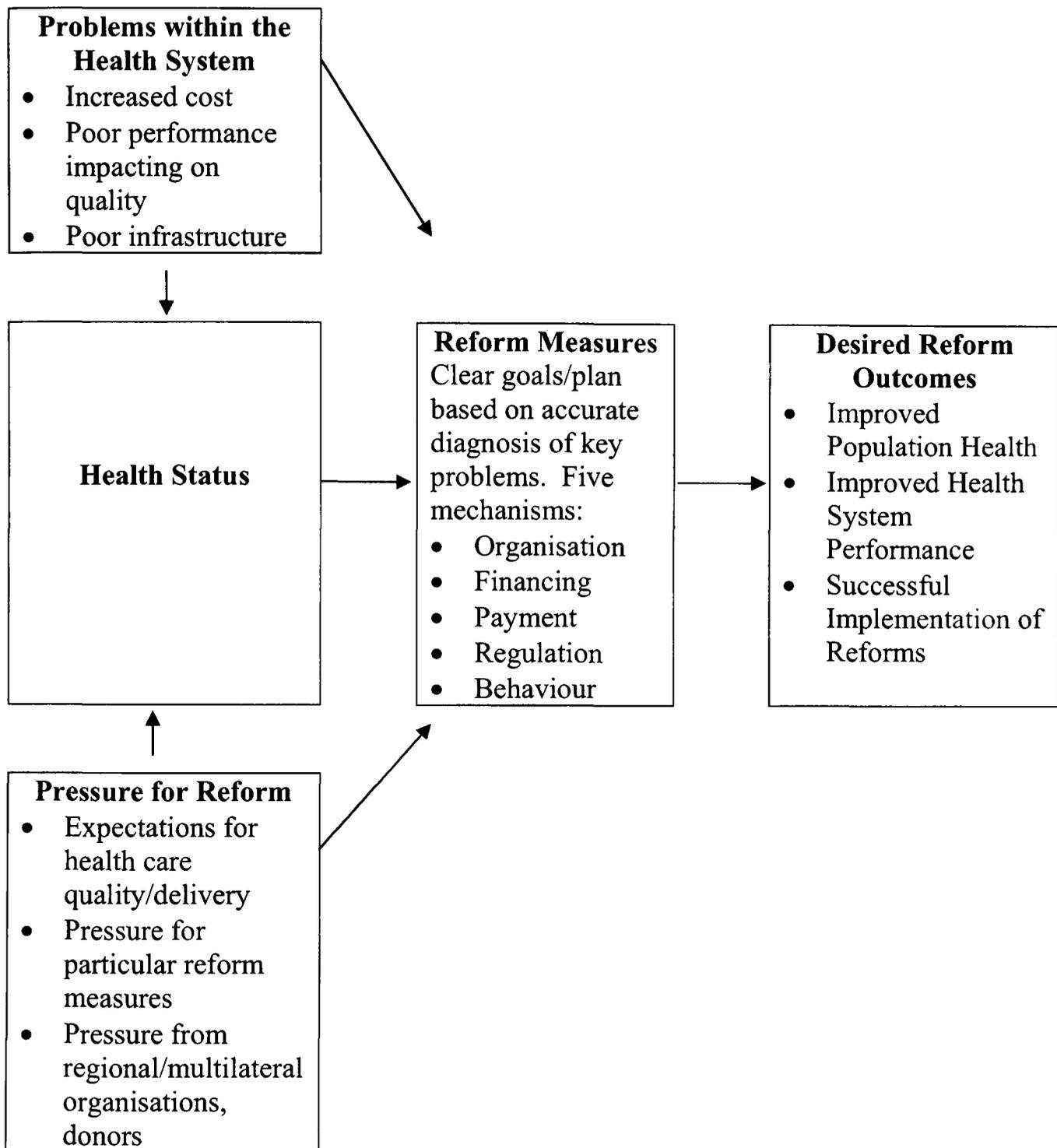
The other possibilities for evaluation of health reforms include an assessment of the performance of the health system through financial and management data, and determining the degree to which the reforms have been implemented. Management data needed to assess improved performance of the health system can also be difficult to obtain, as this data is also obtained through functioning health information systems. Therefore, the one feasible option for evaluation in post-conflict societies is to determine the success in *implementing* reform measures: to what degree were reformers successful in establishing the various programmes outlined by health reform.

IV. SUMMARY: KEY FACTORS EMERGING FROM LITERATURE

Figure Three summarizes the key factors that emerged from the key literature on health reform which inform the conceptual framework to analyse post-conflict health reform. Problems within the health care system such as high costs, poor performance, and poor infrastructure combine with concerns regarding health status and external pressure for reform. Reform measures tend to be composed of interventions focusing on financing, payments, organisation of the system, regulations, or behavioural changes. And the objective of reform is improved population health and improved health system performance (improving public satisfaction and expanding risk protection).

³⁶ High rates of morbidity and mortality from communicable diseases characteristic of humanitarian emergencies can, under the right circumstances be reduced quite quickly. However, dramatic health improvements in populations with lower morbidity and mortality, with a high burden of non-communicable diseases can be more challenging.

Figure Three: The Basic Health Reform Process



While the literature on health reform describes the pressures for reform and the reform measures typically implemented and provides another important building block in our conceptual framework, it assumes that a strong and capable government exists and that the health system is already functioning at a sufficient level to generate health and management information. While the literature does mention the challenge of implementation, it does not address sufficiently the key obstacles in the implementation process such as the challenge of implementing health reform in an environment with low government capacity, damaged infrastructure, dispersed human resources, and a difficult socio-economic context. To better understand the challenges associated with this type of environment, Chapter Two examines the challenges faced

in implementing the health reform process in Central and Eastern Europe, with the objective of further developing the conceptual framework for post-conflict health reform.

CHAPTER TWO: HEALTH REFORM IN EASTERN EUROPE

The countries in Central and South Eastern Europe have witnessed dramatic social, political, and economic changes over the past fifteen years. The fall of the Berlin Wall precipitated the relatively peaceful collapse of communism throughout the region. Post-communist governments allowed political parties to form and hold democratic elections. Market-oriented reforms were initiated in formerly state-controlled economies. People and ideas began to flow freely into the region. These sweeping changes included a radical restructuring of health care systems, with most countries implementing similar reforms of their health systems.

The health reform effort in Kosovo was similar in scope to health reform programs implemented across Central and Eastern Europe after the fall of the Berlin Wall. Moreover, the health system prior to the conflict in Kosovo and the health system prior to the reform effort in Central and Eastern Europe were similar. This chapter outlines these reform programs with the view to building the conceptual framework to analyse health reform in Kosovo. It begins by describing the context for health reform, including problems faced by the pre-transition system and political and economic pressures for reform. It then examines the reform program, assesses its impact, and outlines the factors that have undermined the reform process. Supporting information detailing the nature of the reform program in Central and Eastern Europe is contained in Appendix One.

I. CONTEXT OF REFORMS IN CENTRAL AND EASTERN EUROPE

Much of the literature on health reform focuses on the type and sequencing of reform measures, arguing for evidence based interventions that are appropriately controlled and sequenced. The literature assumes a functioning government, a stable political environment, and reform measures that have originated—at least in part—from stakeholders within society. Little analysis is made of the implementation of health reform, particularly in difficult settings. The health reform experience in Central and Eastern Europe can add to the conceptual framework by outlining the pitfalls encountered during the implementation of reforms in a politically charged environment.

Pressure for health reform in the countries of Central and Eastern Europe began after countries in the region began to liberalize their economies. The reforms implemented across the region were largely similar – a reorientation to primary care, reforming the role of secondary and tertiary care, strengthening the public health

system, decentralization, and financing reforms. Both problems with the health system as well as political and economic forces outside the health sector drove health system changes. The forces driving reform, the reform measures implemented, and the successes and failures of the reform program are outlined in detail in Appendix One. As detailed, all countries throughout the region struggled with the reform process, particularly with the effort to transition from a specialized to a primary care based system and to reform the financing of health care.

II. FACTORS UNDERMINING REFORM:

The reform program has not been fully implemented in most countries in Central and Eastern Europe. Many reform programs were derailed by factors external to the health system and problems with the reform program itself. While significant regional variation existed, there were general trends. Table Three presents the key problems associated with reforms and identifies the factors that undermined the implementation of reforms. These factors are then explained in detail below.

Table Three: Key Findings from Health Reform in Central and Eastern Europe

Package of Reform Measures	Key Problems	Factors Affecting Implementation
<i>Reforming the Organisation of the System</i>		
<i>Strengthening Primary Care</i>	<ul style="list-style-type: none"> • Specialists and public alike have resisted changes • Gatekeeping function not working: patients bypass primary care based system, or are referred to secondary care for problems easily treated at primary care level • Referral system does not function well: patients returning from hospital do not have follow-up from primary care doctors 	<ul style="list-style-type: none"> • Lack of financial resources (economic instability) • Lack of political will • In Albania and Balkans, political instability • Pace of change too fast • Poor policy planning • Financing failures • Failure to establish effective primary/secondary care interface • Human resource problems—inappropriately trained doctors, lack of support for family medicine.
<i>Reform of Secondary and Tertiary Care</i>	<ul style="list-style-type: none"> • While hospitals have been closed, in those that remain open, the occupancy rate is quite high • Focus of reforms on primary care has meant important quality issues at the secondary level have been ignored • Specialist care and hospitalisation pose significant financial burden as under-the-table payments are frequently demanded 	<ul style="list-style-type: none"> • Lack of financial resources (economic instability) • Pace of change too fast • Poor policy planning • Financing failures • Failure to establish effective primary/secondary care interface
<i>Strengthening Public Health</i>	<ul style="list-style-type: none"> • Public health systems continue to emphasize vertical programs like immunisation rather than prevention of diseases and injuries • Unable to respond to significant public health challenges exacerbated by transition to liberal democracy (alcoholism, substance abuse, malnutrition, homicide, suicide, preventable injuries) • Lack of attention to preventable childhood injuries extremely problematic 	<ul style="list-style-type: none"> • Unhealthy lifestyles • Poor policy planning • Financing failures • Weak data collection

Package of Reform Measures	Key Problems	Factors Affecting Implementation
	<ul style="list-style-type: none"> • Rise of drug resistant strains of tuberculosis 	
<i>Human Resources and Quality of Care</i>	<ul style="list-style-type: none"> • Training programs in family medicine have not significantly changed the bias against primary care • Little incentive to put clinical guidelines, if produced, into practise • Few incentives to change behaviour at patient-practitioner level • Emigration is causing 'brain drain' in some countries 	<ul style="list-style-type: none"> • Poor policy planning • Weak capacity • Financing failures • Weak data collection
<i>Decentralisation</i>	<ul style="list-style-type: none"> • In some regions, inadequate resources as rich areas are reluctant to allocate resources to poorer areas • Decentralisation took place only on paper, as capacity did not exist locally to manage resources 	<ul style="list-style-type: none"> • Lack of political will • Poor policy planning • Weak capacity • Financing failures
Reforming Financing and Payments		
<i>Health Care Financing</i>	<ul style="list-style-type: none"> • Social insurance schemes suffer from a narrow revenue base, with many countries experiencing high levels of unemployment and low formal labour-market activity • Rise in informal payments has generated inequity • Private practise often unregulated and siphons resources away from public system • Inability to identify publicly funded health benefits package • Effort to set up performance based systems inadvertently established perverse incentives to bypass primary care • Contracting undermined by weak data and low technical and management capacity 	<ul style="list-style-type: none"> • Lack of financial resources (economic instability) • Poor policy planning • Financing failures • Weak data collection • Low capacity
Behaviour		
	Little attention paid to behaviour interventions	

A. External Factors Undermining Reform

1. Economic Instability

For most of Central and South Eastern Europe, a period of severe economic turmoil accompanied the transition to a market economy. Tight fiscal reform policies were introduced, economic productivity plummeted, and massive layoffs ensued causing high unemployment rates. Price and wage liberalisation led to inflation, as well as a widening gap in income distribution. Privatisation of state enterprises often resulted in the pillaging of assets, rather than investment in competitive enterprise. A breakdown in the distribution system caused supply shortages. Crumbling infrastructure also created a disincentive for investment (Kanavos and McKee, 1998, Basch, 1999).

After 1989, the economies of countries in South Eastern Europe suffered greatly from this transition as well from instability in the former Yugoslavia. A comparison of GDP in 1989 to GDP in 2000, as outlined in Table Four, demonstrates how the economic fortunes of the region fell during the 1990s.

Table Four: Real GDP in 2000 as Percentage of Value in 1989

Country	Real GDP in 2000 as % of value in 1989
Albania	101.7 %
Bosnia and Herzegovina	35 % (in 2001 compared to 1990)
Bulgaria	69.6 %
Croatia	80.4 %
Macedonia	77.4 %
Moldova	30.6 %
Romania	76.8 %
Serbia and Montenegro	41.6 %
EU average	156 %

Source: (Rechel and McKee, 2003).

This economic instability placed an extra burden on the health reform process. While the costs of health care increased after 1989, because the economy was so weak governments were unable to increase their health spending. Capital investments in health centres decreased. Hospitals were old and poorly equipped, and capital expenditures were unable to support existing facilities or introduce new technology (Hinkov et al., 1999, Kanavos and McKee, 1998).

Due to resource shortages, many primary care health facilities lacked basic drugs and equipment was old and poorly maintained (Ensor, 1993). This financial strain slowed and in some cases stalled the implementation of health reforms, and

provided impetus for an informal market in health services (Figueras et al., 2000). In Albania, for example, health care spending remained too low to provide quality care and make the necessary investments in facility infrastructure and equipment. Total spending on health care is approximately only three percent of GDP (Tragakes, 2003).

2. *Unhealthy Lifestyles*

As outlined above, health reforms were introduced to improve the efficiency, equity, and effectiveness of the health sector with the objective of improving health status, obtaining greater equity, and greater cost-effectiveness (Basch, 1999). The focus on health status in the reform program was important. Poor population health undermines economic development, and health systems exist to respond to the burden of disease in a population (McKee, 2004).

One of the objectives of reform was to improve health status, but reformers did little to implement behavioural change. Efforts to improve population health were often undermined by factors outside the health system. Abuse of alcohol, poor diet, smoking, narcotics use, and deaths from injury and homicide were key health issues in the region (McKee, 2004). Altering individual lifestyles, particularly in a context of the turmoil resulting from political transition, is far more challenging than reorganizing the health care system (Saltman and Figueras, 1997). Health services can only have a limited impact on the causes of ill health (Saltman and Figueras, 1997, Nuri and Healy, 1999, Hinkov et al., 1999, Gaal et al., 1999, Karski et al., 1999). While these lifestyle factors derailed many health benefits from the restructuring of health systems, the reform program generally placed too little emphasis on changing individual patterns of behaviour.

3. *Lack of Government Capacity: Political Will*

Strong political commitment is required to develop and implement reforms. Changes proposed by the reform process were resisted for a variety of reasons. First, the status quo is comfortable, and organisational change will always be resisted by certain elements within the health care system. Second, reforms threatened embedded interests, including the authority and power of state agencies. Ministry officials were often corrupt and were reluctant to give up their rent-seeking opportunities (Mills, 2000, Mills et al., 2001, Figueras et al., 2000). Strong commitment from politicians was necessary to overcome resistance from these embedded interests. And third, wider commitment from the public service was necessary. Ministries of health were part of government and did not have the authority to introduce new accounting systems, hire

and fire personnel, increase fee levels, or change funding arrangements. Reforms in the health sector therefore required overarching reforms within the public sector (Figueras et al., 2000, Mills et al., 2001).

Yet political commitment for these reforms was difficult to secure. As seen below, the long-term horizon of health reform implementation was at odds with the short-term vision of politicians.

4. *Lack of Government Capacity: Political Instability*

The region has been characterized by political instability. The political cycle of elections impeded the progress of reforms in many countries in Eastern Europe. Therefore, the support of politicians for health reform was not constant. Strong supporters of health reform were either voted out of office, or quickly lost their appetite for change. In Bulgaria, although health reforms were initiated early on in the transition process, the lack of political will for change meant that reforms were not implemented until the late 1990s (Koulaksazov et al., 2003). Frequent turnovers in government have been problematic for the consistency and continuity of the reform process. Often such changes meant that civil servants at all levels of the policy process were fired, undermining the administrative capacity to implement change and politicizing the civil service (Nuri and Healy, 1999, Gaal et al., 1999, Goicoechea, 1993, Rathwell, 1998).

Frequent political turnovers undermined initial reform efforts, particularly in countries where national-level stakeholders strongly resisted reform measures (Figueras et al., 2004). In Albania, Poland, and Bulgaria, among others, turnovers in government have stalled reform progress, halting important reform efforts such as decentralisation, regulation of private practice, and stamping out corruption. In Hungary, for example, there were nine health ministers from 1999 until 2004. Each minister created new reform objectives, and often changed critical staff in health care organisations (Szocska et al., 2005). This lack of political will to support reform became a major impediment to health reform and, as a result, change was introduced very slowly, if at all (Figueras et al., 2004).

While some countries experienced instability in the political arena, civil unrest in other countries undermined the reform effort. In Albania, civil unrest in the 1990s impeded the implementation of many of its reform measures. Almost a quarter of health centres in Tirana and one-third of village health centres were destroyed in the civil unrest of 1991 and 1992. In 1997, further unrest resulted in the looting of drugs

and equipment. Instability in neighbouring Kosovo and the influx of refugees further strained the delivery capacity of primary care health care services (Nuri and Healy, 1999, Tragakes, 2003).

5. *Lack of Governance Capacity: Weak Administrative Capacity*

Reform programs required strong government administrations, which were willing and able to recognize their 'stewardship' role in the health sector (WHO, 2000b). Yet governments throughout the region are characterized by weak administrative capacity. As part of the overall reform process, entire government administrations were fundamentally restructured throughout the region. Ministries of health were reorganized to reflect the changing responsibilities of the government in the health sector. Reforms, including the decentralisation of responsibility for primary care and the division of the purchaser and provider functions, often reduced the role of the central government to regulation and monitoring.

The restructuring of health care administrations reduced the capacity of the state to manage the reform process. The goals and objectives of reform were rarely defined, as health ministries were stretched by multiple demands to manage the administration of the health system while simultaneously reforming it. There was a rapid turnover of public-sector personnel with the best people leaving for better-paid jobs in the private sector or with international agencies, or emigrating abroad (Figueras et al., 2000, Mills et al., 2001). This undermined the ability of the state to monitor the reforms. Key financial, management, and information systems remained underdeveloped. And the technical skills required to interpret the health and financial information that did exist were lacking (Figueras et al., 2000, Mills et al., 2001, Figueras et al., 2004).

The analysis of experience in the region shows that the introduction of reforms succeeds only when they are accompanied by strong regulatory, managerial, and information capacity, which is often lacking in countries. In other words, if the stewardship role of the government is weak, regardless of the merits or otherwise of particular reform models, they may lead to catastrophic results for the society (Figueras et al., 2004).

This lack of capacity was particularly true at the local level. Given the emphasis on decentralisation as part of the reform package and the implementation of primary care at the municipal level, the lack of local administrative capacity was extremely problematic for the implementation of the transition to primary care (Nuri and Healy, 1999, Hinkov et al., 1999, Gaal et al., 1999). The failure to address

informal payments, widespread in primary and secondary care settings, is one example of how this weak capacity impacted on reform objectives.(Figueras et al., 2004).

Donors inadvertently contributed to problems of weak capacity. Mechanisms for planning and monitoring assistance diverted government capacity away from reform planning and implementation to aid management. Despite the emphasis of donors on capacity development, most donors establish their own independent enclaves for project implementation rather than building capacity in the system more broadly (Mills et al., 2001).

Pressures external to health ministries also reduced their capacity. These factors included the cultural legacy of socialism where individual initiative was stifled and corruption was entrenched. External constraints should have been better understood and incorporated into health reform packages, with the understanding that certain reforms were not feasible or desirable in the short term (Bennett, 2000, Mills et al., 2001).

Capacity building is by its nature incremental and slow. Therefore, reform objectives should incorporate long timeframes and realistic objectives before significant results can be achieved (Bennett, 2000, Mills et al., 2001, Walt, 1998).

Above, the thesis examined the external social, political, and economic factors that undermined the reform process. Below, the thesis examines factors internal to reforms—the implementation of the reform measures—that impacted on the success of the reform program.

B. The Implementation of Reform Efforts

1. Pace of Change: Too Much Change, Too Fast

Many advocates of reform argued that the collapse of communism offered an important opportunity for introducing new, modern health systems. This was a period of intense political and social transformation. Stakeholders with an interest in blocking reform had lost their political base of support. Donor investment to support the reforms was readily available. And progressive members of the medical community and the public supported the modernisation of the health system. Reformers argued that to be successful changes to the health system should be introduced as quickly and completely as possible, while these facilitating conditions existed.

As a result, health reforms were introduced very quickly—and, in some contexts, too quickly. As one analyst noted:

Rapid ‘big bang’ reforms such as in the Czech Republic were effective in bringing about change in a short time. However, experience shows that for this

to be sustainable and effective in the long term, two prerequisites are crucial: a degree of technical ‘certainty’ as regards the reform model to be introduced, and a broad social consensus behind the chosen model. The lack of either one of these in some countries that underwent a ‘big bang’ reform has resulted in major reversals (Figueras et al., 2004).

As seen above, reform depends on factors outside the health system such as political will and stability, the macro-economic situation, and governance capacity (Figueras et al., 2000). The post-communism period did create a window of opportunity for reform, however, the ensuing economic crisis and frequent changes in government that occurred in many countries throughout the region weakened government capacity to plan for and implement change (Mills et al., 2001).

A rapid pace of change is difficult to sustain. While incremental approaches to reform allow stakeholders to organize resistance to policy changes, it may be more sustainable than radical ‘big bang’ reform (Figueras et al., 2004). Incremental change facilitates buy-in from stakeholders, and the implementation process is easier to manage. Reform programs are most successful when reform measures match the knowledge, technology, and resources that already exist in the system, and when the change from the status quo is relatively marginal (Walt, 1998). Albania has pursued a slow pace of change in financing and organisational reforms, and as a result some stability has been preserved (Tragakes, 2003).

2. *Poor Policy Planning*

Reforming the health sector is a difficult process. The health care system is complex, composed of heterogeneous actors, and prone to market failure. Reform measures often change the role of government from direct provision to regulation and enforcement. The process of reform subsequently becomes more complex as the government must create incentives for actors outside government to implement the reforms (Mills et al., 2001).

Many well-intentioned health reforms have exacerbated inefficiencies and inequities (Frenk, 2000). As seen above, financing reforms in Central and Eastern Europe inadvertently created incentives for physicians to refer patients up to the secondary level, when treatment could have been provided at the primary care level. In addition, the poor economic situation and the lack of oversight meant that under-the-table payments for medical services and pharmaceuticals became prevalent, undermining equity of access.

Reforms therefore need to be carefully designed and the implementation process planned to avoid such problems. Health reform efforts have largely focused

on the technical features of reform policies such as the ‘best’ method of health care financing, the advantages of a system focused on primary care, and the introduction of family medicine (Figueras et al., 2000, Walt, 1998). Although reforms may be technically brilliant, their implementation could be difficult or impossible due to political, social, and economic realities (Mills et al., 2001). Planning for the implementation of the reform program is a critical yet often omitted step that increases the risk of reform failure.

In designing the reform program, a number of factors need to be taken into account. The prior health system and its capabilities, political realities such as multi-party or coalition governments, the technical complexity of reforms, and the interrelationship among different reform elements should be part of the planning process (Mills et al., 2001). Implementers must assess macroeconomic and other resource constraints, culture and values, and available technical skills (Figueras et al., 2000, Walt, 1998).

After such an assessment, an implementation strategy should be developed which makes reform objectives explicit; establishes management structures; allocates responsibility for implementation; assesses available financial, technical, and managerial resources; puts in place appropriate information and management systems; and develops and enacts enabling legislation for reform (Figueras et al., 2000, Figueras et al., 2004).

However, the critical step of implementation planning is rarely undertaken. Donors, international organisations, and national policy elites often drive the reform process and lack sensitivity to issues that will impede implementation. Civil society, such as non-governmental organisations and the media, is rarely consulted on the nature of reforms. If they are consulted, such groups are asked to rubber-stamp readymade reform programs, rather than contribute to the development of reform measures.

The issue of local ownership of reforms is critical. Too often, reforms were developed in western countries and transferred to the region, rather than reflecting the local social and historical context (Figueras et al., 2004). “Unless health sector reform strategies are capable of rooting themselves in national cultural ‘soil,’ they are not likely to produce the expected outcomes or to be sustainable over the medium to the long term” (Figueras et al., 2000).

As a result of the lack of local consultation, policy makers often ignored contextual factors that undermined the reform process, including the legacy of the past system, the unrealistic timeframes for reform, and the wider public sector and government context.

Health systems in Central and Eastern Europe were traditionally highly centralised, and the informal values, norms and conventions that constituted the management culture of these bureaucracies also tended to be centralised. Reforms threatened key stakeholders such as politicians, health workers, and health service users, yet these were typically the individuals who were expected to carry them out (Bennett, 2000, Mills et al., 2001, Walt, 1998).

This system did not facilitate change, let alone far-reaching reforms. Therefore, implementing reform in such an environment was extremely difficult.

Many of the difficulties experienced [in implementing reforms] have had more to do with the complexity of changing customs and practices than the actual content of the reform programmes, and to a significant extent the success or failure of reform has depended on the ability of policy-makers to implement and manage change (Figueras et al., 2004).

To be successful, reforms should have been less ambitious, maintained existing structures, and focused on high-priority health issues (Figueras et al., 2004).

3. *Financing Failures*

Health reform efforts were also derailed by a shortage of funds. Because of the poor state of the economy and pressure from international organisations such as the World Bank and the IMF to rein in public spending, governments were reluctant and unable to increase dramatically the resources channelled to the health sector. Therefore, the reform program focused on efforts to increase the cost-effectiveness of health care services. As outlined above, reforms included efforts to split the purchaser and provider functions through the creation of social insurance agencies, but these reforms faltered.

In Albania, health care expenditure was only three percent of GDP in 2000, so the government was encouraged to increase health expenditure to meet reform objectives (Tragakes, 2003). However, Albania like most other governments could not afford to increase resources to the health sector and therefore worked on reforms to make services more cost-effective. Large segments of the population are not yet making financial contributions to the health insurance scheme, but are making out-of-pocket payments for pharmaceuticals and services, which have reduced access for

lower-income groups (Tragakes, 2003). Money is available—the willingness exists to pay for services—but that money is not being channelled into the health system.

Attempts to split the purchaser and provider functions were problematic due to inadequate and unpredictable funding, low provider autonomy, absence of information systems, lack of timely information and sparse technical capacity and information management skills (Figueras et al., 2004). In addition, for the purchaser/provider split to work properly, the technical and administrative capacity of purchasers must be high and they must have access to information and monitoring systems (Figueras et al., 2004). Throughout much of Central and Eastern Europe these conditions did not exist.

Governments throughout the region also pursued efforts to promote cost-sharing through market incentives such as competition amongst insurers. However, such efforts undermined universal access (Figueras et al., 1998), particularly when coupled with the failure to identify a realistic benefits package. Defining such a package is a critical step in the effort to balance concerns about equity with limiting entitlements so public revenue is spent on cost-effective interventions (Figueras et al., 2004).

4. *Lack of Enthusiasm for Organisational Change*

Family medicine, considered a cornerstone of primary care, was a new concept for the region. Given the emphasis placed on specialist training in the pre-transition period, the quality of general practitioners tends to be quite low. Therefore many patients historically have bypassed the ‘gatekeeper’ role of general practitioners or family doctors and have gone straight to specialists (Ensor, 1993, Bladescu et al., 2000). Patients resisted primary care reforms and the appropriate point of first contact was often contested (Hinkov et al., 1999). In Bulgaria, because of long waiting times, poor quality of services, and excessive cost sharing, polls show that much of the population objects to primary care reforms (Koulaksazov et al., 2003).

The medical profession also resisted the concept of family medicine; it became difficult to introduce it as a specialisation. Most medical schools in Central and South Eastern Europe introduced training of family doctors only grudgingly (Nuri and Healy, 1999).

In many regions, more than one scheme of primary health care services (i.e. specialists performing primary health care functions) led to the duplication of services, the waste of resources, and the fragmentation of care (Goicoechea, 1993). In Albania, specialists often accept under-the-table payments and have little incentive to buttress

the primary care system (Tragakes, 2003) For health reforms to be effective, services provided at the primary care level must increase, and family doctors need to have the authority to direct patients to the most appropriate level of care (Figueras et al., 2004)

5. *Organisational Changes: Weak Primary-Secondary Care Interface*

While reforms attempted to strengthen primary care, this effort was undermined by the traditional strength of the secondary level of care. This tradition has made efforts to cut secondary-care services difficult, made establishment of a referral system problematic, and undermined the power of primary care professionals.

Efforts to transfer resources from secondary care to primary care, including cutting hospital beds, often undermined population health. In a system where primary care services are weak, hospitals are the main providers of health care. Cutting resources to secondary care left patients with few other options (Figueras et al., 2004) Moreover, the establishment of a properly functioning referral system, including how and when patients are admitted to hospital and when they are discharged, was undermined. Primary care professionals were unable to follow up properly on patients discharged from hospital because the interface between primary and secondary care was undeveloped (Figueras et al., 2004)

The interface between primary and secondary care has been difficult to establish because primary care professionals lack authority within the system. For medical graduates, specialisation is more prestigious than pursuing a career in family medicine. Financial incentives to work at the primary care level also do not exist. Family doctors are often reluctant to provide treatment themselves. In most states, they receive little financial benefit for retaining patients rather than refer them to hospitals (The Monee Project, 2001)

For the primary-secondary care interface to operate effectively, the services provided by primary care level need to be increased. Primary care professionals need to have more control over levels of care, be able to direct patients to the most appropriate level of care, and monitor patients in hospital and after they have been discharged from hospital (Figueras et al., 2004)

6. *Weak Data Collection*

Health reforms require sophisticated information systems outlining health, financial, and other management data to assess the kind of reforms that are needed, and whether these reforms are meeting their objectives once implemented (Figueras et al., 2004)

Unfortunately, in many countries in Central and Eastern Europe, data on the health system are unavailable or inaccurate. Health information systems in the region are often in disarray. Collection of routine data on mortality is not systematic, while morbidity data are even more problematic (Rechel and McKee, 2003) Information systems upon which to measure the performance of both primary and secondary levels of care or to assess whether staff have the right skill sets or are using evidence-based interventions are often not available. Therefore, efforts to improve efficiency and cost-effectiveness of health services often lack the foundation of evidence (Figueras et al., 2004)

Data that does exist on population health is often suspect due to the scale of population movements since 1990. Because population size is the denominator when calculating rates, the lack of accurate population data casts doubt on many health statistics (Rechel and McKee, 2003) Therefore, the accuracy of data from both before and after the reform efforts is questionable (Gaal et al., 1999, Busse, 2000, Nuri and Healy, 1999)

7. *Human-Resource Problems*

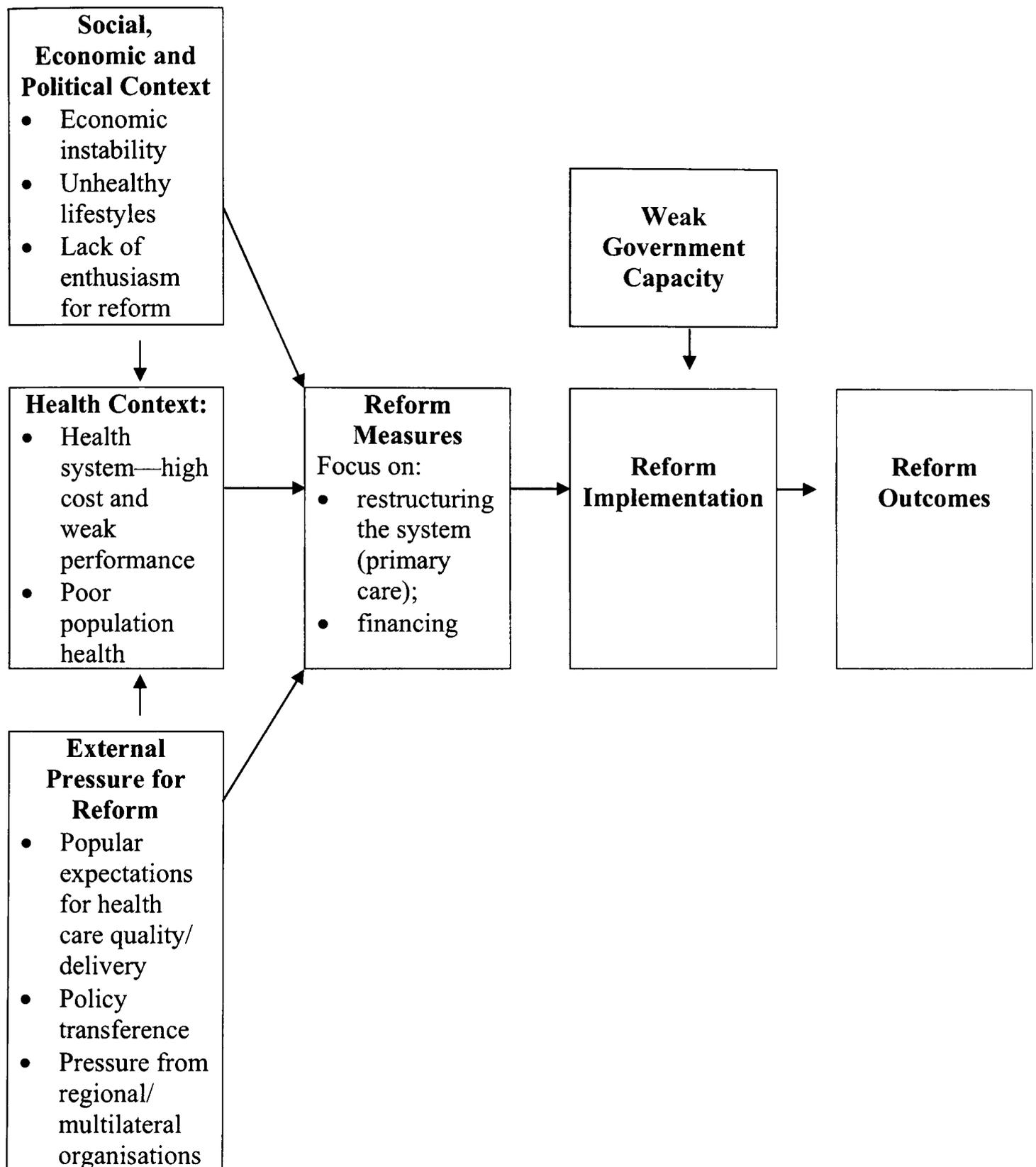
To meet reform objectives, the quality and quantity of health care professionals needs to be improved. The right mix of health professionals in the areas of family medicine, public health, specialists, and managers must be achieved. Moreover, the prerequisites for maintaining and enhancing skills through continuing education and professional standards and accreditation should be developed. Health care professionals must also feel motivated through pay, employment security, and working conditions to provide health care and to advance health reforms (Figueras et al., 2004)

III. SUMMARY: KEY FACTORS EMERGING FROM LITERATURE

The analysis of the factors—external social, economic, and political factors, as well as those internal to the reform process—that impeded the reform program provide an important input into the conceptual framework to analyse health reform. Figure Three outlined the basic reform process, but the analysis of health reform efforts that informed Figure Three assumed a functioning state with the capacity to implement reforms. The most critical ingredient to health reform process was the quality and sequencing of the reforms—ensuring that the reform program was evidence-based and that the various ‘control knobs’ were turned the right way. This framework did not sufficiently factor in the social, economic, and political circumstances impacting on the reform process.

The experience of health reform in Eastern Europe points to factors internal to the process of implementing reforms: time horizons too short for implementation, poor policy planning, the failure of financing reforms, the lack of enthusiasm for the reform program, and the difficulty to implement organisational change with weak human resources and poor health data. The Eastern European reform program also points to economic instability, unhealthy lifestyles, the lack of government capacity to implement reforms, and political instability all impacting on the reform program. Figure Four incorporates these elements into the Conceptual Framework for analysing post-conflict health reform.

Figure Four: Factors Impacting on the Reform Process in Central and Eastern Europe



CHAPTER THREE: THE POST-CONFLICT REFORM AGENDA

One of the key forces driving health reform in Kosovo was the international agenda for post-conflict Kosovo: the effort of the international community to build the foundation of a liberal democracy. This spirit of international engagement—the desire for broad political, economic, and social change—shaped the overarching public-sector reform underway in Kosovo, including the reform of the health sector. Understanding this peacebuilding context is critical to understanding the external forces driving health reform.

I. THE ERA OF PEACEBUILDING

From Iraq to Afghanistan, Haiti to East Timor, the international community is undertaking more frequent and complex interventions in states that are at war, are emerging from war, or are seen as a threat to international peace and stability. Such interventions are ambitious, including military engagement to overthrow repressive regimes and unprecedented efforts to reform the political and institutional structures of the state. The logic behind these interventions, which require significant international investment, is that reformed, liberal, democratic states are less likely to relapse into internal conflict or go to war with other democratic states, and thus are important for regional and international stability.

One of the first of these interventions occurred in Kosovo. Air bombardments carried out by forces operating under the umbrella of the North Atlantic Treaty Organization (NATO) forced the withdrawal of the Federal Republic of Yugoslavia's (FRY) troops and police, as well as the withdrawal of Serbian political authority from the province.³⁷ The United Nations assumed political and administrative responsibility and began a process of building autonomous institutions of self-government. The international community subsequently invested over two billion dollars in assistance in the effort to build liberal democratic institutions.

This chapter outlines the forces that led to this new era of interventionism, and details lessons learned from the international community's ambitious peacebuilding efforts. It argues that the international community attempts "compressed development" in post-conflict environments. Massive resources are committed to ambitious political, social, and economic reform projects in the effort to avert a return

³⁷ Kosovo is a province of the Republic of Serbia. The Federal Republic of Yugoslavia (FRY), which dissolved in 2003, included the Republics of Serbia and Montenegro. The FRY transformed into the Union of Serbia and Montenegro.

to violence. These projects often have short time horizons, as policy makers believe that the political will and resources of the international community, coupled with the fluid political and social dynamics of post-conflict settings, present a window of opportunity for rapid reform. However, as the international community is discovering, building democratic institutions is a time-consuming and difficult process.

II. THE NEW INTERVENTIONISM

Although the end of the Cold War stopped the arms race between the United States and the Soviet Union, the cessation of superpower rivalry contributed to an explosion in the number of civil wars throughout the developing world, termed by some as an era of “new interventionism”.³⁸ Since the end of the Cold War, more than 120 wars have been fought worldwide, and more than ninety percent of these wars have been internal conflicts (Smith, 2003)

International intervention in unstable states is not a new phenomenon. During the Cold War, the United States and the Soviet Union spent millions of dollars in civilian and military aid supporting proxy regimes. Peacekeeping missions under the auspices of the United Nations worked to support the implementation of ceasefires. International humanitarian organisations such as the International Committee of the Red Cross (ICRC) and the United Nations High Commissioner for Refugees (UNHCR), as well as non-governmental organisations such as Médecins Sans Frontières (MSF), CARE, Oxfam, the International Rescue Committee (IRC), and many others, provided medical and food aid to civilians fleeing conflicts.

While the international community’s presence in crisis situations is not new, the current scale and intensity of international intervention to prevent conflict, halt civil wars, and protect civilians from the impact of violent conflict is largely unprecedented.³⁹ Although some may believe that the international community intervenes more frequently in internal conflicts because the number of civil wars has risen, this is actually not the case. The number of civil wars did increase between 1990 and 1992, but by 2003 the number of internal conflicts declined by forty percent. This

³⁸ The phrase the ‘new interventionism’ was used by Michael Doyle to describe the heightened engagement of the international community in sovereign states, particularly those that are unstable. DOYLE, M. W. (January 2001) The New Interventionism. *Metaphilosophy*. Volume 32, 212-235.

³⁹ Some authors compare current levels of international engagement to the situation after World War II, where the Allies reformed the state institutions of Germany and Japan. ORR, R. C. (2004d) The United States as Nation Builder: Facing the Challenge of Post-Conflict Reconstruction. IN ORR, R. C. (Ed.) *Winning the Peace: An American Strategy for Post-Conflict Reconstruction*. Washington, Center for Strategic and International Studies.

decline coincided with the rapid growth of United Nations activity in these conflicts (The UN Secretary General's High-Level Panel, 2004) Several factors account for the heightened engagement of the international community in unstable states around the world.

A. New Opportunities for International Cooperation

New peacemaking opportunities emerged as antagonism between the United States and the Soviet Union diminished, the Berlin Wall fell, the Soviet Union collapsed, and a transition to a market economy began throughout most of the former Soviet Bloc. The Security Council was able to function more effectively in the absence of the enmity between the United States and Russia. The ability of the United Nations to supply peacekeeping missions therefore increased. From 1989 to 1999, the United Nations initiated thirty-three peace operations, while in the previous four decades it had deployed only fifteen (Paris, 2004)

B. The Legacy of Rwanda and Bosnia

The failed efforts of the international community, led by the United States, to bring peace to Somalia in 1993 increased the reluctance of the international community to intervene in civil conflict, particularly in Africa. The Rwandan genocide, which occurred just six months after peacekeeping troops left Somalia, illustrated in stark terms the costs of inaction. Between 800 thousand and a million people were killed under the eyes of United Nations peacekeepers. These soldiers were deployed with the mandate of monitoring the implementation of the Arusha Accords, not with a mandate to stop widespread violence. The Security Council refused to change the mandate of the mission, forcing peacekeepers to become witnesses to war crimes. Many people, such as the commander of the failed peacekeeping mission in Rwanda, Canadian Lieutenant General Roméo Dallaire, argued convincingly that effective international military intervention could have averted the genocide and saved hundreds of thousands of lives (Dallaire, 2003)

During the Bosnian conflict, peacekeeping and the protection of humanitarian aid was a substitute for political and military action to stop ethnic cleansing and genocide. Despite promises of safe havens and the presence of United Nations troops, 250 thousand people were massacred on the doorstep of Europe between 1992 and 1995. Chilling pictures of concentration camps and mass roundups of civilians for execution elicited comparisons with the Holocaust.

Together, Bosnia and Rwanda provided chilling examples of the costs of international inaction in the face of flagrant and brutal attacks against civilians. The limitations of traditional peacekeeping missions, with their exclusive focus on observing and enforcing ceasefires, became painfully apparent.

C. Effective Lobbying by International Organisations

The deliberate attacks against civilians and civilian infrastructure characteristic of contemporary warfare violate the Geneva Conventions. These conventions outline the basic rules of law in situations of armed conflict, and serve as a bellwether for the depravity of contemporary war.

Violations of the Geneva Conventions have been well documented by humanitarian agencies, human-rights organisations, and the global media. Humanitarian and human-rights organisations such as Médecins Sans Frontières, Human Rights Watch, and Amnesty International use these violations as a basis to lobby the international community for enhanced protection of civilians and interventions to stop the bloodshed. Think tanks, such as the International Crisis Group, and international commissions of inquiry (most notably commissions investigating international inaction in Srebrenica and Rwanda (Carlsson et al., 1999, United Nations Secretary General, 1999) have provided convincing arguments that with the right planning and preparations, international interventions can effectively thwart the momentum towards widespread conflict.

The media also brings daily images of the costs of war to television screens around the world. This coverage coupled with public commentary by international organisations has raised public awareness of the devastating impact of civil war. Their efforts to convince governments that the costs of inaction outweigh the costs of action have been successful in places such as Kosovo, East Timor, and Liberia. In politically sensitive areas such as Chechnya or strategically unimportant regions such as Nepal, lobbying efforts for international action go largely unheeded.

D. The Military Intervention in Kosovo

The NATO bombing campaign in Kosovo in the spring of 1999 was the beginning of a new kind of international intervention: the use of military force to stop widespread human-rights abuses. A NATO-led coalition undertook strategic air strikes against Yugoslav military forces in Kosovo and key civilian and military installations in Serbia to compel the government of the Federal Republic of Yugoslavia to stop committing war crimes against Albanian civilians. When Yugoslavia acquiesced, the

United Nations, through Security Council Resolution 1244, took control of the institutions of government in Kosovo, interrupting the ability of the government of Yugoslavia to exercise political authority over its southern province.

Kosovo set a remarkable precedent. First, the international community intervened militarily with the objective of protecting civilians; and second, it subsequently worked to create democratic institutions of self-government virtually from scratch (Judah, 2000, International Crisis Group, 2002b) At the time, the Kosovo intervention was the most ambitious experiment in peacebuilding ever undertaken, with over forty thousand peacekeepers, thousands of UN civilian staff, and hundreds of non-governmental organisations operating in a small area with a population of two million. It sparked the International Commission on Intervention and State Sovereignty, whose recommendations to use international action to protect civilians from violations committed by their governments have recently been endorsed in the agreement on UN reform (The UN Secretary General's High-Level Panel, 2004)

E. September 11, 2001

The tragic terrorist attacks against the Pentagon and the World Trade Center prompted several reactions. First, they provoked feelings of extreme vulnerability and fear within developed countries, feelings that had largely vanished after the end of the Cold War.

Second, they prompted the United States to change its security policy from that of containment of security threats to pre-emptive action to remove those threats, a change that many in the international community strongly criticized. Sanctioned by the Security Council, the United States invaded Afghanistan to topple the Taliban regime and to destroy the capability of Al-Qaeda to undertake terrorist attacks. It then took the contentious decision to attack and invade Iraq without the approval of the Security Council. The stated objective of this invasion was to pre-empt Saddam Hussein from using weapons of mass destruction against the United States and its allies; weapons the United States argued that Iraq already possessed. In both Afghanistan and Iraq, the American administration has been faced with the difficult task of rebuilding the state and creating democratic institutions to avert a return to unstable pariah regimes.

And third, September 11 and the subsequent terrorist attacks in Bali, Madrid, and London have prompted international analysts to reflect anew on the need for collective security, as “ours is an age of unparalleled interconnection among threats to

international peace and security, and mutual vulnerability between weak and strong” (The UN Secretary General's High-Level Panel, 2004). The United Nations commissioned a panel of eminent persons to outline a new vision for collective security, and to propose reform to make the United Nations more effective. In both the High Level Panel Report and the Secretary General’s response, post-conflict peacebuilding was identified as an area of vital concern (The UN Secretary General's High-Level Panel, 2004, United Nations Office of the Secretary General, 2005)

III. PEACEBUILDING: OPPORTUNITY AND CHALLENGE

These various forces drive interventions by the international community to end violence, create stability, build democratic institutions, and instil a sustainable peace in an increasing number of states around the world. The concept of peacebuilding was first introduced by Johann Galtung (Galtung, 1975) and gained prominence with the release of Boutros Boutros-Ghali’s *Agenda for Peace* in 1992 (United Nations Office of the Secretary General, 1992) However, the complete range of activities that encompasses peacebuilding, as well as an analysis of the challenges faced by peacebuilding missions, has only emerged as the UN and other multilateral institutions gain concrete peacebuilding experiences and learn from their successes and failures.

Table Five outlines the main peacebuilding missions undertaken between 1990 and 2004. At the beginning of 2005, the United Nations had sixteen active peacekeeping missions, and eleven peacebuilding and political missions.

Table Five: UN Peacebuilding and Peacekeeping Missions (1990-2004)

Mission	ACRONYM	DATES
<i>Europe</i>		
Croatia: United Nations Transitional Administration of Eastern Slavonia	UNTAES	January 1996 to January 1998
Bosnia: United Nations Mission in Bosnia and Herzegovina	UNMIBH	December 1995 to December 2002
Kosovo: United Nations Interim Administration Mission in Kosovo	UNMIK	Since June 1999
Georgia: United Nations Observer Mission in Georgia	UNOMIG	Since August 1993
<i>Africa</i>		
Western Sahara: United Nations Mission for the Referendum in Western Sahara	MINURSO	Since April 1991
Guinea Bissau: United Nations Peacebuilding Support Office in Guinea-Bissau	UNOGBIS	Since March 1999
Sierra Leone: United Nations Mission in Sierra Leone	UNAMSIL	Since October 1999
Congo: United Nations Organization Mission in the Democratic Republic of the Congo	MONUC	Since November 1999
Central Africa Republic: United Nations Peacebuilding Office in the Central African Republic	BONUCA	Since February 2000
Ethiopia: United Nations Mission in Ethiopia and Eritrea	UNMEE	Since July 2000
Liberia: United Nations Mission in Liberia	UNMIL	Since September 2003
Côte d'Ivoire: United Nations Mission in Cote d'Ivoire	UNOCI	Since April 2004
Burundi: United Nations Operation in Burundi	ONUB	Since June 2004
Sudan: United Nations Advance Mission in Sudan	UNAMIS	Since June 2004
<i>Middle East</i>		
Middle East Peace Process: Office of the United Nations Special Coordinator for the Middle East	UNSCO	Since October 1999
Iraq: United Nations Assistance Mission for Iraq	UNAMI	Since August 2003
<i>Central Asia</i>		
Afghanistan: United Nations Assistance Mission in Afghanistan	UNAMA	Since March 2002
Tajikistan: United Nations Tajikistan Office for Peacebuilding	UNTOP	Since June 2000
<i>East Asia</i>		
East Timor: United Nations Mission in Support of East Timor	UNMISET	Since May 2002
<i>Caribbean</i>		
Haiti: United Nations Stabilisation Mission in Haiti	MINUSTAH	Since June 2004

Source: (United Nations, 2005)

Billions of dollars have been invested on these military interventions to stabilize states, and on humanitarian, reconstruction, and development aid to assist in the process of rebuilding.

A. Peacebuilding Interventions: Compressing Development?

Early peacebuilding efforts, such as Namibia, Cambodia, Mozambique, and El Salvador, were basically extensions of peacekeeping missions. The international community focused on monitoring ceasefires, providing humanitarian and

rehabilitation relief, and supervising elections (Jeong, 2005) While some of these missions were successful, others relapsed into violence. The renewal of fighting is not surprising, as in the immediate post-conflict period there is a high risk of societies slipping back into violent conflict. In forty-four percent of post-conflict situations, violence returns within five years, while fifty percent of post-conflict societies return to civil war after ten years (Jenne and Verkoren, 2005). Moreover, failed peace implementation can lead to even worse violence. If the Angola peace agreement in 1991 and the Arusha Accords in Rwanda in 1993 had been successfully implemented, two million persons might not have died (Call, 2005).

Establishing a safe and secure environment remains the most critical element of these post-conflict operations, particularly the demilitarisation, demobilisation, and reintegration (DDR) of former combatants (The UN Secretary General's High-Level Panel, 2004) Other important security sector reform activities include establishing the minimal rule of law, ensuring civilian control over the military, and reforming and modernizing the police.

However, to prevent the recurrence of violence, the objectives of peacebuilding missions began to include a conflict-prevention element, attempting to address the root causes of violence in society. Interventions are guided by a particular theory of conflict management with its foundation in the liberal peace literature: Liberal democracies are inherently more peaceful, less likely to go to war, and less likely to disintegrate into internal violence (Gleditsch, 1992, Doyle, 1986) As a result, the typical menu of peacebuilding activities has grown. In 2001, the Security Council affirmed this shift, emphasising that the ultimate objective is to prevent the recurrence of hostilities through the establishment of democratic institutions.

The Security Council recognizes that peace-building is aimed at preventing the outbreak, the recurrence or continuation of armed conflict and therefore encompasses a wide range of political, development, humanitarian and human rights programmes and mechanisms. This requires short and long-term actions tailored to address the particular needs of societies sliding into conflict or emerging from it. These actions should focus on fostering sustainable governance, the promotion of democracy, respect for human rights and the rule of law and the promotion of a culture of peace and non-violence (President of the Security Council, 2001).

The objectives of more recent interventions in Kosovo, East Timor, Afghanistan, and Liberia (2003) reflect this expansion of peacebuilding activities. In the effort to address the root causes of conflict and prevent a return to violence, transitional justice initiatives as well as socio-economic and political reform have

become integral components of these missions (Junne and Verkoren, 2005, Call, 2005) The typical menu of activities now undertaken in peacebuilding missions is outlined in Table Six.

Table Six: Main Peacebuilding Interventions⁴⁰

Security Sector Reform	Police Reform Demilitarisation, Demobilisation, and Reintegration, Civilian Control of Military
Transitional Justice	Prosecuting War Crimes and Crimes against Humanity Building Local Judicial Capacity Reconciliation Activities
Socio-Economic	Economic Development Initiatives Health care Provision and Reform Education Reform
Reform of Elected Institutions	Political Party Development Preparation for Elections Building a Civil Service

Massive resources are invested in these ambitious political, social and economic reform projects in the effort to avert a return to violence.

[T]he primordial task of post conflict development is not just rebuilding or reconstruction, because this may lead to the rebuilding of the very structures that gave rise to the devastating conflicts. What the situation demands is another type of development that addresses these structures and helps to avoid violent conflict (Junne and Verkoren, 2005).

Peacebuilding initiatives often have short time horizons of two to five years. While these horizons are short, however, project objectives are extremely ambitious, amounting to plans for sweeping socio-economic development and institutional reform. Reforming the health system, revitalising the education system, creating an impartial judiciary, building regulatory capacity within public institutions, and creating conditions for competitive industry to flourish are typical development projects. Such initiatives are usually implemented by development agencies, working slowly over many years to build consensus for project goals and indigenous capacity to make these projects sustainable. In post-conflict settings, for better or for worse, such development projects are fast-tracked.

This expansion of activities undertaken in peacebuilding missions amounts to ‘compressed development.’ Ambitious projects are undertaken in the effort to build liberal-democratic states. This is in fact an effort at conflict prevention, given the belief that democracies are inherently more peaceful. Moreover, policy makers believe that critical preconditions—financial resources and a political vacuum—exist for

⁴⁰ Adapted from, Ibid.

reform: “The immediate aftermath of such conflicts can create a political window of opportunity in which all parties agree that basic structures of society have to be changed to avoid a repetition of disastrous destruction” (Junne and Verkoren, 2005) Analysts argue that the political will and resources of the international community, coupled with the fluid political and social dynamics of post-conflict settings, create an ideal implementing environment.

This assumption is flawed. The pursuit of development objectives in a post-conflict environment is problematic. Projects are conceived quickly, without the careful planning, data and evidence gathering, and consultation that occur in traditional development planning. ‘Truisms’ of development, such as spending less of the public budget on the military and police, are not applicable (Junne and Verkoren, 2005) The precarious security environment and pervasive criminality requires agencies to undertake more risk. Field staff recruited to work in post-conflict settings are often veterans of humanitarian and rehabilitation missions, lacking the expertise and experience to implement development projects (Tulloch et al., 2003). While a strong, transparent, and accountable state is critical to avert a return to violence, states emerge from conflict contested and weakened, and development agencies therefore lack solid local counterparts. Civil society is fragmented, as many of its key members have fled during the conflict, which undermines its ability to effectively contribute to the policy process. Moreover, the post-conflict environment is politically charged, such that every project is deeply political (Junne and Verkoren, 2005)

B. Factors Undermining Peacebuilding

The success of international peacebuilding missions is decidedly mixed. One analyst noted, “[A] UN field mission had been established in exactly half of the 54 conflicts that had ended between 1988 and 2003, but these were just as likely to revert to war as countries with no UN presence” (Call, 2005) However, the High Level Panel counters that: “in the last 15 years, more civil wars were ended through negotiation than in the previous two centuries in large part because the United Nations provided leadership, opportunities for negotiation, strategic coordination and the resources needed for implementation” (The UN Secretary General's High-Level Panel, 2004)

Several ‘lessons learned’ exercises have been undertaken with the objective of understanding the perils of post-conflict environments and assessing how peacebuilding efforts could be more effectively structured. Early assessments, including the August 2000 Report of the Panel on UN Peacekeeping Operations

(otherwise known as the Brahimi Report), focused on operational issues such as donor coordination, the need for effective disarmament, demobilisation and reintegration, a comprehensive approach to policing, a clear and realistic mandate, deployment of staff to the field, and the relationship between the headquarters and the field (Brahimi, 2000) More recent analysis focused less on the operational challenges for the international community and more on the difficulties of changing social, economic, and political dynamics in countries emerging from warfare.

Some critics contend that post-conflict programs are not sufficiently focused. Needs must be prioritised and activities sequenced accordingly. While all peacebuilding analysts agree that establishing a secure environment is the highest priority, other projects are more contentious (Orr, 2004c) In their effort to radically reform societies, every sector tends to be prioritised with wish lists generated for every possible problem facing society. As a result, missions are unable to establish and meet key strategic goals that would lead to a more stable state. One analyst critiqued Liberian peacebuilding efforts for their lack of prioritisation.

[T]he Liberia Joint Needs Assessment identified twenty sectors as ‘priorities’ listing virtually every conceivable sector including security, the rule of law, DDR, governance, civil society, elections, health, education, water and sanitation, agriculture and food security, infrastructure, economic management, HIV/AIDS, job creation, environment, gender, forestry, and shelter and urban management. As of 9 August 2004, only \$345 million was available to cover these 20 priority sectors—an average of \$18 million each. Furthermore according to the JNA, reintegration of tens of thousands of ex-combatants was not slated to begin until a year after the first several thousands of disarmed combatants had demobilized. This laundry-list approach reflects the triumph of bureaucracy over strategy, and fails to identify and direct resources to the main sources of insecurity and potential warfare (Call, 2005)

Such criticism reflects unease with the broad reform agenda of many peacebuilding missions, particularly among those who believe that international interventions in the immediate post-conflict environment should focus on security issues.

Critics also argue that international organisations must work more effectively with local actors, building—not bypassing—local governance structures and indigenous capacity. All too often, the views and expertise of national and local groups are not effectively incorporated into projects, with international officials believing that ‘they know best’ how to implement programs (Call, 2005, Orr, 2004a) Both local and international actors must be in some way accountable to the local population for the decisions that they make (Orr, 2004a)

Naturally important checks on abuse and corruption are required. However, avoiding or undermining local or national state institutions because they may be slow, inefficient, or corrupt is not the answer. Instead the hard work of building in mechanisms of transparency, accountability and participation are required to ensure that state institutions function well (Call, 2005).

The failure to build this local ownership results in a lack of local buy-in to reforms, undermining the sustainability of reform efforts.

International organisations are also excessively driven by external deadlines set according to their own bureaucratic purposes rather than circumstances on the ground (Orr, 2004a) Examples include elections being held too quickly, troops downsizing before the security situation has stabilized, and a focus on rapid training for police officers rather than comprehensive training. Peacebuilding missions also do not clearly identify an exit strategy, outline criteria for their departure, and plan for hand-over of projects to development agencies or regional organisations. Such an exercise would focus the efforts of the international community, and could create an incentive structure for progress within the local government (Brahimi, 2000, Percival and Lyon, 2003)

C. The Critical Importance of Institution Building

In one 'lessons learned' exercise, Roland Paris compared peacebuilding interventions across a number of states in several continents. He argues that these interventions are guided by a particular theory of conflict management: building liberal democracy means creating the conditions for a more peaceful state (Paris, 2004)

Peacebuilding activities are therefore part of an effort to liberalize the state:

The typical formula for peacebuilding included promoting civil and political rights, such as the right to free speech and a free press, as well as freedom of association and movement; preparing and administering democratic elections; drafting national constitutions that codified civil and political rights; training or retraining police and justice officials in the appropriate behaviour for state functionaries in a liberal democracy; promoting the development of independent 'civil society' organisations and the transformation of formerly warring groups into democratic political parties; encouraging the development of free-market economies by eliminating barriers to the free flow of capital and goods within and across a country's borders; and stimulating the growth of private enterprise while reducing the state's role in the economy (Paris, 2004).

While liberal democracies are more peaceful (Gleditsch, 1992, Doyle, 1986), applying that truism to shape reform efforts in post-conflict states is extremely problematic. Functioning states are taken as a given in much of the liberal peace literature. Yet countries emerging from conflict lack even the most basic governmental institutions. Intense social conflicts are in place, while natural conflict

dampeners such as a tradition of non-violence and cross-cutting social cleavages are non-existent. Because the state does not have a monopoly over means of violence, social groups face a security dilemma: they are unable to rely on the state to provide a secure environment. Paris argues that “by taking the existence of a working government for granted, many authors have effectively ‘assumed away’ one of the most difficult and important problems that peacebuilders confront in their field operations: namely, how to establish functioning governments and stable non-violent politics in conditions of virtual anarchy” (Paris, 2004)

Paris terms the rapid effort of the international community to undertake peacebuilding activities ‘shock therapy.’ He contends that such efforts to implement liberal reforms without the existence of institutional state structures can be counterproductive. In their attempt to gain popular support and political power, political leaders will often attempt to exploit ethnic divisions. Elections held too quickly after a conflict ends can therefore exacerbate tensions between previously conflicting groups and legitimise the power of politicians profiting from such divisions. Liberal reforms also assume that civil society is virtuous, when in many conflict situations some elements of civil society can be extremely pernicious, unable to act as an effective check upon politicians or the institutions of the state (Paris, 2004)

To ensure that peacebuilding efforts do not increase the potential for violence in post-conflict settings, Paris advocates “institutionalisation before liberalisation” (Paris, 2004)

Rebuilding effective governmental institutions, managing a phased and gradual transition to market democracy, and ensuring that the rule of law is sufficiently strong to defend the new state against inevitable challenges (including challenges posed by the competitive character of democracy and capitalism themselves) require a more interventionist and long term approach to peacebuilding than that which has been practised to date. They require international peacebuilders to take on the role of nation builders—to serve as surrogate governing authorities for as long as it takes to implement the liberalizing reforms that the peacebuilders themselves prescribe for war-shattered states (Paris, 2004).

According to this model, after security is guaranteed, international officials should prioritize the establishment of rudimentary domestic institutions. Once these institutions are in place, the reform process should be a series of incremental steps taken in tandem with the ability of the government institutions to manage the reform process (Paris, 2004) Paris argues, “...the guiding doctrine of peacebuilding should

emphasize the gradual and controlled liberalisation of political and economic life” (Paris, 2004)

Although Paris’ ‘institutionalisation before reform’ argument is compelling, he fails to provide details about what institutionalisation means in practise. Democratic institutions are incredibly complex, with checks and balances established through various political and legal mechanisms. How should institution building be implemented? In the absence of elections, what legitimacy does the international community have to build these institutions and enact reforms? How should the international community determine when institutions are functional? And how does the political, social, and economic context impact on the reform process?

Paris also does not address the priorities of reform in post-conflict settings. His main focus is on security institutions, the justice sector, media, and elections. But he does not address other key areas where reform is taking place. Although ensuring a secure and safe environment is the highest priority, social services such as health care and education are also critically important for the wellbeing of a society. As outlined below, population health is one of the first casualties of war, and health interventions are therefore an important component of the international response to a crisis.

As part of their peacebuilding efforts, significant resources are invested to build a liberal-democratic state in countries emerging from conflict. The international community believes that a window of opportunity exists for such radical change, and therefore attempts to ‘compress development’—to undertake initiatives that would normally be characterized as development projects in a shortened time period. Analysts of peacebuilding argue that the international community has failed to focus sufficient attention on building institutions prior to reforms, ensure local ownership of the reform effort, incorporate to the social, political, and economic context for reform, prioritize their initiatives, and develop an exit strategy by ensuring their intervention was sustainable.

Despite this emphasis on institution building, the crucial variable of government or state capacity has been neglected in the peacebuilding literature. Frequently cited, state capacity is rarely defined. One author has attempted to disaggregate the various components of state capacity. To function effectively, he argues that the state requires the following elements:

- Human Capital: A sufficient number of well-trained civil servants.
- Enforcement Capacity: The ability of the state to develop policy guidelines and implement this policy.

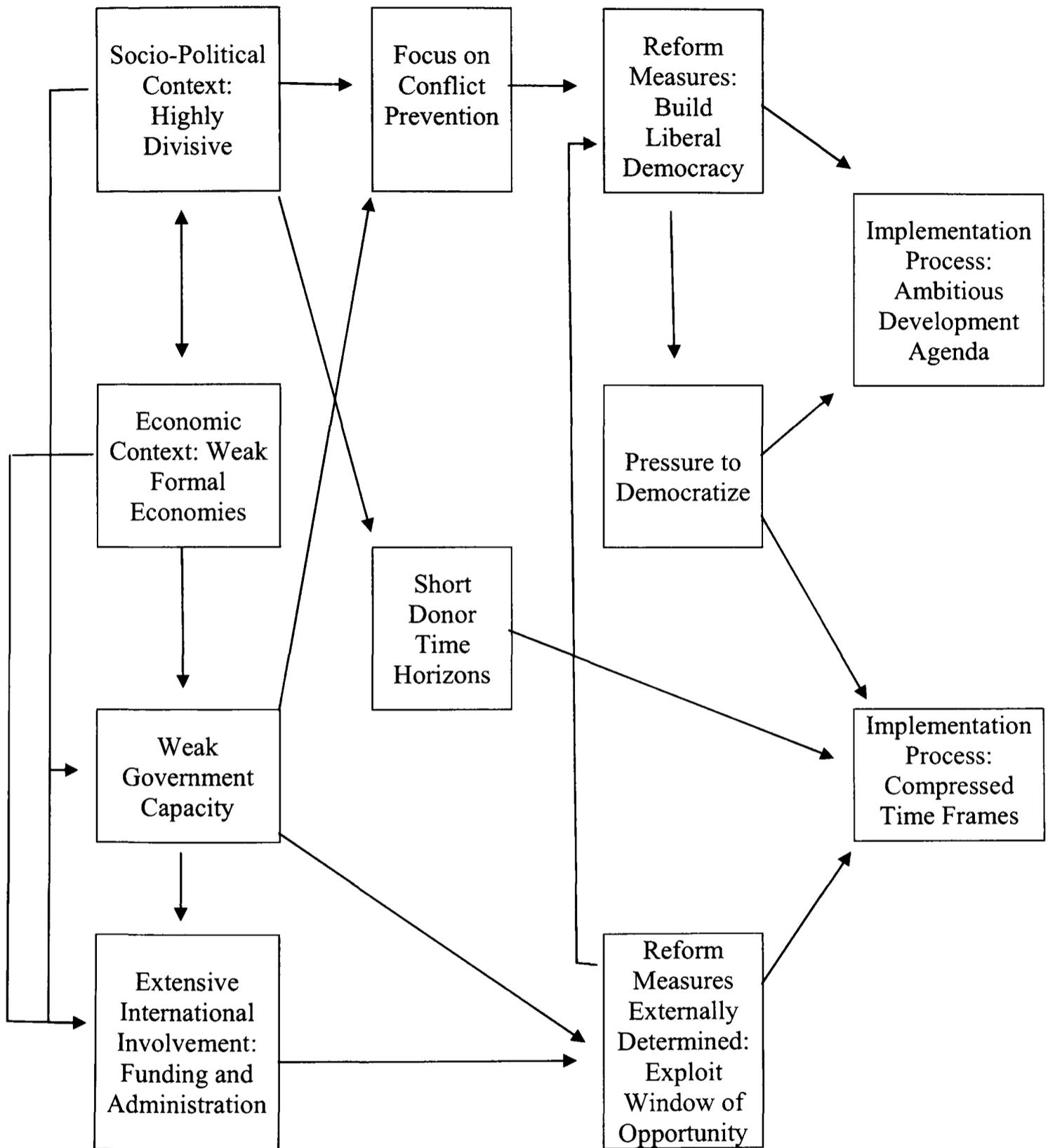
- **Coherence:** The state's ability to implement reform measures in a reasonably equal fashion throughout its territory.
- **Fiscal Resources:** Sufficient financial resources to administer the system and implement reform programs.
- **Reach and Responsiveness:** The reform vision of the state should be accepted by key stakeholders, and the state should be responsive to their views and inputs.
- **Legitimacy:** The moral authority of the state to govern should be recognized by social groups. (Homer-Dixon, 1996)

Conflict directly impacts on human capital and fiscal resources. Given the highly divisive socio-political post-conflict context, the state's legitimacy, reach/responsiveness, and coherence are also impacted. The state is often unable to enforce its policies through the territory. While weak government capacity necessitates the focus on institution building, it also means that the international community lacks a strong institutional foundation for these reforms.

IV. KEY FACTORS EMERGING FROM LITERATURE

The examination of the recent series of international interventions in post-conflict countries is relevant for the conceptual framework to examine post-conflict health reform for several reasons. It demonstrates that health reforms are one component of a larger international intervention in post-conflict societies, designed to build liberal-democratic institutions. Health reform needs to be seen as part of this larger wave of reform efforts, and significant pressure exists for donors and international agencies to use this opportunity to improve institutions, rather than simply refurbish the old ones. This dynamic creates significant pressure for health reform—and the time period for reform as outlined above is compressed. Within this compressed time frame, reformed institutions are to be created, while little effort has gone into analysing the process of institution building. Figure Five outlines the key factors emerging from an analysis of peacebuilding literature that inform the conceptual framework for analysing health reform. The socio-political and economic context is characterized by highly divisive politics, a weak economy, and weak government capacity. The international community's involvement in the post-conflict environment is extensive, with reform measures externally driven and determined. Given the risk of returning to conflict, donor time horizons are short, and efforts are made to build liberal democratic institutions which the international community believes will be more stable. The implementation agenda is therefore very ambitious, and very compressed.

Figure Five: Key Factors Emerging from the Examination of Post-Conflict Peacebuilding



CHAPTER FOUR: A FRAMEWORK FOR HEALTH REFORM

The conceptual framework to analyse and assess post-conflict health reform was built in Chapters One to Three by examining bodies of literature on health and conflict, health reform, the health-reform process in Central and Eastern Europe, and peacebuilding. The analysis and conclusions in each set of literature adds critical elements to our understanding of how various pieces of the post-conflict reform puzzle fit together. Table Seven provides a summary of the major conclusions from the examination of the health and conflict literature, the literature examining health reform throughout Central and Eastern Europe, as well as examinations of contemporary peacebuilding efforts.

Table Seven: Relevant Points from Literature for Kosovo Case Study

HEALTH AND CONFLICT LITERATURE	HEALTH REFORM LITERATURE	REFORM IN CENTRAL AND EASTERN EUROPE LITERATURE	POST-CONFLICT PEACEBUILDING LITERATURE
<i>Major Conclusions</i>	<i>Major Conclusions</i>	<i>Major Conclusions</i>	<i>Major Conclusions</i>
<ul style="list-style-type: none"> • There are three stages of health interventions after a conflict is over. • In the immediate post-conflict period, the international community attempts to address basic threats to population health and ensure that the assistance flowing into the region is coordinated and appropriate. Critics have argued that coordination is often lacking, and that NGOs, multilateral agencies, and donors do not work enough at sustaining/building local capacities during this period. • As the situation stabilizes, efforts focus on repair of infrastructure, short-term training programs, and gathering basic data on population health. Critics argue that to avoid rebuilding inefficient or 	<ul style="list-style-type: none"> • Focus on how pressures for reform from within and outside of the health system, as well as population health status force policy-makers to reflect on the efficacy and efficiency of the health system and to contemplate health reform. • Reform programs should ensure clear goals and undertake careful planning of reforms based on an accurate diagnosis of the key problems plaguing the health sector. • Reforms should focus on five mechanisms (“control knobs”) for change: <ul style="list-style-type: none"> ○ Financing Systems; ○ Adjusting payments; ○ The organisation of the health system; ○ Regulations; and, ○ Influencing individual behaviour. • Reform plans should be developed with the 	<ul style="list-style-type: none"> • Many Central and Eastern European countries began health reform programs after the collapse of communism in the early 1990s. These reform programs were strikingly similar—the reorientation of the health system to primary care, hospital reform, health care financing, strengthening of public-health systems, human-resource programs, and decentralisation. • Reforms have been plagued by external challenges—the economic instability in the region, the lack of political will and general political instability, as well as unhealthy lifestyles. • There have also been serious problems with the reform process itself. Reforms were often introduced too quickly, the implementation of the reforms was not planned, 	<ul style="list-style-type: none"> • Increased international engagement in societies that are unstable, at war, and emerging from war. Such engagement results from several factors, including the changing geopolitical landscape, the legacy of Rwanda and Bosnia, lobbying by international organisations, the growing success of international engagement, and the terrorist attacks of 9/11. • The international community engages in peacebuilding activities—programs to stabilize societies and introduce liberal market reforms. Such reforms are based on the finding that liberal democracies are more peaceful. • Reforms include efforts to establish security and reform security institutions; transitional justice

HEALTH AND CONFLICT LITERATURE	HEALTH REFORM LITERATURE	REFORM IN CENTRAL AND EASTERN EUROPE LITERATURE	POST-CONFLICT PEACEBUILDING LITERATURE
<p>inappropriate services and to ensure proper coordination of resources, during this period a longer-term health-sector strategy should be developed outlining what facilities should remain open and which ones should close, essential equipment lists, and human-resource planning.</p> <ul style="list-style-type: none"> As the international community engages in long-term development, an overarching health reform program is implemented. This includes the transition to a system focused on primary care, reform of health-financing methods, and efforts to improve public health and human-resource planning. 	<p>participation of stakeholders and focused on the problems of implementation.</p> <ul style="list-style-type: none"> Evaluation systems should be built into the reform program to learn from and correct mistakes. 	<p>governments had little capacity to introduce and manage these complex changes to the health system, and efforts to implement health-financing models suffered from a shortage of funds and problematic efforts to split the purchaser/provider functions. There was also little enthusiasm for family medicine, a weak interface between the primary and secondary care systems, weak data collection, and inappropriately trained health professionals.</p>	<p>initiatives; socio-economic reforms in health and education; and efforts to establish elected institutions and build political parties.</p> <ul style="list-style-type: none"> Peacebuilding missions have suffered from several shortcomings, including lack of prioritisation, failure to establish local ownership of the reform program, external agendas driving reforms, and timeframes for reform that amount to efforts to “compress development.” They have also failed to build institutions of government before initiating ambitious programs of reform.
<i>Research Gaps</i>	<i>Research Gaps</i>	<i>Research Gaps</i>	<i>Research Gaps</i>
<ul style="list-style-type: none"> Donors are implementing similar sweeping reform programs in post-conflict settings. However, little assessment has been made of the success of these 	<ul style="list-style-type: none"> No reflection on the administrative capacity needed to undertake health reform. The literature assumes a functioning state with 	<ul style="list-style-type: none"> Failure to identify the lessons from failed reform efforts. What reform measures should receive priority? How can issues such as weak political will 	<ul style="list-style-type: none"> Unclear what is entailed in building institutions of government. What does institutionalisation mean in practise? How long does this take? How to ensure

HEALTH AND CONFLICT LITERATURE	HEALTH REFORM LITERATURE	REFORM IN CENTRAL AND EASTERN EUROPE LITERATURE	POST-CONFLICT PEACEBUILDING LITERATURE
<p>reforms, and appropriateness of attempting reforms in such settings. The lessons learned from broad-based examinations of peacebuilding missions have not filtered into the health community.</p>	<p>existing health infrastructure.</p> <ul style="list-style-type: none"> • Insufficient numbers of case studies have been undertaken to examine the health reform process. 	<p>and economic instability be overcome? How can capacity be built as part of the reform effort?</p>	<p>local ownership? When are institutions functional? What are the priorities of the reform program?</p> <ul style="list-style-type: none"> • Not enough emphasis is placed on understanding how the political, social, and economic context impacts on reforms.
Key Lessons	Key Lessons	Key Lessons	Key Lessons
<ul style="list-style-type: none"> • In the immediate post-conflict period, emphasis should be placed on coordinating resources, identifying key actors, and ensuring that humanitarian assistance, where possible, builds local capacities. • A longer-term health strategy should be developed to ensure that critical resources are not wasted. • Few assessments have been done of health reforms in post-conflict situations. 	<ul style="list-style-type: none"> • The reform plan requires clear goals, and accurate diagnoses of the problems plaguing the health sector, the participation of stakeholders, a focus on the implementation process, and evaluation systems built in to monitor the impact and success of reforms. 	<ul style="list-style-type: none"> • Careful attention should be paid to the political, social, and economic environment to ensure that the reform effort is in harmony with these external factors. • The implementation of reforms should be planned; ambitious reforms should not be attempted without building concomitant government capacity; care should be taken when introducing health-financing reforms (i.e. social insurance) that the economy is strong enough for such reforms, and efforts to introduce a system focused on primary care must 	<ul style="list-style-type: none"> • While undertaking peacebuilding reforms, it is important to prioritise reform efforts and establish local ownership of reform efforts. • Focus should be on building institutions of government to support reform process, rather than implementing reforms per se. • Careful attention should be paid to social, political, and economic context for reform—reforms should not be driven by external agendas. • Careful attention should be paid to the timeframes for reform to ensure that they

HEALTH AND CONFLICT LITERATURE	HEALTH REFORM LITERATURE	REFORM IN CENTRAL AND EASTERN EUROPE LITERATURE	POST-CONFLICT PEACEBUILDING LITERATURE
		address the problems of a lack of enthusiasm, the primary/secondary care interface, training, and data collection.	are not attempting to compress development projects requiring longer timeframes into one or two years.

The conceptual framework for health reform is outlined below in Figure Six. This conceptual framework is built from key variables identified in the literature review, with the relationships among these variables highlighted in Figures Two, Three, Four, and Five. The summary of these findings is outlined in Table Seven. Below, the thesis describes how the variables identified through the analysis of the literature are integrated into the conceptual framework in Figure Six.

Forces Leading to Post-Conflict Health Reform: Recall that Figure Two highlighted the external political pressures for reform (to ensure sustainability of resources), the pressures for particular reform measures (to heighten the efficiency of the system), and the health context (health status and infrastructure), lead to the effort to reform the health system. These variables are effectively integrated into the “External Pressures for Reform”, “Reform Measures” and “Health Context” variables highlighted in Figure Six.

Health Reform: Figure Three highlighted that problems within the health system (inequities, inefficiencies in the system), population health status, and pressures for reform (popular expectations for health care services, pressure from regional or multilateral organizations) led to reform being undertaken. Reform measures are focused on five key areas: financing, payments, organization, regulation, and efforts to shape behaviour. The objective of these reforms is to successfully implement reforms to improve population health and system performance. These variables are represented in Figure Six (health context, health status, pressures for reform, the implementation process, and reform outcomes). This analysis provides an insight into the particular challenges facing health reform.

Health Reform in Central and Eastern Europe: Figure Four summarized the key variables that emerged from the implementation of health reforms in Central and Eastern Europe. These key variables include the socio-political and economic context, which combined with external pressure for reform and the resulting implementation of specific reform measures. This analysis highlighted the particular challenges associated with health reform implementation. One of the key variables that emerged in this analysis – the issue of weak government capacity - is incorporated into the conceptual framework as an element impacting on the implementation of reforms.

Post-Conflict Peacebuilding: While the other sets of literature were directly focused on the health sector, this literature provided insight into the particular circumstances surrounding post-conflict peacebuilding interventions by the

international community. Figure Five highlights the highly divisive socio-political context, economic weakness, and the weak government capacity that characterizes this environment. These variables are represented in Figure Six (“Socio-Economic Context” and “Government Capacity”). The analysis also focuses on the extensive involvement of the international community, focusing on initiatives to prevent conflict and undertake reform measures to build liberal democracy. Figure Six also incorporates these factors in “External Pressures for Reform” and “Reform Measures”. The short-time horizons for reform and the belief that the post-conflict period and the significant engagement by the international community present a window of opportunity for radical reform lead to an ambitious development agenda and a compressed time frame for reform. These variables are represented in Figure Six with the variable “Implementation of Reform.”

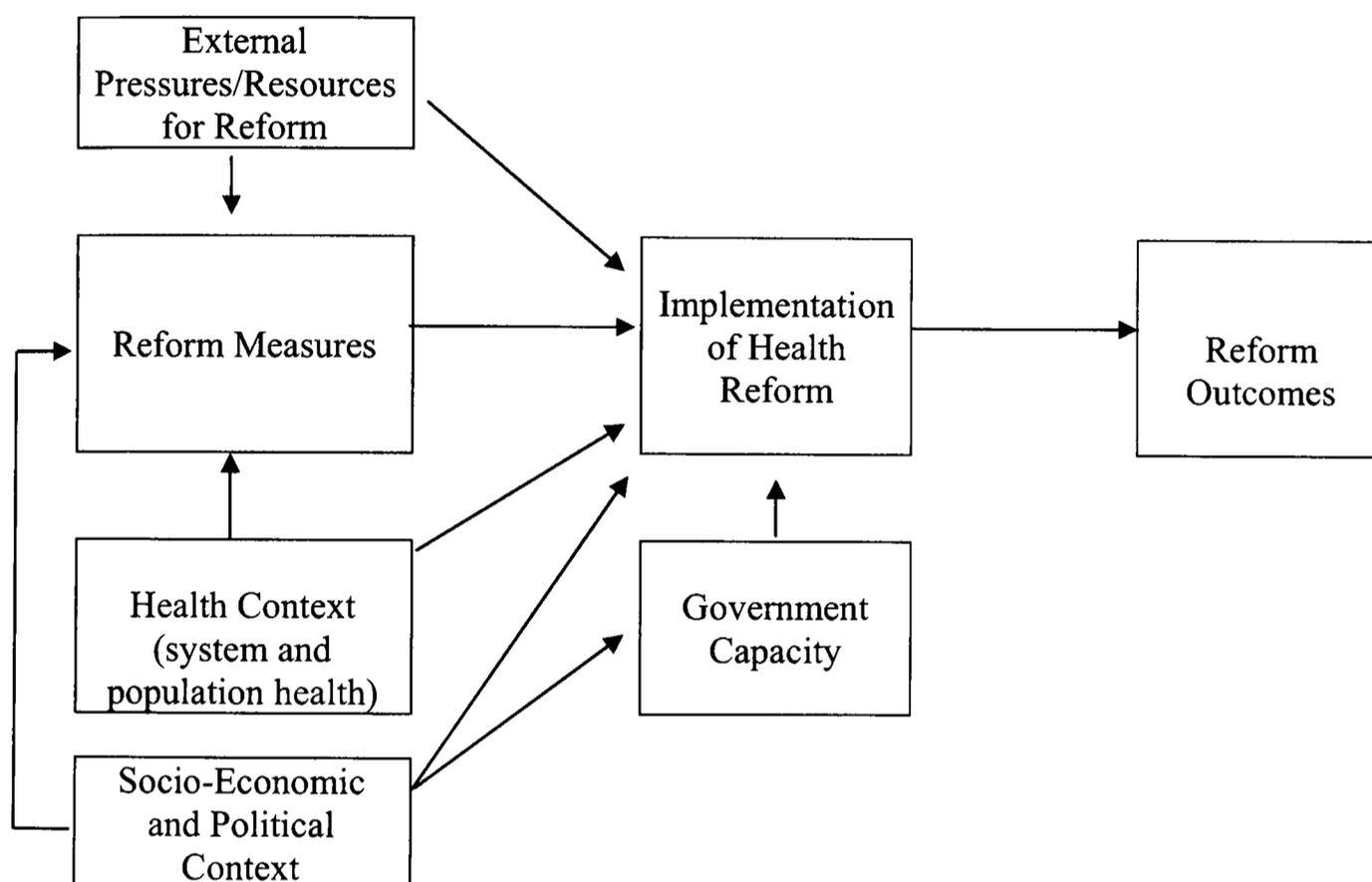
To summarize the conceptual framework, while reform programs are launched as a result of health status and the need for rehabilitation of health infrastructure, external pressures for reform and the socio-economic and political context also shape the type of reforms selected, with the health reform process forming part of the international community’s effort to build liberal democratic states. (See the specific references to health context/status in Figures Two, Three and Four. The external pressures for reform are outlined in Figures Two, Three, Four, and Five. The socio-economic and political context for reform is outlined in Figures Four and Five.) Socio-economic and political forces also affect the capacity of the state to oversee and implement reform measures. (The specific reference to state capacity is found in Figures Four and Five.) Short donor horizons coupled with an ambitious reform agenda, lead to compressed time frames for reform. (See Figure Five for reference to this compressed time frame for development). As outlined in Figure Three, in a post-conflict society, the success of reforms can best be analysed through an examination of the extent to which health reforms are implemented—efforts to examine health status and performance indicators can be difficult due to absence of operating health and management information systems.

The advantage of this framework is that it outlines the pressures for reform (both health factors, socio-economic and political factors, as well as external pressures), the reform measures themselves, and the factors impacting on the implementation of reform, including the quality of the reform measures, external pressures and resources for the reform process, the socio-economic and political

context and the challenges of the health context. Importantly, it integrates the capacity of the government into the analysis of health reform.

This framework will be applied in the case of Kosovo. Using this framework, the thesis will test the hypothesis that the post-conflict social, economic, and political context, the externally driven nature of the health reform process, and the compressed timeframe for reforms undermined the progress of health reform.

Figure Six: The Conceptual Framework for Analysing Post-Conflict Health Reform



To apply this conceptual framework and to test the hypothesis outlined above, Chapter Five provides background information on Kosovo, including the pre-war health system, the civil war, the international intervention, and the broad post-conflict reform agenda. Chapter Six describes the status of the health system and population health after the war, the socio-economic context, the weak capacity of the government, external pressures for reform, and the nature of the reforms. Chapter Seven assesses the progress of reform, including the degree to which health reform was implemented. The Conclusion outlines how the case study of Kosovo supports the research hypothesis that the post-conflict social, economic, and political context, the externally driven nature of the health reform process, and the compressed timeframe for reforms all impacted on the ability of the health reform program to achieve its objectives, and sets out an agenda for future research.

PART TWO: APPLYING THE FRAMEWORK TO KOSOVO
CHAPTER FIVE: INTERNATIONAL INTERVENTION IN KOSOVO

In 1999, the international community undertook a military intervention in Kosovo with the objective of ending widespread human-rights violations by the police and military forces of the Federal Republic of Yugoslavia against the province's Albanian population. This intervention, and the subsequent establishment of a UN Mission to govern Kosovo, was notable for three reasons. First, the principle impetus for action was humanitarian: the need to confront a brutal aggression by the state against a weak and vulnerable minority. Second, under the aegis of the United Nations, the international community was given sweeping powers to build autonomous self-government and undertake political, social, and economic reform. And finally, unlike other post-conflict states such as Afghanistan and Iraq, the implementing environment in Kosovo was favourable: high levels of donor assistance were dispersed, the majority of the population supported the military intervention and the presence of the international community, and the province was small, with reasonably high levels of human capital and a historical, economically important industrial and natural resource base. As a result of these factors, Kosovo is in many ways a laboratory case study for examining the efficacy of peacebuilding efforts, including health reform.

Annex Two outlines in detail the roots of the conflict. This chapter provides the backdrop for the reform process: it outlines the history of the healthcare system, briefly addresses the impact of the conflict on the health system, and the ambitious intervention by the international community. It concludes by outlining the initial efforts of the international community to provide humanitarian and rehabilitation assistance.

I. HEALTHCARE UNDER SOCIALISM, HEALTHCARE UNDER WAR

A. The Health System Prior to 1989

The health system in Kosovo, as elsewhere in Eastern Europe, was largely based on the Semashko model of healthcare delivery. Yugoslavia adapted the Semashko system to reflect its version of socialism—a system of self-management. Decision-making was decentralized in enterprises and service institutes such as hospitals and health centres. While some argued that such decentralisation was inefficient, the healthcare system did succeed in expanding the provision of healthcare to people who would not otherwise have been able to afford it (Kunitz, 2004).

Primary care was organized around polyclinics in small communities and health houses in larger communities. Although these clinics did include general practitioners, patients used these physicians as a referral mechanism to specialists, who often worked in the same clinics (UNMIK, 2001).

Hospital capacity in Kosovo—as measured by the number of hospital beds—was low by regional or European averages. Even so, hospitals were quite large, with multiple buildings, resulting in inefficient duplication of administrative and other services. Moreover, few linkages existed between hospital care and primary care (UNMIK, 2001).

The health system was financed from a combination of social insurance, tax revenues, and out-of-pocket payments. The health insurance fund (HIF) was organized as a ‘self-managing community of interest’ (SIZ) located in Pristina, with twenty-nine ‘elementary units’ (OZs) operating as the municipal branches of the HIF. Eighty percent of the HIF’s revenue was derived from a compulsory employee contribution of nine percent of gross salary. To ensure that pensioners also received benefits, the pension fund made contributions amounting to fourteen percent of pensioners’ incomes. Farmers and small businesses were also expected to contribute twenty percent of their total incomes, but collection at this level was never achieved. The HIF provided healthcare and benefits, including sick leave, disability, funeral benefits, eyeglasses, and orthopaedics to those who contributed (World Bank, 2001). Over four hundred thousand government employees and factory workers received coverage.

In the 1980s, average per capita health expenditure was U.S. \$55 per annum, which amounted to approximately 3.6 to four percent of GDP. By 1989, the insurance fund was in debt, with healthcare expenditures (U.S. \$89.8 million) exceeding revenues (\$68.9 million) by 24.5 percent. While physicians were salaried, facilities were reimbursed using the fee-for-service system, which encouraged higher numbers of hospital-bed days. Prices were not based on any true estimate of cost and were adjusted according to available funding. Payments for services declined, and facilities faced shortfalls in funding. As a result, under-the-table payments by patients became more common. Doctors also received such payments as supplements to their low salaries (World Bank, 2001, UNDP, 2002).

Under the decentralized Yugoslav version of the Semashko system, the Ministry of Health was the regulator of the health system. Health organisations, such as hospitals, major health houses, the Institute of Public Health, and the Institute for

Occupational Health, elected their directors and boards independently. These organisations reported to the Kosovo parliament (UNMIK, 2001). Pristina University founded a medical faculty, which provided medical training in Albanian and became the focal point of medical research in Kosovo (Tolaj, 1999).

Health indicators improved significantly over this period, following on improvements in living and education standards in the population. The mortality rate declined from 46 per 1,000 in 1956 to 29 per 1,000 in 1990. Diphtheria, typhus, endemic syphilis, and trachoma were eliminated, and the number of cases of pertussis, rubella, and abdominal typhus declined every year. No cases of poliomyelitis were registered between 1983 and 1990. Immunisation rates rose, and in 1988, 86 percent of the population was immunised against polio, 83 percent against diphtheria, tetanus, and pertussis, and 80 percent against measles, mumps, and rubella (Tolaj, 1999).

B. The Health System as Battleground: 1989 to 1999

1. Serbs Take Control

The health system was highly valued in communist societies, and the favourable health statistics of Central and Eastern Europe were often cited as a sign of the success of communism. Many physicians in Yugoslavia were involved in politics. As a result, healthcare was highly politicized, and the health sector therefore became a natural arena for political wrangling and disputes. When Kosovo lost its autonomy in March 1989, the health sector became a battleground for the conflict between Albanians and the federal government in Belgrade.

The Belgrade Ministry of Health assumed control of the health system in Kosovo, and the decentralized 'self-managing' system was abolished. Directors and boards of health institutions were forced to report directly to Belgrade. Pristina University's medical faculty was closed, and the medical training of many students was interrupted. The dean of the Medical School, Dr. Alush Gashi, who protested the closure by chaining himself to a radiator, was beaten, handcuffed, and taken away by police (Tolaj, 1999).

Many Albanian health professionals were forced out of the healthcare system, either directly fired or through harassment. Sixty-four percent of ethnic Albanian health workers (an estimated 2,400 people) left their jobs; some were fired while others were subject to vicious smear campaigns (UNMIK, 2001). Four hundred and forty of those dismissed were specialist physicians. The gynaecology and maternity clinics were particularly hard hit, with all Albanian doctors working in these units

dismissed from their positions. Those healthcare workers that remained in the system were ordered to speak Serbian and to write in Cyrillic (Tolaj, 1999).

Access to healthcare suffered as a result of these dismissals, and also because many Albanians lost their entitlements to healthcare. Many ordinary Albanians were fired from their jobs after 1989, and as a result, lost their insurance coverage. During the 1990s, more than fifty percent of Albanians lacked a social insurance card needed for healthcare (World Bank, 2001).

2. *The Albanian Response*

In conjunction with the parallel government that was established in the early 1990s, Albanians organized a parallel primary healthcare system. This system, known as the Mother Theresa Society, operated ninety-six clinics throughout Kosovo, many in remote areas. Healthcare workers volunteered their services, with financing for supplies and medicines provided by a parallel tax system (World Bank, 2001). Many Albanian health professionals—who had been dismissed from their jobs—also established private healthcare facilities, including clinics and laboratories, during this period.

Because Albanians were no longer able to receive medical training in their own language at Pristina University, they created a parallel system of medical education. In the 1990s, 600 doctors and 1,200 nurses graduated from this parallel system. While this system provided students with a high degree of theoretical knowledge, given the lack of access of medical students to healthcare facilities, clinical training was problematic (World Bank, 2001). This left a generation of Albanians with uncertain expertise and unrecognised qualifications.

3. *The Health Impact of the Loss of Autonomy*

Despite these efforts to establish parallel healthcare services and training, population health deteriorated in the 1990s. The incidence rate of infectious diseases rose, with increases in the rates of intestinal typhus, tuberculosis, brucellosis, and neonatal tetanus. Immunisation rates declined, with vaccination coverage for children against polio, diphtheria, tetanus, pertussis, measles, mumps, and rubella falling below sixty percent, with some areas falling below thirty percent coverage. Polio reared its ugly head, with fifty-two cases reported between 1990 and 1997 (Tolaj, 1999).

C. 1998: The Outbreak of War and Its Impact on Health

When armed conflict broke out in 1998, it caused massive population displacements in rural areas of Kosovo. In the fall of 1998, UNHCR estimated that

two hundred thousand Albanians were displaced. While many civilians fled to neighbouring Albania and Macedonia, others left their villages and took refuge in the hills of Kosovo. Food shortages and a lack of potable water undermined population health. While no formal health surveys were undertaken, humanitarian agencies working in the region cited heightened incidence rates of Hepatitis A, diarrhea, respiratory problems, and skin infections among those displaced. Particularly vulnerable were children, pregnant women, and those with chronic conditions such as diabetes (Medecins Sans Frontieres, 1998, UNHCR, 1998).

Albanian healthcare professionals attempted to assist those displaced and wounded by war. However, this resulted in health professionals themselves becoming targets. Healthcare workers were frequently interrogated and harassed. Numerous doctors were abducted, arrested, or killed by the Yugoslav police, army, or paramilitary forces. Once in custody, they were often brutally interrogated. To extract confessions of complicity with the KLA, prisoners were physically beaten, given electric shocks, or subjected to other methods of torture (Physicians for Human Rights, 1998). Others were killed while on the job, the victims of landmines while traveling to or from healthcare facilities, or hit by stray bullets (Tolaj, 1999, Medecins Sans Frontieres, 1998, Physicians for Human Rights, 1998). Medical facilities operated by Albanians were also targeted. Clinics were searched and property confiscated. In areas of heavy fighting, some facilities were burned to the ground. Jennifer Leaning of Physicians for Human Rights described this campaign against Albanian doctors:

The Serbian authorities have defied the principle that civilians and combatants alike are entitled to medical treatment in times of conflict. Instead, Serb police have branded medical practices as acts of 'terrorism,' and abused physicians and patients, calling them 'terrorists.' Further, by attacking community leaders such as these physicians, and creating fear throughout the population, the Serbian authorities are conducting a campaign against ethnic Albanian society. (Physicians for Human Rights, 1998)

The health crisis escalated dramatically during the NATO bombardment. Police, paramilitary, and army officials escalated their attacks on Albanian villages and stepped up their campaign of ethnic cleansing. Almost a million Albanians were displaced from their homes. While many were housed with relatives in Albania or Macedonia, others took refuge in camps in neighbouring countries, while some remained displaced within Kosovo.

The displacement, as well as the violence against Albanian civilians, took a devastating toll on population health. Between February 1998—roughly when the

conflict between the KLA and Yugoslav authorities began—and June 1999, when NATO forces entered Kosovo, the crude mortality rate was 2.3 times higher than the pre-conflict baseline. War-related trauma was the major cause of death, with an estimated twelve thousand deaths directly related to the war. The second leading cause of mortality was chronic disease (Spiegel and Salama, 2000).

II. AFTER THE WAR: OF HUMANITARIANS AND CHAOS

When UNMIK and KFOR arrived on June 11, 1999, the security situation was precarious, with extensive looting and crimes of revenge and retribution. There was a vacuum of authority that the KLA was exploiting to establish its own provisional government. Kosovo's indigenous civil service (overwhelmingly Serb) had fled, leaving few trained officials to administer the province. Some with the KLA-led provisional government exploited their positions to dismiss political rivals, as well as for personal financial gain.

Albanian refugees and those displaced within Kosovo quickly returned. Over ninety-five percent of those who had been displaced returned to their homes after six months. Once back in Kosovo, they found their livelihoods destroyed, their houses damaged, and public services obliterated. Meanwhile, hundreds of international organisations, funded with millions of dollars from donor agencies, poured into Kosovo and began implementing a wide range of projects. Donor agencies spent over a billion U.S. dollars on humanitarian assistance, and over two billion on rehabilitation projects. Three-quarters of these rehabilitation funds were spent within the first two years of the international community's presence in Kosovo. In the health sector, twenty-one donors spent more than U.S. \$100 million (European Commission and World Bank, 2001).

A. Kosovo under International Administration

After two and a half months of bombing, the Yugoslav government agreed to the deployment of NATO troops in Kosovo and to the United Nations administering the province. On June 10, 1999, NATO ended its aerial bombardments and the United Nations Security Council passed Resolution 1244, which provided the legal foundation for United Nations political control over the province. The long-term status of Kosovo—i.e. whether it would become independent or whether it would remain part of the Federal Republic of Yugoslavia—remained purposively unclear.

The United Nations Interim Administrative Mission in Kosovo (UNMIK) was formed, charged with building autonomous institutions of self-government. It created

four ‘pillars’: humanitarian assistance (run by UNHCR), institution building (run by the OSCE), civil administration (run by the United Nations), and reconstruction (run by the European Union). The mandate of UNMIK was to administer the province, while establishing and overseeing the development of provisional self-governing institutions (United Nations Security Council, 1999). The NATO-led KFOR (the Kosovo Force) provided security.

The Yugoslav army, Serbian police and paramilitary forces left Kosovo, and NATO forces, as well as United Nations police, arrived. The vast majority of Albanians refugees and internally displaced persons rapidly returned home. Many found their houses destroyed and/or looted, their livelihoods ruined, and their futures uncertain.

B. The Exodus of Serbs

While the vast majority of Albanians returned to Kosovo, another exodus began. After the arrival of KFOR and UNMIK, extremist Albanians carried out crimes of revenge and retribution against the province’s minority Serb and Roma populations. In one particularly brutal incident on July 23, 1999, fourteen Serb farmers were gunned down with AK-47s while harvesting their crops in Gracko, a small village south of Pristina (OSCE, 1999).

As a result of this violence, approximately 250,000 people, including Serb, Roma, Ashkali, and other minorities, fled the province after June 1999 (International Crisis Group, 2002a, International Crisis Group, 2002d) due to fear, intimidation, and direct physical violence (International Crisis Group, 2002a, International Crisis Group, 2002d, Human Rights Watch, 2001). Some fled to Serbia and Montenegro, while others remained within KFOR-guarded enclaves in Kosovo.⁴¹ Hundreds of murders took place, with Serbs forming a disproportionate number of the victims. From KFOR’s arrival in June 1999 until the end of November (five months), there were 379 murders, including 135 Serb victims (Human Rights Watch, 2001). These attacks were conducted with complete impunity; the justice system has not been able to find and punish the perpetrators (International Crisis Group, 2002a).

⁴¹ IDP estimates were obtained from UNHCR. These figures include all displaced ethnicities: Serbs, Albanians, Roma, Ashkali, and other minorities. UNHCR emphasizes that, in the absence of a complete registration process, such numbers remain estimates.

C. The Humanitarian Phase and the Challenge of Coordination

UNMIK's immediate priorities in the summer of 1999 were to establish its presence, build a safe and secure environment, coordinate the hundreds of international agencies and non-governmental organisations, ensure that the population's basic humanitarian needs were met, and avert a humanitarian crisis by preparing for the upcoming winter.

Eighty-seven percent of the Albanian population had been displaced at some point during the war, and by September 1999, twelve percent remained displaced. Due to the extent of damage to housing, ensuring that those returning had access to shelter was a challenge. Nine percent of dwellings provided shelter for two or more households (Spiegel and Salama, 1999). The international community began an extensive winterisation campaign to repair houses before the onset of winter. This effort was quite successful; despite an unusually harsh winter in 1999-2000, there were no deaths from exposure to the cold.

While malnutrition rates were relatively low in July 1999 (with 3.1 percent of children acutely malnourished) food security remained fragile. The conflict had disrupted food supplies: the planting of crops was interrupted and much of the livestock had been looted and taken to Serbia (Spiegel and Salama, 1999). While shops filled relatively quickly, many Albanians had lost their jobs during the war, as well as their savings during their flight from Kosovo, and initially lacked the ability to feed their families. In the summer of 1999, more Albanians utilised food assistance than the World Food Program (WFP) had planned for, partly because more people returned than the international community had anticipated.

UNMIK also faced the mundane but critical challenge of getting essential public services such as electricity, water supplies, and garbage collection operational. These services had largely been run by Serbs, most of who fled Kosovo in the summer of 1999. Although many Albanians returned to public-sector jobs they had held before being dismissed in 1989 and were supported by international experts, the turnover in staff led to significant disruption of these services. The infrastructure itself—the electricity grid, water mains, and telephone lines—was old and few investments had been made over the years. These systems ran precariously, if they were functional at all, and were subject to frequent failure.

While UNMIK officially held authority throughout Kosovo, the situation on the ground was very different. As noted above, the KLA rapidly set up a provisional

government, creating government departments, municipal administrations, and appointing staff at public institutions such as health centres and schools. Competing governance structures from the LDK were also in place, remnants of the parallel structures of the 1990s. In Serb-controlled enclaves, Belgrade's authority continued, with local officials reporting to Belgrade, and staff and teachers receiving instructions, pay, and supplies from their central ministries in Serbia.

D. Immediate Challenges in the Health Sector

Before NATO and the UN established control in Kosovo, UNHCR together with NGOs that had been operational in Kosovo prior to the NATO bombardment outlined geographic areas of responsibility for NGO activities. Médecins Sans Frontières was responsible for the north of Kosovo, International Medical Corps for the Southwest Region, and Médecins du Monde for the Pristina region. These areas of responsibility were initially respected, which enhanced coordination among medical NGOs and greatly facilitated the initial delivery of health services.

However, hundreds of other NGOs arrived in Kosovo in June 1999, many undertaking activities in the health sector. As a result, coordination became a critical priority. The WHO office in Kosovo, in collaboration with the Kosovo Institute of Public Health, held weekly coordination meetings for NGOs and donors.

Representatives from UNMIK's Department of Health were key participants in these coordination meetings. Although coordination and collaboration was far from ideal, these meetings helped ensure that major program initiatives were communicated, information sharing enhanced, and duplication of activities minimized.

Non-governmental organisations initially provided direct healthcare through mobile clinics, often working alongside local health professionals in health clinics to support their re-establishment and build capacity. Training programs were also established, particularly in the area of reproductive health, to ensure that local health professionals were better equipped to address population-health issues. Despite these efforts to build local capacity, international organisations also created a brain drain, as the salaries of the local health system could not compete with those being offered by international agencies. Many English-speaking physicians found lucrative work with international medical NGOs or outside the health sector.

The health system had been seriously weakened by years of political and economic turmoil and by several months of conflict. Over ninety percent of the clinics of the parallel Mother Theresa Network were damaged or destroyed during the war,

and many private clinics of Albanian health professionals had also been damaged (Shuey et al., 2003). Most public-health facilities were spared war-related damage, as Serbian doctors had staffed these clinics. However, the vast majority of facilities had been looted of supplies and equipment, and the infrastructure reflected years of neglect. The general collapse of public-service infrastructure—particularly water and electricity—deeply affected the health sector. Many hospitals lacked running water twenty-four hours a day (WHO, 1999a).

Just as control of health facilities was an important priority for the Yugoslav government during the 1990s, it became equally important for Albanian leaders in the summer of 1999. The health system experienced a dramatic turnover in staff. While in June 1999 the majority of the staff and patients at Pristina Hospital were Serb, by August 1999 the hospital staff and patients were almost exclusively Albanian.

Serbian healthcare workers joined the general exodus of Serbs from Kosovo. A Physicians for Human Rights investigator found that fear of Albanian extremists caused this flight:

Recent interviews with the few remaining Serb physicians and patients [in Pristina Hospital] revealed that there is a general fear of Kosovo Liberation Army (KLA) and other Albanian hard-liners both inside and outside the hospital. One physician was threatened by a KLA member admitted as a patient. 'I must say I am afraid. But, I am not afraid of my Albanian colleagues. I had an incident with an UCK (KLA) patient who attempted to beat me and (my Albanian colleagues) protected me. It is even more dangerous on the street and at market places where there is no one to protect us.'

(Physicians for Human Rights, 1999)

Those Serbs who chose to remain in Kosovo lived in Serbian enclaves and worked in the parallel Serbian health system that was funded and administered by the Serbian government in Belgrade.

While UNMIK appointed international managers at hospitals, the KLA in turn appointed local managers—a process that further politicized these health facilities. Many of those Albanians who returned to the system had spent ten years working in the parallel system, with little access to professional development. Others were educated in the parallel system and lacked official certification, and their clinical skills were uncertain. Doctors and nurses spent months without receiving salaries, as UNMIK was slow to establish payroll systems and register facility staff.⁴²

⁴² When payroll was established, many health clinics—particularly minority clinics—inflated the numbers of those working. Thus, the healthcare system acted as a social-welfare system to minority communities.

Accurate data detailing the major health issues in Kosovo was almost non-existent, as health-information systems had largely broken down during the 1990s. Therefore, the International Rescue Committee (IRC) undertook a rapid epidemiological survey to guide health interventions. The IRC study discovered that mortality rates were relatively low, largely because the majority of the population was between the ages of fifteen and fifty (Spiegel and Salama, 1999). The IRC's examination of hospital mortality showed that communicable diseases accounted for only twelve percent of all causes of death. However, the survey produced disturbing results regarding infant and child health.

Infants accounted for forty percent of all hospital deaths, disproportionately high given that they comprised only two percent of the total population (Spiegel and Salama, 1999). Children suffered from a high rate of diarrhea and acute respiratory infection. This was a reflection of poor sanitation, lack of access to clean drinking water, and inadequate shelter. More worrying was the lack of knowledge regarding the appropriate treatment of diarrhea. Many mothers surveyed (54.6 percent) said they stopped breastfeeding when their child had diarrhea. Moreover, significant numbers of children had not completed their full course of vaccinations (Spiegel and Salama, 1999).

Another agency examining infant health in hospitals found equally disturbing results. In the Pristina hospital, the number of premature births had increased in the summer and fall of 1999, primarily as a result of high levels of stress and poor nutrition. Half of the infants born died prematurely due to a lack of care (medicine and incubators) or poor hygiene (Agence France Press, 1999).

E. Governance Structures

UNMIK initially competed with parallel Albanian institutions, including those established by the KLA, for control of municipalities, health facilities, schools, and other public-sector institutions. The KLA appointed officials to public institutions, which generally refused to acknowledge the UN's authority. Other Albanian political parties such as the LDK also clamoured for control of institutions, and in many areas tension between the KLA and the LDK became violent, resulting in assassinations of key LDK figures. A power-sharing agreement was reached in December 2000 in which the United Nations agreed to govern with Albanian authorities.⁴³ This included appointing co-directors in UNMIK-led departments such as health. The respective

⁴³ This agreement also included representatives from minority groups.

political parties nominated these co-directors, with UNMIK government departments divided among the parties.

Therefore, Kosovo's initial post-war period had two phases of governance. The first (failed) phase, with exclusive international authority, is represented in Figure Seven. The second phase was the Joint Interim Administrative Structure (JIAS), where the United Nations maintained political authority, but included formal representation and consultative mechanisms with Kosovo political parties. This phase is represented in Figure Eight. The JIAS structure was maintained until Kosovo-wide elections were held in November 2001.

Figure Seven: Initial UNMIK Structure

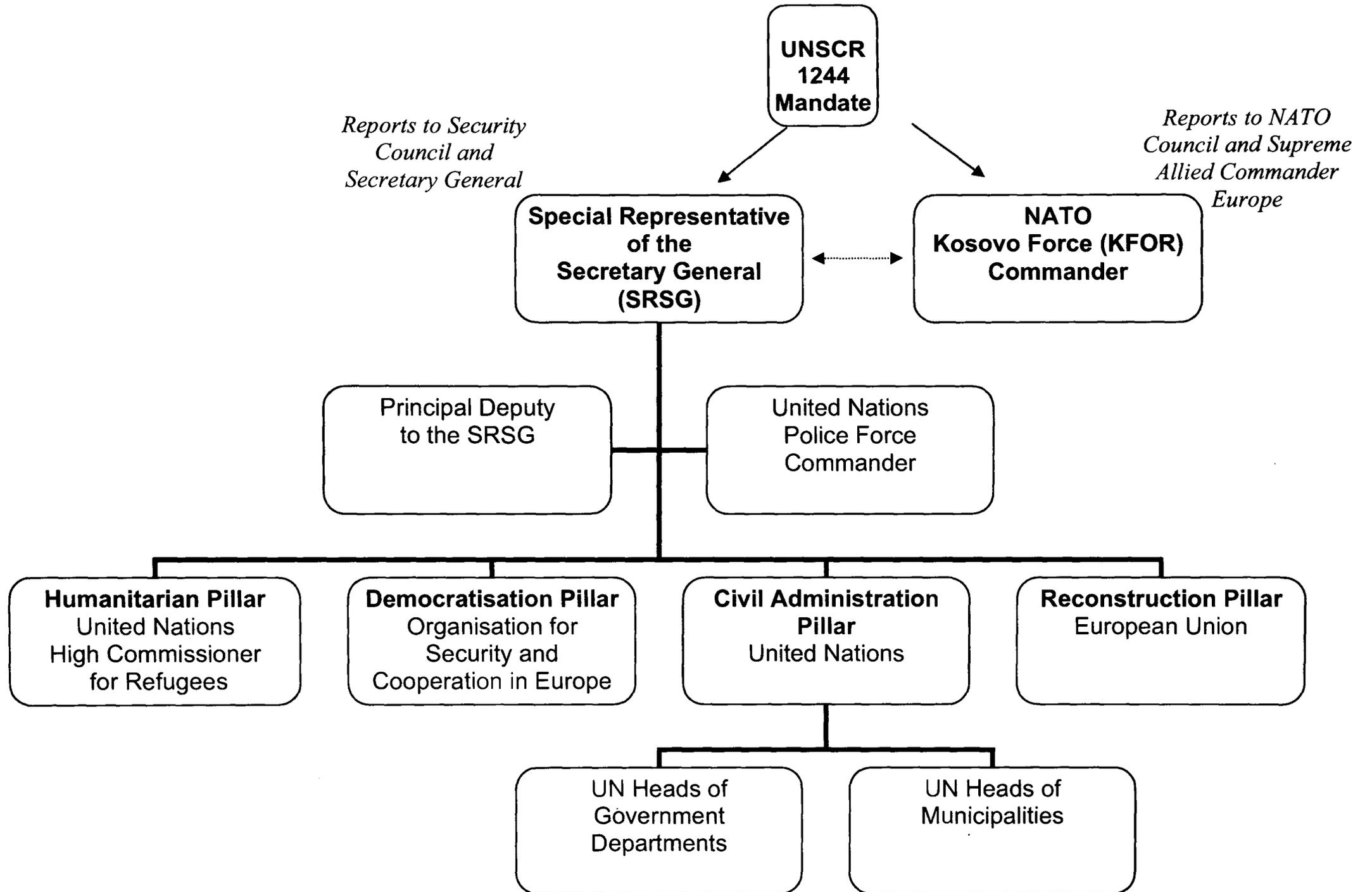
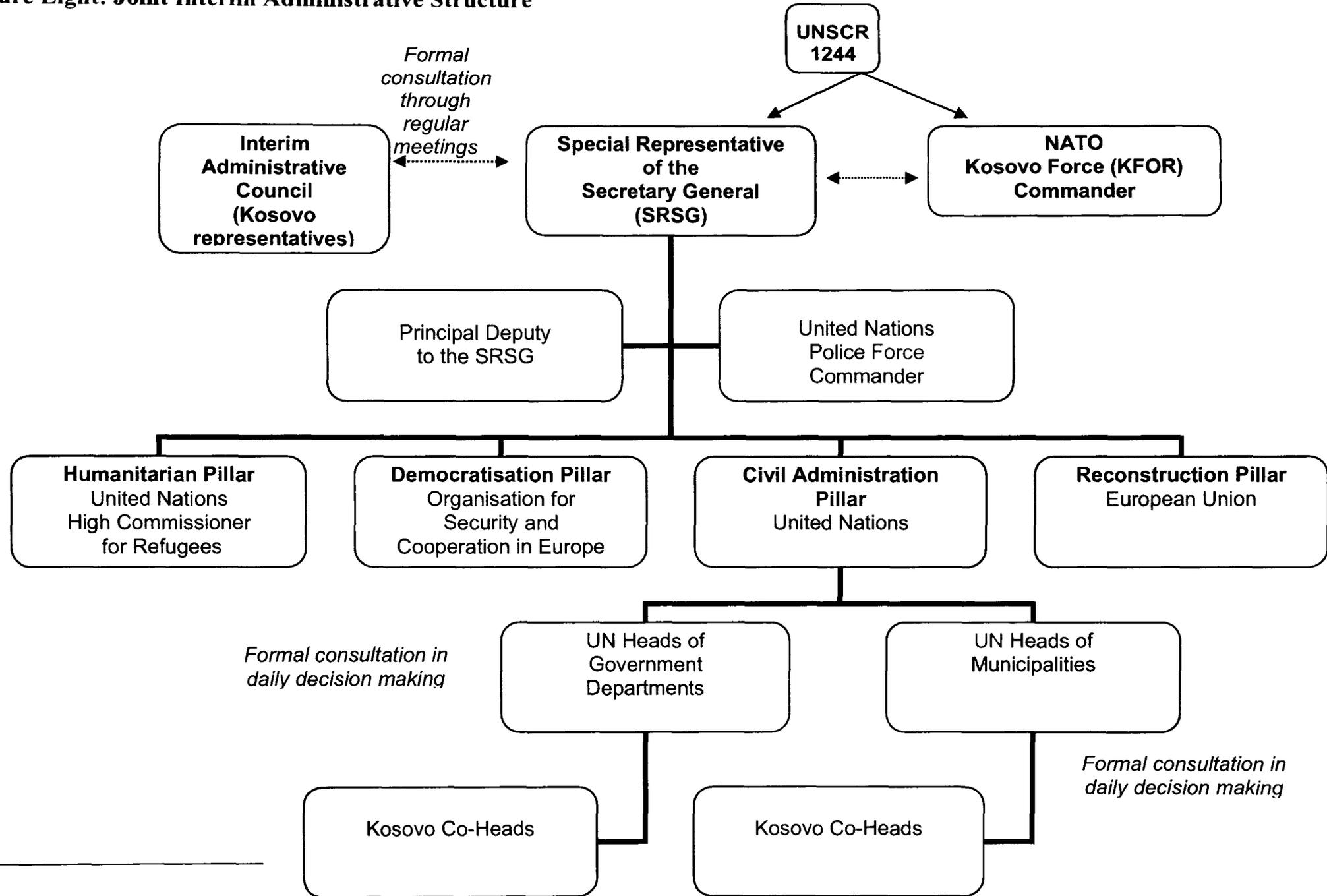


Figure Eight: Joint Interim Administrative Structure⁴⁴



⁴⁴ Note that both the SRSG and the Commander of the NATO Forces continue to maintain their reporting relationships to the Security Council and the Secretary General of the United Nations, and the NATO Council and the Supreme Allied Commander Europe.

III. THE BEGINNINGS OF REFORM

A. The Vision of WHO's Blue Book

Examinations of other post-conflict health interventions (outlined in Chapter One) emphasized the importance of building a longer-term strategy to ensure that assistance is directed towards sustainable activities and is channelled to meet the objectives of the health sector. This lesson was successfully applied in the case of Kosovo. The local WHO office, reporting to the WHO regional European office in Copenhagen, played a critical role in Kosovo's post-conflict health coordination and planning. The Kosovo office of the WHO worked to support UNMIK's Department of Health, although there was no reporting relationship between UNMIK and WHO. One of the WHO's objectives was to establish a policy framework that would maximize the use of the extensive resources available in 1999 and ensure that health interventions were not harmful to future health-sector development (Shuey et al., 2003). Dr. Dean Shuey, a veteran of Uganda's post-conflict reconstruction process, led the task of developing these health guidelines, and was assisted by an Albanian physician, Dr. Fatime Qosaj.

By mid-July 1999, only a month after the international community arrived in Pristina, the WHO released some basic guidelines for health projects (Shuey et al., 2003). After a summer of further consultations with both local and international experts, the "Interim Health Policy Guidelines" were released in September 1999. These policy guidelines, known informally as the "Blue Book," included eight objectives:

1. Primary care would be strengthened with the development of family-medicine teams;
2. Specialist care would be provided through referral from primary care;
3. The size and location of facilities would be established through the identification of population catchment areas—which meant that some facilities would be closed, while services in other facilities would be reduced;
4. No expansion of services should be undertaken to ensure sustainable financing. Public financing would be maintained, but other financing models would be studied;
5. Public provision of services would predominate;
6. Regulated private practise would be allowed;
7. An essential drugs program and a regulatory agency would be introduced; and
8. The provision of healthcare and employment within the system would be non-discriminatory. (WHO, 1999b)

The Blue Book was a critically important step in policy development in Kosovo. While it was non-binding on donors and NGOs, it established an important framework and point of reference for donor activity, guiding many donor

interventions. Given the vast amount of donor resources available, the commitment not to expand services was critical to ensure that donor-funded projects and programs were dedicated to sustainable activities that could realistically be supported in the future under the Kosovo budget. The WHO also produced a facility plan, which determined what facilities would remain open, the services provided, equipment lists, and staffing requirements. This plan was basically followed. Efforts to provide healthcare for minorities meant that some facilities remained open that were not on the facility plan, and one hospital facility funded by the United Arab Emirates was built despite protests from the Department of Health and the WHO.

The Blue Book also established the basis for a further policy-planning exercise, which took place in the summer of 2000 and is described below. This exercise would lay the foundations for wide-ranging health reform in Kosovo.

B. Lessons Learned, Lessons Applied

Examinations of post-conflict interventions in the health sector outlined in Chapter One generated three key recommendations. First, in the immediate post-conflict period (humanitarian phase), emphasis should be placed on coordinating resources and defining the role of key actors. Second, humanitarian and reconstruction assistance, where possible, should build local capacities rather than detract from them. And third, a longer-term health strategy should be developed to ensure that resources are channelled towards activities that will benefit the long-term development of the health sector.

As outlined above, the WHO quickly assumed a coordination role in the chaotic post-conflict environment. The sheer number of NGOs and the scale of humanitarian assistance pouring into the province made this task extremely difficult. While renegade donors and some uncooperative NGOs frustrated coordination, the WHO maintained a basic overview of NGO activity and worked to influence donor and NGO interventions. The WHO worked to ensure that health interventions did not create recurrent expenditures that the future health system would be unable to support. A facility master plan was established, outlining what facilities would remain open and the services they would provide, as well as what facilities would be closed. WHO was initially supported in this role by the Department of Health, which gradually took over this coordination function.

While activities were coordinated, no sector-wide planning approach was implemented. Donors consulted the WHO, but made their own decisions regarding

funding priorities. Time horizons were short; most donors implementing projects in the summers of 1999 and 2000 had budgets to cover project work for two years. Project priorities were more often based on donor objectives rather than needs on the ground. For example, donors funded projects in the geographic areas where their troops were deployed. Donors were also risk-averse, fearful that the precarious security environment and political tensions would disrupt attainment of project objectives. Because of donors' short funding horizons and their aversion to risk, they focused on high-cost projects with quantitative outputs, such as clinics rebuilt, personnel trained, and wells cleaned. Long-term capacity building, such as development of management and information systems, was initially neglected.

The record of the international community was mixed in the area of capacity building during the humanitarian period. While NGOs implemented training programs, limited the number of mobile clinics, and often worked out of local health clinics (functioning as a form of on-the-job training), they also siphoned off local health professionals with salaries that far exceeded what they would have received from the Kosovo health clinics. This particularly affected the Department of Health, which paid its staff out of the Kosovo Consolidated Budget and was unable to attract sufficient numbers of highly skilled administrators.

A key lesson that the international community applied in Kosovo was in the area of health-policy development. The initial policy guidelines established by the WHO helped ensure that projects in the emergency phase did not undermine the long-term sustainability of the health system.⁴⁵ And, as outlined below, these guidelines set the stage for wide-ranging health reform.

⁴⁵ While projects did not undermine the sustainability of the system, much more could have been done in the early post-conflict period to undertake projects that would support the development of an efficient, effective, and equitable system.

CHAPTER SIX: THE PATH TO HEALTH REFORM IN KOSOVO

By the spring of 2000, the situation in Kosovo had normalized. For the majority of the population, the humanitarian phase of the international intervention had been a success. Most people had access to healthcare, adequate shelter, food, and water. Mistakes had been made, and overlap and duplication of humanitarian projects had occurred. However, the immense amount of resources that poured into the province, combined with the hard work of the local population and international organisations, meant that Kosovo quickly moved into its peacebuilding phase. Rehabilitation of basic infrastructure and efforts to reform key sectors began in earnest.

Under United Nations Security Council Resolution 1244, one of the objectives of the mission in Kosovo was to reform governance structures and build autonomous institutions of self-government. As described in Chapter Three, this meant that the United Nations was charged with building liberal democracy in the province under the assumption it would create the foundation for peace and prosperity. UNMIK therefore undertook the following ambitious activities:

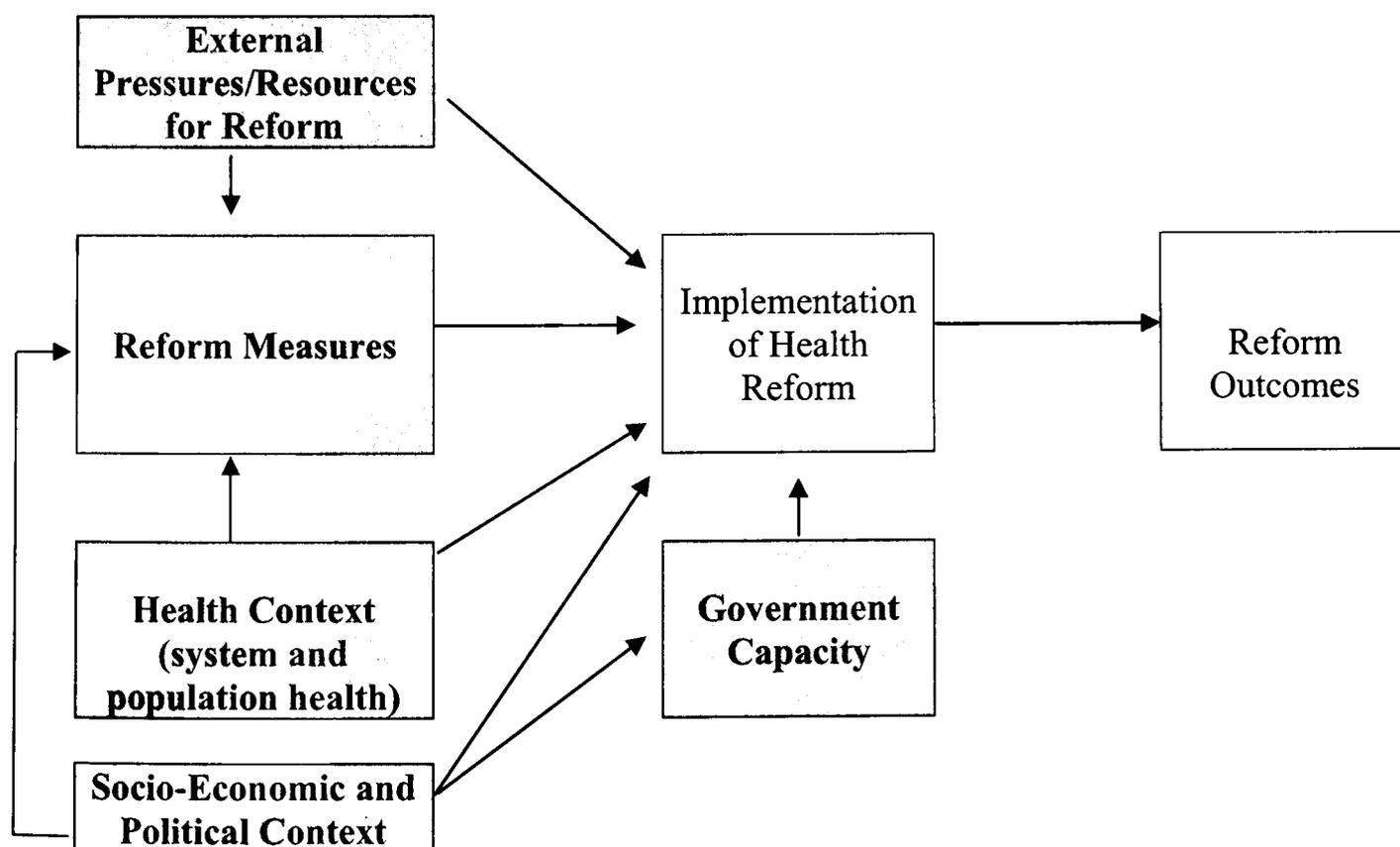
- Security-sector reform, including building a Kosovo police service, and demilitarisation and demobilisation of the KLA;
- Reform of elected institutions, including development of political parties, holding elections, and creating governing assemblies at both the local and central levels;
- Transitional justice issues, such as investigating and prosecuting war crimes, and building local judicial capacity;
- The creation of a market economy through planned privatisation of socialist enterprises; and
- Reform in key social sectors such as health and education.

UNMIK adopted a three-pronged approach to this task. First, it set up and managed administrative departments, outlined above in Figure Eight. In some areas, these departments were led by internationals, but staffed in the majority with national personnel (such as health), while other departments (such as the police) were almost completely staffed by internationals while national staff members were being trained. Second, UNMIK worked to reform institutions according to European standards. For example, the education curriculum was rewritten and new laws conforming to international human-rights norms were promulgated. And third, UNMIK worked to build an indigenous capacity capable of administering these reformed institutions after the international community left (International Crisis Group, 2002b). The challenge was immense.

The conceptual framework for post-conflict health reform is applied to the Kosovo health-reform process below. With the application of this conceptual framework, the hypothesis that the socio-economic and political context, the externally driven nature of the reform process, and the compressed timeframe for reform undermined the ability to the reform program to achieve its objectives can be tested.

Figure Nine once again presents the conceptual framework for health reform. As noted above, the advantage to this framework is that it provides an analytical tool to trace the various inputs into the reform measures, the measures themselves, as well as the factors impacting on the implementation process. The framework also necessitates identifying the concrete outcomes of reform, rather than the reform process in isolation. The various elements of the conceptual framework that will be applied in the first part of this chapter are highlighted in bold and shaded in Figure Nine, namely the health context, the socio-economic and political context, the external pressures and resources for reform, and the capacity of the new Kosovo government to administer and oversee the reforms. Chapter Seven will examine the implementation of the reform program and the outcomes of reform efforts.

Figure Nine: Application of the Conceptual Framework to Kosovo Case



I. HEALTH CONTEXT: HEALTH SYSTEM AND POPULATION HEALTH

A. The Health System

After the war, the healthcare system had more than 10,000 workers at the following facilities:

- Tertiary hospital (Pristina): 2,500 beds
- Five Regional hospitals: approximately 450 to 550 beds each
- 30 Main Family Health Centres
- 173 Smaller Family Health Centres
- 162 Punctas (primary care outposts)
- Institute of Public Health: Central 1, District 6
- Institute of Transfusiology: 1
- Institute of Occupational Health: 1
- Institute of Rehabilitation: 2

These facilities were generally in a state of disrepair, with poor sanitary conditions and crumbling infrastructure. Much of the equipment was outdated, non-functional, or had been taken during the war (UNDP, 2002). Health clinics in rural areas suffered from an acute lack of personnel and equipment. Access to emergency and after-hours care was variable; while these services were often accessible in large cities, they were not available in rural areas (Shuey et al., 2003, UNMIK, 2001). The availability of services through private practise had increased dramatically. After the war, the parallel Mother Theresa Network was virtually abandoned. Most Albanian health workers returned to public-health institutions, but those that had developed private practises during the 1990s maintained them (Shuey et al., 2003, UNMIK, 2001). While no official registry of private practise existed, the Ministry of Health estimated that there were approximately fifty private paediatric clinics, thirty-seven gynaecology clinics, fifty-nine internal medicine clinics, forty-eight surgeries, and nineteen orthopaedic clinics. They charged anywhere from ten Euros for an ultrasound to 750 Euros for a caesarean (Kosovo Ministry of Health, 2003).

The quality of the public healthcare system was compromised by several factors. Access to primary care was variable and consistent levels of care were not provided. Shortages of health personnel in rural areas, the specialised nature of healthcare in Kosovo, and the lack of a functioning referral system undermined the quality of care. Moreover the efficiency of services was minimal. Hospitals were composed of several separate buildings, which contained separate clinics with their own laboratories, intensive-care facilities, and operating theatres. Services among the buildings were not shared, which resulted in duplication and inefficiency (Shuey et al.,

2003, UNMIK, 2001). Maternity services were also far from satisfactory. Sanitation of the maternity wards was suboptimal, proper hygiene etiquette was often not followed by maternity staff, privacy was minimal, and rooming-in of babies was not promoted, interrupting bonding and breastfeeding.

Kosovo also faced a shortage of physicians. The number of doctors was less than 2,500—or on average thirteen doctors for every ten thousand inhabitants (the European average is about thirty-five doctors per ten thousand inhabitants). Many doctors had trained in the parallel system and required skills upgrading (Shuey et al., 2003, UNMIK, 2001). The exodus of Serb doctors in 1999 exacerbated this shortage. The number of doctors willing to work in rural areas was minimal, and rural residents often had to travel long distances to receive treatment.

While the shortage of physicians and the poor state of health facilities contributed to variable access to healthcare, economic factors greatly impacted on the ability of individuals to access health services. The World Bank found that the main barrier to healthcare was cost—despite the fact that healthcare was supposed to be free. Twenty-eight percent of those surveyed reported that they could not access healthcare because of cost. Over ninety-five percent of Albanians reported buying healthcare services, paying approximately three Euros for general expenses and five Euros in ‘gifts’ to healthcare providers. The average household spent thirty-five Euros annually on drugs (Simpson and Maxhuni, 2003, World Bank, 2000b). These costs were particularly debilitating given the high rate of poverty in Kosovo (which is outlined in further detail below).

After the war, the healthcare system was funded by revenue out of the Kosovo Consolidated Budget. This budget was a combination of donor funds and locally collected revenue (Shuey et al., 2003, UNMIK, 2001). In the summer of 2000, the Department of Health also instituted a co-payment system to fill a financing gap and support the primary care system (a financial penalty was incurred if patients bypassed the primary care system) (Shuey et al., 2003, UNMIK, 2001). These funding sources were largely inadequate, unsustainable, and regressive. Donor contributions were waning, and both co-payments and under-the-table payments placed a heavy burden on the poor (IHSD, 2003b).

B. Population Health Status

Kosovo suffers from a lack of basic demographic data, as there has been no reliable census in decades: the last census that included full Albanian participation

was conducted in 1981. The population of Kosovo is quite young; the mean age is estimated to be just 24.6 years. Twenty-three percent of the population is under 14, while 52 percent is between the ages of 15 and 49. There has been a clear preference for male children, with selective abortion in favour of boys. As a result, the overall population balance is skewed: 50.3 percent of the population are male, while 49.7 percent are female, and the ratio of newborn male babies to females is 106:100. The last-born child in a family is more likely to be a boy than a girl, and there are three times as many male-single-child families as female-single-child families (Kosovo Ministry of Health, 2005). Life expectancy at birth for children born during 1995-96 was projected to be 71.45 years for males and 76.64 years for females (Simpson and Maxhuni, 2003). Women of childbearing age (between the ages of 15 to 45) constituted 56 percent of the female population and 26.2 percent of the total population (UNMIK, 2001).

The validity and reliability of health data is similarly problematic, and as a result the epidemiological situation was uncertain in 1999 and 2000. Estimates for the crude mortality rate for deaths due to natural causes varied between 4.5 and 5.4 deaths per 10,000 population (Kosovo Ministry of Health, 2005). Hospital mortality studies showed that 12 percent of deaths were from communicable diseases, 53.2 percent from non-communicable diseases, three percent from maternal conditions, 29.1 percent from neonatal conditions (0 to 28 days of age), 3.4 percent from injuries, and 0.6 percent from nutritional illnesses (UNMIK, 2001).

Health surveys taken immediately after the war indicated that reproductive health, as well the health of infants and children, was a major concern. In 1999, 15 percent of pregnant women did not see a healthcare worker, 47 percent had less than two medical visits during their pregnancies, 20 percent gave birth at home, and 17 percent delivered their babies without professional help, while 5.4 percent of new mothers were undernourished. Fewer than 20 percent of women report were using contraception, while 12 percent of women reported never having heard of any method of contraception (Kosovo Ministry of Health, 2005). As a result, the maternal mortality ratio was 509 per 100,000 live births (Simpson and Maxhuni, 2003).

In 1999, the infant mortality rate was 45 per 1,000 births (UNMIK, 2001). Infant mortality was the highest in Europe, about two or three times the rate of other South Eastern European countries. Perinatal mortality was also high. In 2000, Pristina Hospital had a perinatal mortality rate of 44 per 1,000. This compares to a rate of 22

per 1,000 in 1988 (Gloeb, 2001). These numbers are particularly troubling when compared with surrounding countries. In the same year, Slovenia had a perinatal mortality rate of 4.09 per 1,000; Croatia's rate was 9.37 per 1,000; Serbia and Montenegro's was 10.31 per 1,000; and Macedonia's was 15.82 per 1,000. The average rate of European Union countries was 6.78 per 1,000 (WHO, 2000a).

Many factors contributed to these disturbing statistics, including poor obstetric standards, inadequate medical services, poverty, and malnutrition—as well as health conditions such as prematurity, asphyxia, congenital anomalies, respiratory diseases, and diarrhea (Kosovo Ministry of Health, 2005). Breastfeeding rates for babies up to the age of six months were low, at 12 percent, which contributed to poor infant health (Kosovo Ministry of Health, 2005). Pristina hospital had on average 43 deliveries per day in the spring of 2000, and was hit by a staphylococcus infection resulting from a lack of sanitation.

Serious public-health issues faced children. Childhood vaccination was disrupted by the war, and was not universal; only 88 percent of children were fully immunised against polio and DPT, and 89 percent against measles (Simpson and Maxhuni, 2003). Improper nutrition was also a concern. Among children aged 5 to 59 months, a UNICEF survey reported stunted growth among 10 percent of children and mild and moderate anaemia in 16 percent of children. More than 50 percent of children between 6 and 12 years of age showed symptoms of iodine deficiency (Simpson and Maxhuni, 2003). Access to clean and safe drinking water was problematic, as some water sources suffered from faecal contamination (UNMIK, 2001). While no data existed on the rate of childhood accidents, elsewhere in Eastern Europe accidents were the leading cause of childhood death and injury (Rechel and McKee, 2003), so accidental death and injury among children was most likely significant.

Non-communicable diseases such as cardiovascular, renal, and lung diseases and chronic back pain and ulcer/gastritis were the most common adult health conditions. Because of the high smoking rate, the incidence of cancer and heart disease was increasing. Tobacco was a major contributor to morbidity and mortality (Kosovo Ministry of Health, 2005). Communicable diseases were also problematic. The incidence of tuberculosis remained high at 60 to 70 cases per 100,000. There was a high case-fatality rate for some communicable diseases such as bacterial meningitis, haemorrhagic fever, viral meningo-encephalitis, shigellosis, and diarrheal diseases.

HIV/AIDS was also a looming health threat. According to the Institute of Public Health, 42 cases of AIDS had been reported between 1986 and 2003. But these numbers are known to be underreported, as risk behaviours for HIV such as unsafe sex and sharing of needles among intravenous drug users are widespread (Simpson and Maxhuni, 2003).

While health data on adult health issues was lacking in the post-conflict period, significant numbers of individuals self-reported ill health in a World Bank survey. Over 15 percent of Albanians and 25 percent of Serbs reported having a limited illness, while 10 percent of Albanians and 34 percent of Serbs self-reported they were in poor health⁴⁶ (World Bank, 2000b).

Mental-health issues were also significant, as much of the population experienced severe trauma during the war. In a mental-health survey, a high percentage of those surveyed experienced trauma during the war: 66 percent of respondents reported having been denied food and/or water and 66 percent reported having been caught in a combat situations (Cardozo et al., 2000).

Figure Ten presents the health context in the post-conflict environment. Access to healthcare was variable for a number of reasons. Health facilities were in a general state of disrepair, had been looted of equipment, and were inefficient. These facilities clearly needed to be rebuilt and re-equipped. Hidden costs such as under-the-table payments meant that significant numbers of individuals could not afford to access health services. These factors, combined with the shortage of physicians and the need for updated training for health care workers, led to a variable quality of care.

The poor state of the health system contributed to generally low health status in Kosovo, in comparison to other countries in Central and Eastern Europe. Kosovo's health status was also undermined by high rates of maternal mortality and infant mortality, caused by poor maternal health, inadequate medical services, and socio-economic factors such as poverty. While precise data on child and adult health was not available, risk factors for communicable diseases (low vaccination rates and poor water quality) and non-communicable diseases (high smoking rates and risk behaviours for STDs) were high. This generally low health status, combined with

⁴⁶ The World Bank questionnaire surveyed 2,800 households. For health status, the questionnaire provided respondents with 5 options to identify their health status: very good, good, fair, poor, and very poor. The significant differences in self-reporting between Albanians and Serbs were probably a result of the demographics of the Serb population, who were generally older than the Albanian population.

significant urban-rural migration and the ensuing pressure on urban health facilities, led to an increased demand for health services.

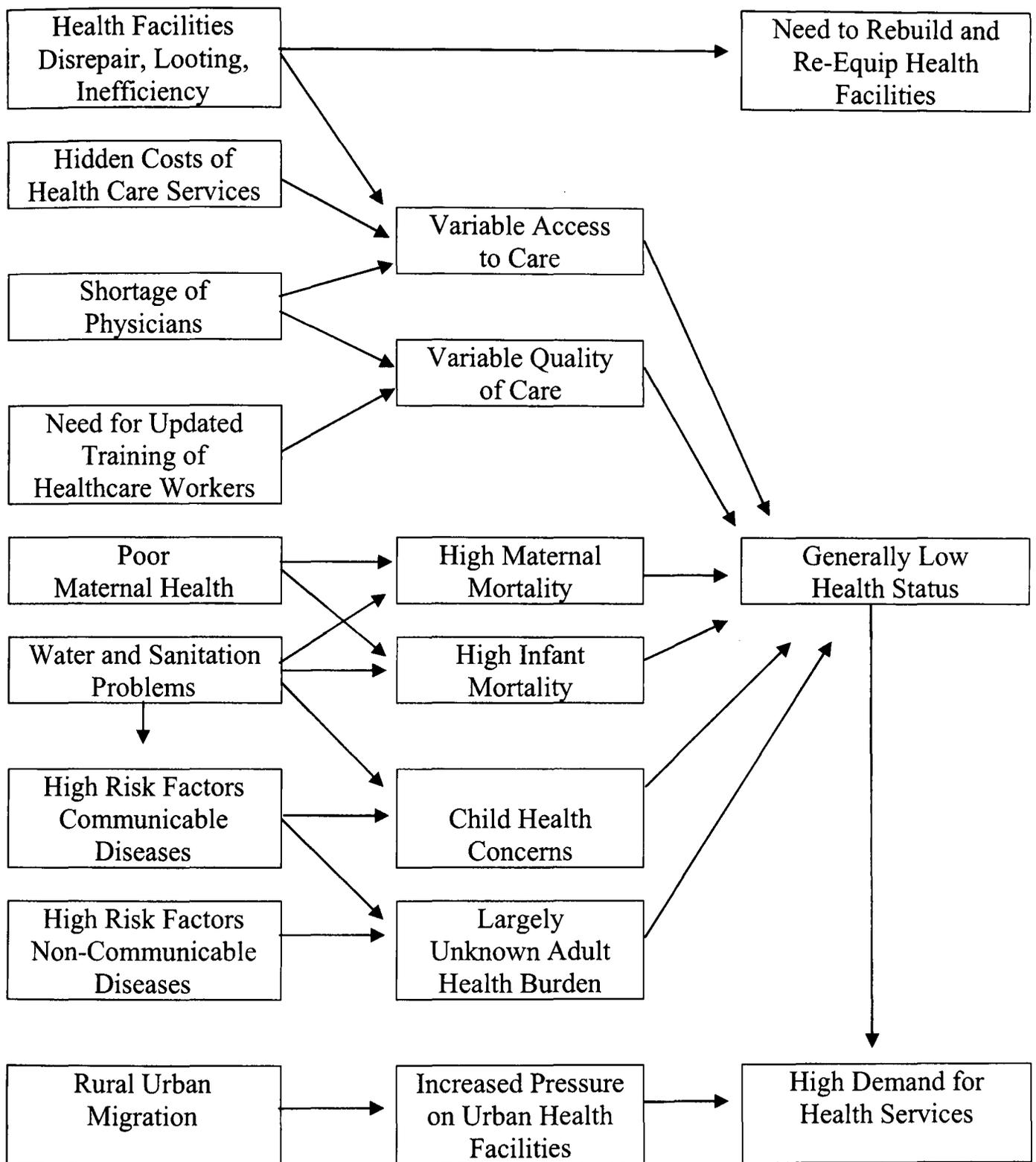
Comparison on these specific health indicators with other post-conflict countries is difficult given the context specific nature of each conflict, and the fact that Kosovo was part of the former Yugoslavia, and as such had a higher level of development than many other conflict areas.⁴⁷ Bosnia could be an appropriate point of comparison with the caveat that the conflict was of a longer and more intense duration than Kosovo. In 1995, Bosnia's infant mortality rate was 14 per thousand births, 30 percent of Bosnia's health professionals were lost to death or migration,⁴⁸ and one-third of Bosnia's medical facilities were thought to be destroyed (Walsh, 1997).

Figure Ten outlines pressure for reform generated by the poor state of the health infrastructure and population health. The majority of regional-level stakeholders identified health issues as a key factor driving the reforms. The efficiency, equity, and effectiveness of the health sector needed improvement, and the system was unable to respond adequately to the health needs of the population.

⁴⁷ While specific comparisons are difficult, Kosovo did follow the pattern of many post-conflict countries: significant percentage of health infrastructure destroyed or damaged, shortages of human resources for health, and low population health status - elevated mortality rates with higher elevations among vulnerable groups such as women and children.

⁴⁸ Prior to the war, there were 7,032 medical doctors, 18,257 nurses and 1,408 dentists in Bosnia.

Figure Ten: Health System and Population Health Challenges in Post-Conflict Kosovo



II. SOCIO-ECONOMIC AND POLITICAL FORCES IMPACTING ON REFORM PROCESS

A. The Socio-Economic Context

Kosovo was the poorest region of the Federal Republic of Yugoslavia, and its economy had been further battered by ten years of discrimination, economic sanctions against Yugoslavia, and the outbreak of hostilities in 1998. While the ethnic animosity and discrimination is outlined in detail in Chapter Six, rural-urban migration and widespread poverty were also significant challenges.

The post-conflict period saw a massive influx of people from rural areas to cities. The population of Pristina almost doubled in the years following the war, and IDPs made up eleven percent of the urban population. This was a result of both ‘push’ factors (houses in rural areas were badly damaged or destroyed during the conflict) and ‘pull’ factors (the promise of a better life in the city) (UNDP, 2002). In 2000, the World Bank estimated that thirty-six percent of the population still lived in damaged housing and seven percent in temporary housing. These households were twice as likely as the rest of the population to be extremely poor (World Bank, 2000b). The massive influx of people into cities put enormous strain on health facilities. The interface between primary and secondary care was problematic, and no clear referral pattern existed. Patients referred themselves to specialist care, which heightened the burden on secondary and tertiary care (UNDP, 2002).

Unemployment was a serious problem in the post-war environment. In a World Bank survey undertaken in 2000, only fifty-five percent of individuals of working age (21 to 65) were actively employed. Moreover, earnings were very low (World Bank, 2000b). Many Albanians had left Kosovo to live and work abroad in the 1990s. Remittances from these relatives were a critical source of income for many families in the post-war period. Almost fifty percent of Albanian rural households received remittances, while Serb households received minimal assistance from relatives abroad (World Bank, 2000b).

Poverty was widespread. Fifty percent of the population exhibited consumption levels just below the poverty line, and a significant percentage of households subsisted just above the poverty line (World Bank, 2000b). Eight percent of households had received social assistance, with sixty-three percent of Albanian households and fifty-eight percent of Serb households surveyed receiving food aid in 2000 (World Bank, 2000b). Twelve percent of Kosovars lived in extreme poverty in the immediate post-war period (World Bank, 2000b).

Those living in extreme poverty were predominantly Albanians, with large households and a high dependency ratio (many children and elderly). Extremely poor households tended to be those directly affected by conflict (displaced with housing destroyed) and those lacking resources (salary, pension, remittances, savings, or property). The conflict increased extreme poverty among the urban poor due to its disruption of urban economic activities.

In Table Eight, below, the characteristics of extremely poor and poor households, as found by the World Bank, are outlined.

Table Eight: Characteristics of Extreme Poor and Poor Households

	Extreme Poor	Poor
Overall	<ul style="list-style-type: none"> • Rural Albanian households with seven members, at least half of which are <15 or >60. • Household head around fifty years of age, with low level of education. • Formerly IDP. • Live in damaged dwellings. • Have <1 hectare of land and no machinery. • Use latrines. 	<ul style="list-style-type: none"> • Eight members (three adults) • Household head has secondary education. • Higher asset value than extreme poor.
Urban	Same as 'overall,' except that: <ul style="list-style-type: none"> • Head has higher education attainment. • Head is not participating in the labour market. • Better sewage (flushing toilet). 	<ul style="list-style-type: none"> • Smaller households with one or no children.
Serb	<ul style="list-style-type: none"> • Rural households concentrated in North and Southeast Regions. • Three-member households with elderly head and no children. • Head has low level of education and works in agriculture. • Did not move during the conflict. 	<ul style="list-style-type: none"> • Equally likely in urban and rural areas. • Larger and younger households. • Head has secondary education.

Source: (World Bank, 2000b)

B. The Political Context

While the international community had been reasonably successful in addressing the post-war humanitarian crisis, the challenge of building administrative structures was enormous.

With the exception of run-down buildings, UNMIK found little of the previous administrative structure intact when it arrived in Kosovo. In contrast to this bleak inheritance, their mandate to provide 'civil administration' was sweeping. To fulfil its mandate, UNMIK had to reconstruct all the institutions of self-government, appoint international and local staff to these institutions, manage

the running costs and equip the facilities while at the same time contending with complicated UN procurement and staffing procedures. (International Crisis Group, 2002b)

Several key factors undermined UNMIK's effort to establish civil administration and build autonomous institutions. The United Nations, as well as the European Union, was slow to deploy personnel. Those that arrived were of mixed quality, often without experience or expertise for the positions they held. The turnover rate for key staff was also high, causing discontinuity and confusion. Critical institutions, such as the judiciary and the police, were not operational as quickly as they were needed. And UNMIK continued to compete with parallel institutions of the KLA, the LDK, and the Serbian government (in Serb enclaves and in the north of the province).

In an effort to build autonomous institutions of self-government, UNMIK established the Joint Interim Administrative Structure in January 2000 (outlined in Figure Eight). This structure created co-governance between UNMIK and local representatives, with the objective of building these autonomous self-government institutions. Departments were established, including the Department of Health, which were designed to become the basis of future Kosovar government ministries (see Figure Eleven, below). However, these institutions lacked staff and struggled to undertake even basic administrative tasks such as establishing a payroll, procuring goods and services, and providing transparent accounting systems. Moreover, many international staff lacked experience working in ministries in their countries of origin. While providing valuable technical advice, they did not have the expertise to train local officials in how government departments should function. Local Kosovar officials were often political appointees, most of who encountered language barriers in dealing with internationals. Their ability to provide substantive input into policy depended on the receptiveness of their international counterpart.⁴⁹

Despite the scale of resources that flowed into Kosovo in the first years of the mission, UNMIK did not develop a serious, overarching development strategy. Little was done to assess how far Kosovo was from reaching basic standards, what activities and training were necessary to meet these standards, what funds were required and the time horizon required to develop autonomous functioning institutions.⁵⁰

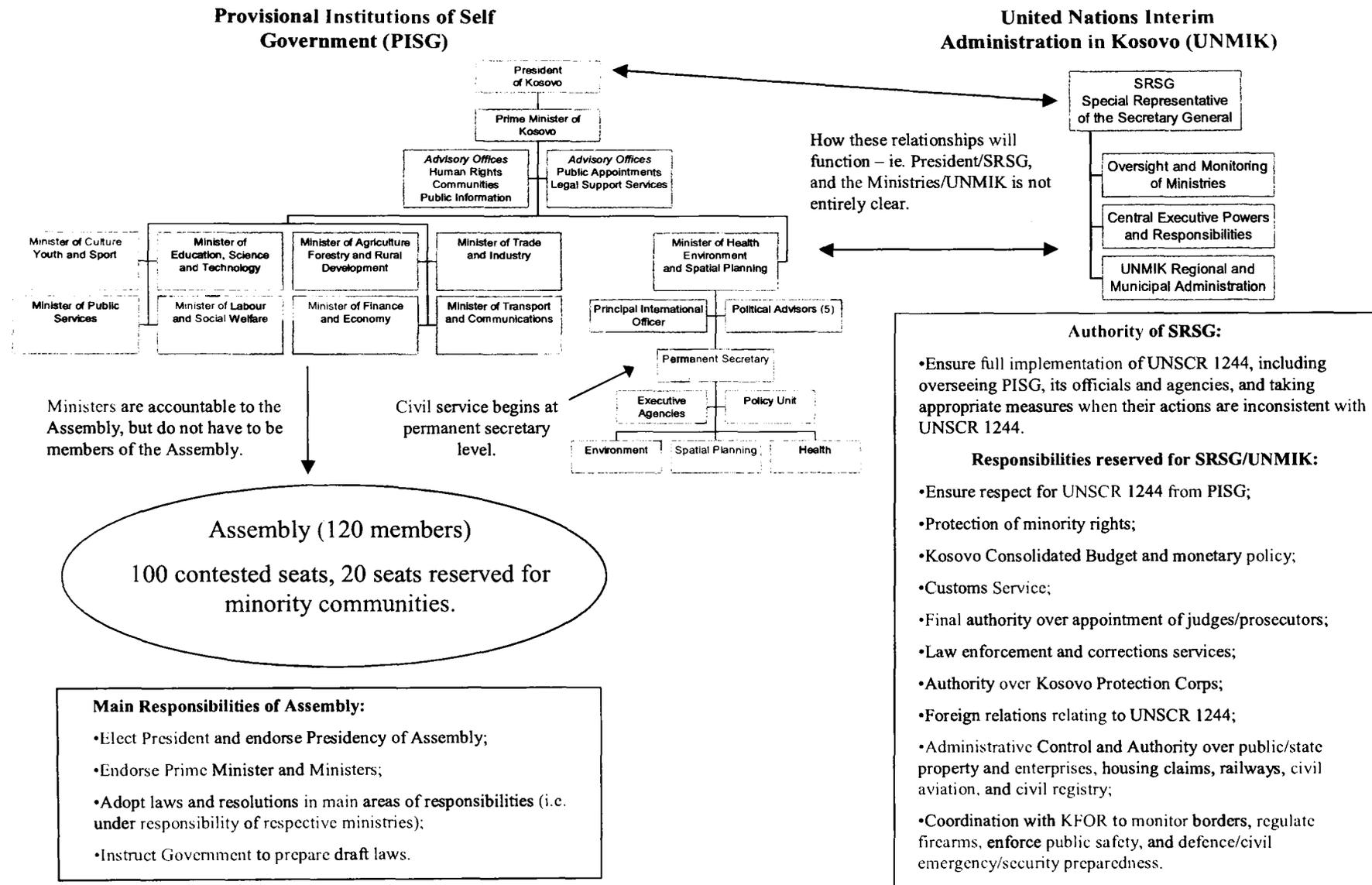
⁴⁹ This was not the case in the Department of Health. The international head of the department, Dr. Hannu Vuori, had a very good working relationship with his Albanian co-head, Dr. Pleurat Sejdiu.

⁵⁰ UNMIK's Department of Reconstruction, run by the European Union, attempted such a strategy in its document, "Reconstruction 2000." However, this was more a wish list of projects than a serious development strategy. Such a strategy was not produced until 2003/2004, when one was developed in

UNMIK held elections at the local level in October 2000 and at the central level in November 2001. These elections paved the way for democratic structures such as the legislative and executive bodies of government. Figure Eleven outlines the structure of the Provisional Institutions of Self-Government (PISG), including the Ministry of Health, and the relationship between the PISG and UNMIK, namely UNMIK's responsibility for oversight of the new ministries. Although the international community reserved the right to intervene in cases of corruption and where minority rights were not respected, local officials became responsible for the vast majority of administrative tasks. While they were democratically elected, both the executive and legislative branches of government at the central and local levels remained weak, a reflection of the lack of experience of politicians and the continuing deep split between the two major Albanian political parties.

conjunction with local institutions to meet international benchmarks. When these benchmarks were reached, discussions on Kosovo's final status would begin.

Figure Eleven: The Post-Election Period—Provisional Institutions of Self-Government⁵¹



⁵¹ ZWI, A., PERCIVAL, V. & CAMPBELL, J. (2001) Hospital Policy in Post-conflict settings, Site of Care and Struggle. *Eurohealth*, 7, 54-56.

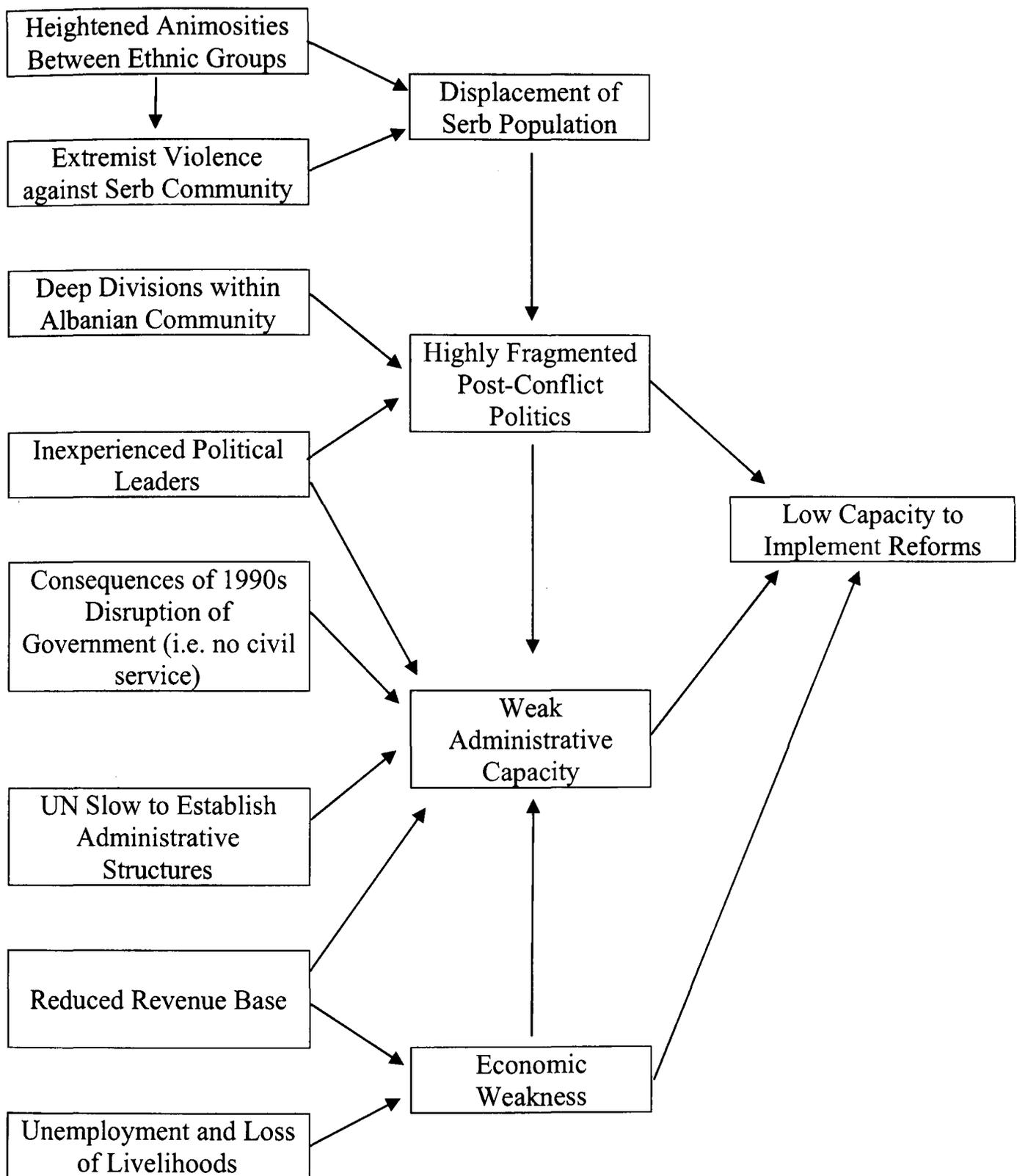
The civil service was also weak. It was not established until after elections were held, which was a missed opportunity to begin the process of building a strong, independent public service prior to the election of elected officials. Moreover, civil-service salaries were extremely low, and government departments lacked the ability to compete with international agencies for recruitment and retention of staff.

Figure Twelve describes how these political issues combined with economic factors to create a low capacity for implementing reforms. Politics in the post-conflict period were highly fragmented, a result of the lingering divisions within the Albanian community because of activities during the war. The Albanian political leadership was experienced only in the politics of defiance, not in the skills of governance. The KLA was struggling to transform itself from a guerrilla movement to a political party, and was vying for political control with the LDK. This competition for power occasionally turned violent, with the assassination of some LDK leaders. Serb leaders had to adjust to a complete reversal of fortunes: from the politically dominant group in Kosovo to almost complete disengagement from the governing structures of Kosovo. Serbs remained dependent upon UNMIK and KFOR for protection and for access to essential services, but few Serb leaders actively participated in politics in Kosovo, and instead relied on direction from their political masters in Belgrade.

The contentious nature of politics in the immediate post-conflict period undermined Kosovo's administrative capacity. This capacity was already weak due to the consequences of the disruption of government during the 1990s, the inexperience of Kosovo's politicians, the sluggish rate of the UN's establishment of government administration, and Kosovo's economic weakness.

Figure Ten outlined the need to improve the efficiency, equity, and effectiveness of health services and made a serious argument for health reform. Figure Twelve sounds a cautionary note about the environment within which this reform program was to be implemented.

Figure Twelve: The Impact of Social, Economic, and Political Context on Administrative Capacity



III. EXTERNAL PRESSURES FOR REFORM: THE INTERNATIONAL COMMUNITY

Donors flooded Kosovo with billions of dollars of assistance, and the massive influx of donor resources in the immediate post-conflict period provided essential humanitarian relief and greatly assisted the process of reconstruction. Between 1999 and 2002, donors spent approximately eighty million Euro on the health sector, which represented the second-largest portion of the Kosovo Consolidated Budget (UNMIK, 2000).

However, the assistance effort was also plagued by a number of problems. Donors had short time horizons and dispersed most of their programming funds in the first two years of the mission. While this ensured that immediate humanitarian needs were met, it undermined efforts to achieve longer-term development goals. These short time horizons made donors risk-averse, as they had to achieve certain objectives within a limited period of time and were reticent to take chances with projects. Donors often had specific national objectives for their money, including support to national non-governmental organisations and specific national projects ('planting their flag'). They often focused on quantitative outputs, such as the number of houses rebuilt, health clinics re-equipped, and schools refurbished. Projects that would contribute to the reform process were secondary considerations. While donors coordinated their activities, they did not engage in a sector-wide approach. Most donor funds went to hundreds of NGOs (not UNMIK or the new government). Donors did not report to the UNMIK Department of Health or its successor, the Ministry of Health. Coordination and collaboration was strictly voluntary. The vast majority of health organisations were professional and veterans of international work. These NGOs worked tremendously hard, particularly during the first year of UNMIK's mission, to deliver healthcare and ensure that the system would be functional. But the government was left woefully under-resourced.

By the summer of 2000, the health sector was no longer in its 'emergency phase' and the international community began to plan for ambitious reform of the health system. The WHO's 'Blue Book' provided the foundation for the reform effort, but it was a generalized health strategy designed to ensure that the humanitarian resources were spent in a manner that ensured that a more modern, sustainable health system was built. The Blue Book did not include much detail on the specific elements of that system, such as financing, human resources, and the role of the government.

In the summer of 2000, the WHO decided to build on the momentum created by the Blue Book to develop a broader, more ambitious health policy for Kosovo. WHO officials believed that a window of opportunity existed for reform of the healthcare system for four main reasons.

First, while humanitarian spending was declining, most donors had allocated large sums of money for rehabilitation assistance in the period of 2000-01. Therefore, resources to support the reform effort would be more readily available than if the reform effort was postponed. Second, consensus existed among key actors—both local and international—that the previous health system needed to be upgraded. The WHO argued that unless a policy reform document was developed donors and NGOs might invest in unsustainable projects. Third, whatever the final political status of Kosovo, its health system needed to be modernized according to European standards. And fourth, during the period of political transition, the international community had full authority. Interest groups were less organized and entrenched. Therefore, those opposing change would be less able to derail the reform process (Shuey et al., 2003). Moreover, because the international community was implementing health reform in a territory that it governed, problems that plagued other reform efforts in Central and Eastern Europe, such as the inability to enact legislation and regulation issues, would theoretically be avoided.

This belief in a window of opportunity for reform was echoed by the World Bank in its health-planning document:

There is a relatively brief window of opportunity during which donors and international experts can have a significant impact on restructuring systems and reformulating policy before these systems and institutions become entrenched and resistant to change. A strong emphasis should be put on aid coordination to ensure complementarity in donor initiatives and a priority focus in view of limited implementation and policy development capacity in Kosovo. Development support should be conditioned on policy and structural changes aimed at providing efficiency incentives and ensuring the long-term sustainability of effective institutions and programs. (World Bank, 2000a)

However, WHO officials in Kosovo were also keenly aware of the potential pitfalls of pursuing an ambitious reform agenda so early in the post-conflict period. They acknowledged that local actors are less organized in post-conflict periods, and therefore establishing local ownership of reforms becomes more difficult and national groups have less ability to resist reforms. Successful, sustainable reform requires social consensus. Such a consensus is difficult to build in post-conflict environments where civil society is divided and enmity exists among groups that were previously in

conflict. Because information systems have been disrupted, inadequate health data is available to guide policy. Local capacity to manage the reform process is also limited. Moreover, mechanisms to communicate policy or debate the future system are lacking. And the skills of international agencies in immediate post-conflict environments are better suited to relief work, whereas reform is a development activity (Shuey et al., 2003). Despite these concerns, the WHO assessed that the benefits of pursuing a more comprehensive health policy outweighed the costs, and in the summer of 2000, WHO officials began planning a more ambitious policy document.

There were three main inputs into the reform plans. First, the WHO assessed major population-health issues based on the available health data. Second, they considered the vision of European healthcare systems, as outlined in the WHO's *Health for All 21*. And third, they undertook consultations with Albanian physicians.⁵² A health-policy working group met regularly in Pristina, while WHO officials travelled throughout Kosovo to solicit the views of physicians practising in other cities and towns.

Despite this effort at consultation, the majority of central stakeholders interviewed believed that UNMIK, the WHO and international donors were behind the reforms, with only moderate local input into the reform process. While half of stakeholders responded that the opinions of Kosovars were incorporated into the health-reform policy, no stakeholder indicated that the opinions of Kosovars effectively altered health policy. Moreover, almost half indicated that the opinions did not significantly alter the health policy.⁵³ Many stakeholders believed that the strategy was pre-formulated and 'sold' during the working-group meetings. Some participants of this working group complained that "the policy framework was already ready, and we were brought into the final act."⁵⁴ However, others were more sanguine: "The content was defined by internationals and the decision makers were internationals. This is not something wrong—it was positive as we did not have a brighter vision."⁵⁵ However, the externally driven nature of the reforms may have undermined the legitimacy of the reform process. The majority of central-level stakeholders

⁵² Efforts were made to consult with Serbian physicians, but they refused to engage in the planning process.

⁵³ See Appendix Three, Questions 9 and 10.

⁵⁴ Dr. Ilir Begolli, Head of Social Medicine Department, National Institute of Public Health, Interviewed in Albanian by Fatime Qosaj, March 24, 2003.

⁵⁵ Dr. Fekrije Hasani, Development of Nursing Program (NGO), Pristina, Interviewed in Albanian by Fatime Qosaj, March 5, 2003.

interviewed expressed doubt that the Kosovars working in the health system were committed to reforms.⁵⁶

This working group developed a set of health-policy guidelines, which were submitted to the UNMIK Department of Health. The guidelines were officially adopted by UNMIK in February 2001 in a document known as the ‘Yellow Book’ (Shuey et al., 2003). The UNMIK Department of Health—which became the Ministry of Health after the province-wide elections—assumed responsibility for implementing the vision set out in the Yellow Book.

When asked if reform was introduced too quickly, central-level stakeholders were evenly divided in their opinions. However, when responding to the open-ended question to explain their views, only two out of the eight central-level stakeholders who provided an explanation of their response provided positive feedback. The others stressed that change was too rapid: the system was in chaos, insufficient data existed to take decisions about reform, and little preparation was undertaken for reform implementation.⁵⁷

Despite acknowledging external pressure for reform, most stakeholders expressed concern that the international community was only somewhat or not very committed to the reform process—particularly in the long term.⁵⁸

IV. THE REFORM MEASURES: THE YELLOW BOOK’S PLAN

The health-policy document outlined an ambitious vision for the health system in Kosovo:

The health care system will be organized on the principles of equity, acceptability, effectiveness, flexibility, sustainability, non-discrimination, appropriateness, and affordability. It is recognized that some of these goals are conflicting, particularly in respect to equity and affordability. Every attempt will be made to balance the competing principles of organisation. The system will offer universal access to all residents of Kosovo to a basic set of primary, secondary, and tertiary care health services, as well as public health protection. In line with WHO’s HEALTH21 policy, it will aim to achieve full health potential for all by promoting and protecting health, reducing the incidence of disease and injury, and alleviating suffering. Access to health care is seen as a basic human right with the means affordable by that society. An emphasis on access for vulnerable groups is to be maintained. (UNMIK, 2001)

The basic components of the health-policy document are outlined below.

⁵⁶ See Appendix Three, Question 13.

⁵⁷ See Appendix Three, Question 3.

⁵⁸ See Appendix Three, Question 14.

A. Primary Care

The Yellow Book maintained a commitment to a primary care-focused health system. Family medicine teams operating in primary care centres would provide initial diagnoses and curative care, with the objective of treating eighty to ninety percent of presenting problems. The location of health clinics would be determined on the basis of population: facilities would have catchment populations of approximately 10,000 individuals. Larger communities would have more extensive primary care facilities known as ‘family medicine centres,’ while smaller communities would have small clinics known as ‘punctas.’ No expansion of public clinics was deemed necessary. (UNMIK, 2001)

Family medicine centres would be responsible for diagnoses and curative care, including minor surgery and drug management; emergency care and stabilisation of emergency patients; maternal and child healthcare; and reproductive health services, including antenatal and post-natal care, as well as family planning and treatment of sexually transmitted diseases and violence. Individuals would choose their family doctor, who would be responsible for coordinating specialist and tertiary-care services. Patients who bypassed the referral system would face a financial penalty. Family medicine centres would also include basic dental services. Prevention activities such as health education and immunisation would be run out of these centres, as would services such as home visits, palliative care, community rehabilitation, and community mental-health services.

Private practise and private institutions would be allowed, but such institutions must be approved and regulated, and private practitioners regulated and licensed. The policy document also accepted the reality of physicians working in both public and private practise. Many Albanian doctors who had been forced out of the public system in the 1990s had invested in private clinics, and were reluctant to forego their investment and this source of income. The policy document specified that, while doctors in the public system could have private practises, clear-cut regulations would be established to limit abuse, and these doctors would be required first to meet their public obligations. If not, public privileges would be revoked (UNMIK, 2001).

As previously noted, early health data identified maternal and child health as critical issues that needed to be addressed. The infant mortality rate was estimated to be among the highest in Europe. Maternal mortality was also unnecessarily high – estimated at 509 per 100,000 live births (Simpson and Maxhuni, 2003), a result of

maternal malnutrition, poor antenatal care, and short intervals between pregnancies. Therefore, the Yellow Book emphasised the importance of addressing maternal and child health. Maternal delivery services would be provided at six hospitals and twelve additional maternities located in family medicine centres throughout Kosovo. Approximately 1,500 to 2,000 deliveries per year would be needed before a facility could justify the opening of a maternity service.

B. Secondary and Tertiary Care

The Yellow Book outlined a system whereby patients would receive specialist care and hospitalisation upon referral only, except in emergencies. Specialists who were not working in family medicine would be hospital-based. Outpatient specialty care would be provided at hospitals and selected family medicine centres on referral. Six hospitals would provide secondary care, and tertiary care would be provided at only one or two sites in Kosovo upon referral only (UNMIK, 2001).

Hospitals in Kosovo were not cost-effective, operating at seventy-five percent capacity with unnecessarily lengthy patient stays. Their physical structure was cumbersome, with multiple buildings and much duplication of services. The Yellow Book specified that hospital master plans would be written, outlining how to increase the efficiency of hospital services. The number of beds would be reduced in most hospitals. In addition, future budget allocations to hospitals would be based upon performance contracts and service agreements (UNMIK, 2001).

C. Mental Health

The foundation of Kosovo's mental-health program would be community-based mental-health care, organized out of family medicine centers. In acute cases, inpatient psychiatric care would be provided in hospitals (UNMIK, 2001).

D. Public and Environmental Health

Kosovo's Institute of Public Health (IPH) consisted of one central institute with five regional offices. These institutes were not well connected with the rest of the health system, their equipment was obsolete, and health-information systems were not functioning. Under Kosovo's health policy, the IPH would be modernized and would concentrate on three areas: communicable disease control, health promotion, and water and food safety. It would also function as the technical arm of the Department of Health, providing it with timely and accurate information on public-health issues. The IPH would also guide and supervise public-health activities at the district and municipal levels (UNMIK, 2001).

E. Financing

No specific financing provisions were outlined in the Yellow Book. It contained a pledge that the Department would study various funding sources. Options included tax revenues, social insurance, voluntary contributions, private insurance, community insurance, co-payments, and a fee-for-service system, with the likely system being some form of pre-payment (through compulsory or voluntary health insurance). Co-payments would remain in place, as they were important sources of income and could support health-policy goals (such as the referral system) (UNMIK, 2001).

F. Organisation and Governance

The Yellow Book outlined the role of the Department of Health, which would later be transformed into the Ministry of Health. Under the Kosovo health guidelines, it would be responsible for policy, strategic planning, regulation and standard setting, monitoring to ensure adherence to regulations, human-resource planning, licensing, quality assurance, and budgeting. Several institutes, including the Institute of Public Health and the Pristina University Hospital, would report directly to the department. In line with the European Union's principle of subsidiarity, oversight of primary care would rest with the municipality, but the Department of Health would ensure that municipalities adhered to central guidelines and standards (UNMIK, 2001).

G. Other Key Health Issues

The health-policy document highlighted the need to upgrade the skills of Kosovo's health professionals to support the modernisation of the health system. This included family-medicine training for doctors, as well as the upgrading of the skills of nurses and paramedical professionals. The policy document confirmed that access to essential pharmaceuticals, rationally prescribed, used, and financed, would be provided by the public system. And a commitment was made to modernize areas such as emergency services, prevention, and rehabilitation of disability. Services for those with learning disabilities and occupational health were also addressed by the Kosovo health policy (UNMIK, 2001).

Below, the capacity of the new Kosovo government to implement reforms is outlined.

V. GOVERNMENT CAPACITY TO IMPLEMENT REFORMS

UNMIK relied on Kosovo's health policy—both the Blue and Yellow books—to guide donor investment and NGO activity. These documents established the vision

of what the health sector should be, but contained little detail on how to realize that vision. The WHO deliberately left the implementation strategy to the Department of Health (later the Ministry of Health). While the U.K. Department for International Development seconded a health consultant to the Department of Health to develop an implementation plan for the Yellow Book, this plan never materialized. The consultant ended up working on hospital management issues, neglecting the task of policy planning. As a result of the lack of focus on policy development, the largest healthcare donor decided to spend significant resources on equipment rather than programs to support reform due to the lack of an implementation plan at the Department of Health (Stevens, 2000).

Most international staff in the Department of Health worked tremendously long hours, and made significant inroads into building a ministry. Regulations were written (although the Department had little capacity to enforce them), a payroll was established, procurement of medicines and supplies was undertaken, and rudimentary oversight of local institutions was provided. Although the Department was successful in putting in place a basic administrative structure and a rudimentary regulatory framework, it did not have the capacity to plan for or undertake reforms. No one within the UN Department had experience working in a Ministry of Health, donors did not provide the Department with the necessary support, and the Department was woefully short-staffed. The staff who were in place were preoccupied with the basic tasks of administering the healthcare system, coordinating donor/NGO activity, and beginning the gradual process of transferring responsibility for healthcare functions to local control. This process began first with the transfer of primary care from the Department of Health to municipalities, a transfer that took place after the municipal elections in October 2000. This process continued as authority for the health sector was shifted from international officials to a Minister of Health, following the central-level elections of November 2001.

The Ministry of Health did not communicate its vision for healthcare. The majority of stakeholders indicated that discussion of the reforms with Kosovo health professionals was moderate or infrequent. The majority of stakeholders expressed concern with the lack of discussion surrounding reforms—particularly after the initial consultations that the WHO had undertaken after the Yellow Book was formulated.⁵⁹ All but one stakeholder indicated that discussion with health professionals in female-

⁵⁹ See Appendix Three, Question 5.

dominated sectors (nurses and midwives) had been moderate or infrequent.⁶⁰ While the majority of stakeholders also stated that the reforms were not sufficiently communicated to the public, some noted that extensive public communication was not possible at that time, given the weak media.⁶¹

The new Ministry of Health had little time or human resources to develop an implementation plan for the health policy. The majority of stakeholders interviewed believed that the Ministry did not act sufficiently to implement reforms. This view was particularly marked among central-level stakeholders.⁶² As one stakeholder stated, “The Ministry did not have the capacity or will to implement the policy. They designed regulations as they needed, but they did not have any systematic plan in place to promote health policy. The right people were not in the right places.”⁶³

Stakeholders believed that national standards for professional qualifications were enforced, and that the national facility standards that were established (not necessarily implemented) did reflect the objectives of the reform program. However, the majority of stakeholders did not believe that the services available at primary healthcare facilities met the objectives of the reform program, and the vast majority of stakeholders agreed that the Ministry of Health was not able to enforce its standards in private healthcare clinics.⁶⁴

In Chapter Two, health reform was described as “sustained, purposive change to improve the efficiency, equity, and effectiveness of the health sector with the goal of improving health status, obtaining greater equity, and obtaining greater cost-effectiveness for services provided” (Basch, 1999). The impetus for health reform comes from both problems within the health sector, as well as economic and political forces outside the health sector that influence the type and pace of reforms undertaken.

Figure Thirteen outlines the implementation process, highlighting the important role of the international community in health reform, and the problematic lack of state capacity to administer and undertake reforms. The WHO was the driving force behind the reform process. While an analysis of problems within the health sector and consultations with Albanian physicians contributed to the types of reforms suggested, the reform program was influenced by the WHO’s premise that primary care based

⁶⁰ See Appendix Three, Question 6.

⁶¹ See Appendix Three, Question 7.

⁶² See Appendix Three, Question 12.

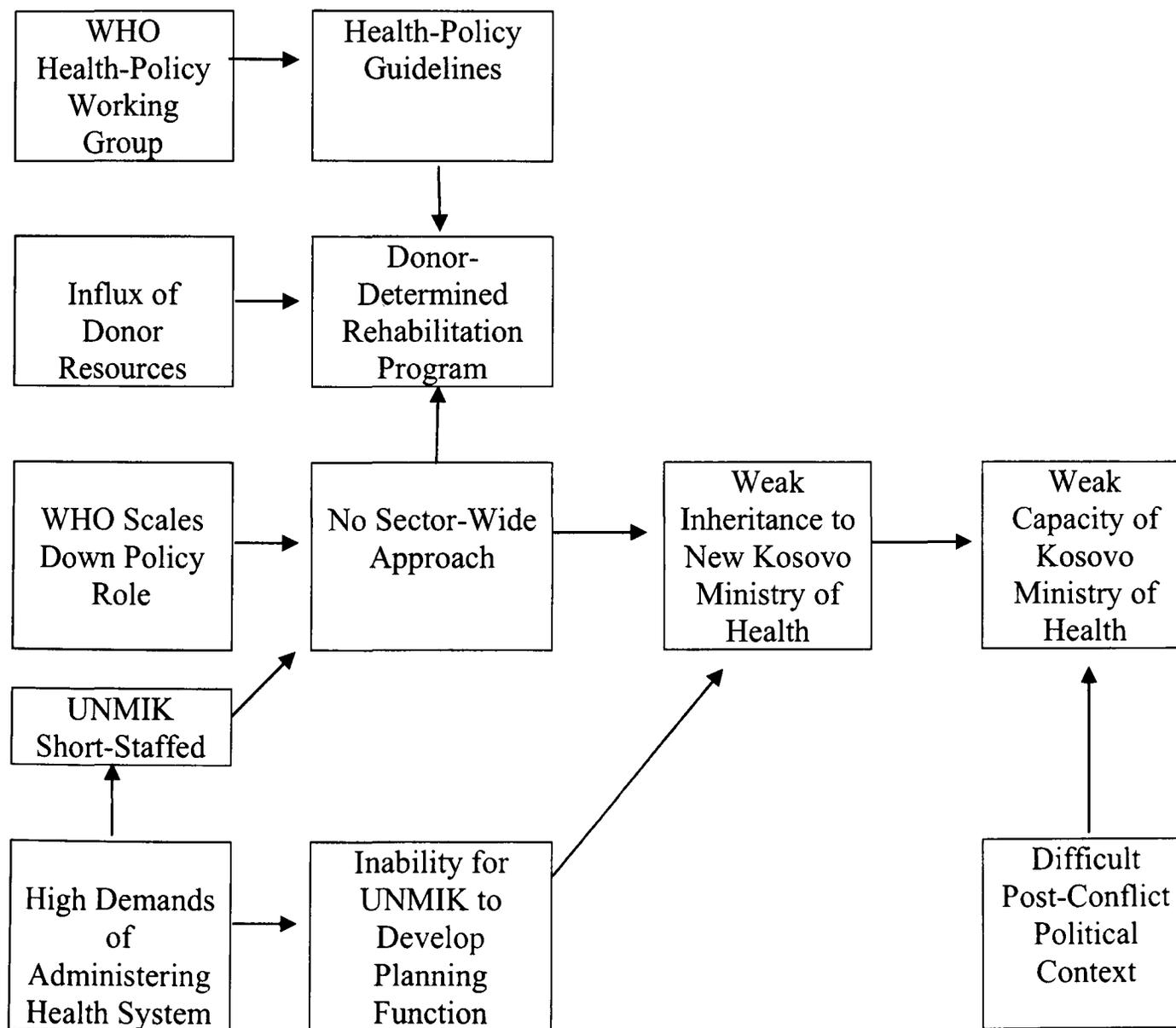
⁶³ Dr. Driton Ukmata, Head of Mission, Handicap International (NGO), Interviewed in Albanian by Fatime Qosaj, March 17, 2003.

⁶⁴ See Appendix Three, Questions 17, 21, 22, and 23.

health systems are the most efficient and effective. The timing and pace of the reform process was driven by the belief (held by the WHO and donors) that a window of opportunity existed for such dramatic reforms in the post-conflict period.

The WHO facilitated the consultations and produced the draft of the health-policy document, and the UNMIK Department of Health was responsible for implementing the suggested policy. But the Department of Health was unable to develop its planning function due to staff shortages, the tremendous demands of administering the system, and lack of experience. UNMIK neither took the critical step of developing an implementation plan, nor developed any sector-wide planning document effectively to guide the investments of donors. The new Kosovo Ministry of Health had even less capacity than UNMIK, inheriting a weak structure from UNMIK and operating within the charged post-conflict political context.

Figure Thirteen: Government Capacity and the Implementation Process



The context for implementing health reform was therefore daunting. Chapter Seven examines progress made in achieving the goals and objectives of health reform.

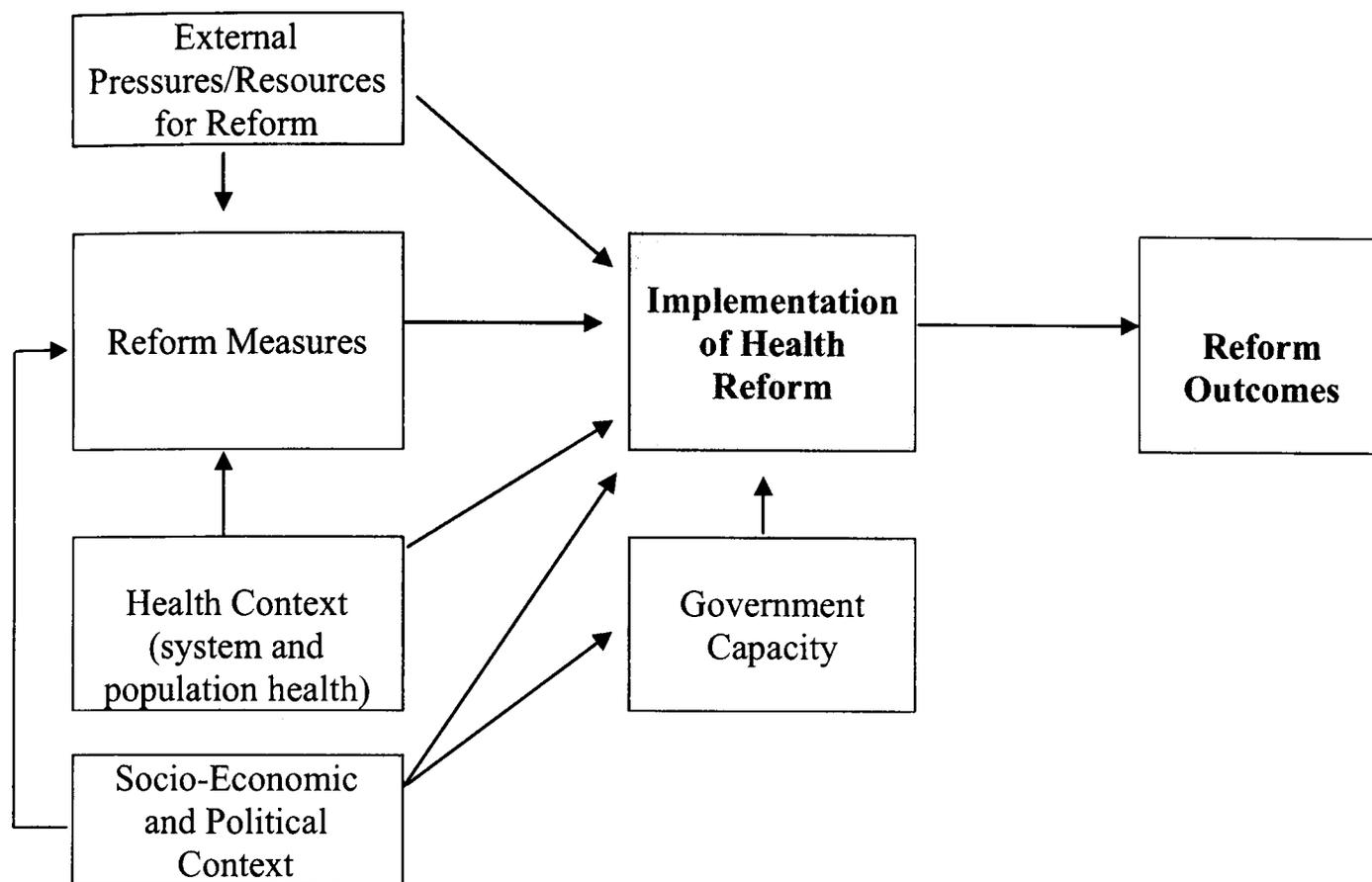
CHAPTER SEVEN: THE PROGRESS OF HEALTH REFORM

Much has changed in Kosovo since the United Nations established administrative control of the province. In 1999, the health system was in crisis. Facilities were in a state of disrepair. Access to healthcare was variable, and the quality of care was problematic. UNMIK suffered from weak administrative capacity, the economy was weak, and the political environment was highly charged.

In 2005, the situation was dramatically different. While economic weakness continued to plague the province, Kosovo's institutions had democratically elected officials at both the local and national levels. The Ministry of Health was under the purview of Kosovo's Provisional Institutions of Self-Government (PISG), and was staffed with civil servants who provided advice to an elected minister. The international community had established standards by which they judged whether Kosovo was ready to begin discussions regarding its final status. One of those standards included the health sector: "The PISG and municipalities ensure the availability of basic public services, such as health care, utilities, and education, without discrimination, to all communities in Kosovo" (UNMIK, 2003).

This chapter continues to apply the Conceptual Framework to the Kosovo case study, focusing on the implementation of the reform program and the progress of reforms as outlined in Figure Fourteen.

Figure Fourteen: Application of the Conceptual Framework to Kosovo Case (Continued)



In 2005, it was too early to fully evaluate the implementation of Kosovo’s health reforms or make final judgements as to their success or failure. Health systems are extremely complex and often resistant to change, the behaviour of the system is not easy to control, and the outcomes are not always predictable (Roberts et al., 2004). However, basic trends in the implementation of health-reform measures could be assessed, the factors impacting on reform analysed, and judgements made on the degree to which the health-reform program had made progress towards achieving its objectives.

I. THE IMPLEMENTATION OF HEALTH REFORM

There was no official, sector-wide strategy beyond the ambitious goals of the Yellow Book and Blue Book to aid in the coordination process. As the WHO scaled down its coordination role, UNMIK lacked the capacity, as well as the control mechanisms, to coordinate NGOs in the effort to build autonomous, sustainable institutions.

However, according to the Ministry of Health, successful implementation of Kosovo’s reform program was underway:

These health care reform attempts have helped Kosovo to streamline the health care system from the small punctas through the main health centers to the Pristina University Hospital. The main groups of health workers have modern job descriptions. The training of family doctors and health care managers is in full swing. New health records are in use and key components of a new management information system are ready. Earlier vertical structures are now an integral part of the health care system. Most health facilities have been refurbished and re-equipped. The public and the professionals are slowly beginning to accept family medicine approach in primary healthcare system. (Kosovo Ministry of Health, 2005)

Below, we assess progress made on various elements of the reform process.

A. Primary Care

The basis of Kosovo's health-reform plan was the reorientation of the health system away from the specialized Semashko model towards a system built on a primary care foundation. Patients would access the health system through physicians trained in family medicine, and would register with a family doctor. Primary care health centres would coordinate the healthcare needs of these patients by providing diagnoses and curative care, undertaking prevention activities, and coordinating community services such as home visits, palliative care, community rehabilitation, and community mental-health services. Responsibility for primary care would rest at the municipal level. Physicians would be able to work in both the private and public sectors.

This was an ambitious policy, which required the introduction of the family-medicine concept; the establishment of a strong interface between primary and secondary or tertiary levels of care; the management of the decentralisation process to ensure that this led to increased responsiveness to local needs rather than a deterioration in the quality of health services provided; and careful oversight by authorities to ensure that physicians did not abuse their ability to work in both the public and private sectors.

The concept of family medicine became part of the health-system lexicon. The Kosovo Health Law enshrined family medicine as the "essential form for provision of overall health care services at the primary care level for individuals and their families" (UNMIK, 2004). Training programs for both physicians and nurses were initiated. The WHO initially developed the family-medicine program in 2000 with a fast-track training course, which included training in family medicine, child health, reproductive health, mental health, common illness in primary care, and common emergencies in

primary care. One hundred doctors attended the first course. Fifty of these doctors became trainers (HLSP, 2004, Hedley and Maxhuni, 2005).

This curriculum was expanded to a two-year specialisation program in family medicine. Training included management of Kosovo's health priorities: maternal and child health; prevention of heart and lung disease; tuberculosis; mental health; quality of care; and patient prescriptions (HLSP, 2004, Hedley and Maxhuni, 2005). To build support for family medicine within the medical establishment, family medicine has been introduced into the curriculum of undergraduate medicine. Students are supposed to have six hours of lectures introducing them to family medicine in their sixth year (as seen below, this has yet to be implemented) (Hedley and Maxhuni, 2005).

Nurses were also trained in family medicine. Eight hundred nurses were trained, which represented about half the primary care nurses. In addition, a nursing college was established whose curricula includes the concept of family medicine (Kosovo Ministry of Health, 2004).

The Ministry of Health established the main Centre for the Development of Family Medicine in Pristina in September 2002, along with eight regional Centres for Family Medicine Training (Kosovo Ministry of Health, 2004). These centres functioned as continuing-education centres and were developing clinical guidelines and a clinical audit for family-medicine physicians (Hedley and Maxhuni, 2005). Clinical guidelines had been established for STDs, heart failure, hypertension, depression, asthma, pneumonia, respiratory-tract infections, anaemia, urinary-tract infections, and renal colic (HLSP, 2004).

The Centre for the Development of Family Medicine opened at Pristina University, and was responsible for advancing family medicine as an academic discipline, while institutionalising family medicine in primary care centres across Kosovo. An Association of Family Physicians was also formed, which oversees continuing professional development. Doctors will be revalidated every five years, and to renew their licenses they must undertake continuing professional development (Hedley and Maxhuni, 2005).

Despite these advances, a family-medicine system is not in place. The majority of stakeholders indicated that family medicine had either been "tolerated" or "resented"; only five out of twenty-three who responded to this question indicated that

it had been received “enthusiastically.”⁶⁵ While some patients have registered with their local health centres, this practise is not widespread. Patient lists have not been universally created. The gate-keeping role of primary care is still underdeveloped. As one doctor complained, “There is no continuity of patient follow-up, patients come and get the referral from the family medicine doctor and just go to the specialist.”⁶⁶ It is estimated that up to eighty percent of the attendances at Pristina University Hospital could be successfully addressed at the primary care level. Family medicine still faces resistance from specialists, who believe that they are in competition with family doctors. One stakeholder stated, “Non-family medicine specialists oppose the health strategy as it is based on family medicine. This is due to a conflict of interest—less patients for specialists.”⁶⁷ These specialists often redirect those arriving at hospitals to their private clinics. The dean at the Medical School (appointed in May 2004) is also reluctant to support family medicine, refusing to implement changes incorporating family medicine in the undergraduate curriculum (Hedley and Maxhuni, 2005).

Because of the difficulties experienced in implementing family medicine, those working on its development fear that support is waning.

If a change process is seen as too quick it can result in rejection as the individuals may feel threatened by the speed of change. Similarly if too slow, people may lose interest. This is the danger with the institutionalisation of family medicine. About 400 doctors have now or are being trained in family medicine, however family medicine as a concept has not been institutionalised so their learning is not being fully used to best effect. There is a danger that they will become disillusioned with their training if family medicine is not introduced soon. In hindsight, it would have been better if some of the principles of institutionalisation had been implemented even before this project had begun. For example, a personal doctor, zoning and the gate keeper role could have been introduced ... alongside the development of family medicine systems. (HLSP, 2004)

While these analysts do not dispute that the introduction of family medicine is an important component of the effort to build a more efficient and effective health service, they believe that the program should have been implemented more slowly and carefully (HLSP, 2004). Members of family-medicine teams complain that although they received training, once back in health clinics, they returned to their old methods

⁶⁵ See Appendix Three, Question 24.

⁶⁶ Mrvete Sopi, Main Nurse, Main Family Medicine Centre, Pristina, Interviewed in Albanian by Fatime Qosaj, March 3, 2003.

⁶⁷ Fekrije Hasani, Development of Nursing Program (NGO), Pristina, Interviewed in Albanian by Fatime Qosaj, March 5, 2003.

of work.⁶⁸ The majority of regional stakeholders stated that family-medicine teams did not function in their areas of responsibility.⁶⁹ A consultant assessing the system noted that critical reforms had not been implemented, and existed only on paper.

There are no standardised protocols, little evidence of team-working and a lack of continuity of care. Medical records are not used systematically. There are few health promotion and disease prevention activities and little or no continuing education. (Centre for Administrative Innovation in the Euro-Mediterranean Region, 2004)

Financing for the training programs has been provided by donors, but these funds are drying up. If donor support for family medicine is not maintained, its sustainability will truly be tested (Hedley and Maxhuni, 2005).

The effort to ensure that physicians did not abuse their ability to practise in both the public and private sectors also proved difficult. The average salary of doctors was extremely low, with primary care doctors earning only two hundred Euros per month. This created an incentive to go into private practise, where doctors could earn many times that amount (Hedley and Maxhuni, 2005).

The Ministry of Health lacked the regulatory capacity to administer these private clinics. Stakeholders indicated that the quality of healthcare in the private sector was of serious concern because regulations were not respected.⁷⁰

The initial analysis ... suggested that the regulation process for the private sector could take up to two years to complete and implement. It is considered that the current uncontrolled and unregulated development poses a serious threat to the stability of the public health care system. This is not to deny a proper role for private sector services. However, the present uncontrolled approach poses a threat to the operation of the public services and also presents serious issues of ethical practise, public safety, and consumer protection. (IHSD, 2003b)

The private sector had been created during the 1990s, when Albanian physicians were largely expelled from the official state system. As outlined in Chapter Six, the number of private clinics was extensive, they were often well equipped, and would not disappear. Given the poor state of Kosovo's health facilities and the shortages of physicians, the Ministry could better harness the capacity of the private sector and formalize its role through incentives and regulation. The contracting process could be

⁶⁸ Myrvete Sopi, Main Nurse, Main Family Medicine Centre, Pristina, Interviewed in Albanian, March 3, 2003.

⁶⁹ See Appendix Three, Question 25a.

⁷⁰ Dr. Abdullah Hoti, Family Medicine Specialist, Director, Pristina Family Medicine Centre, Interviewed in Albanian by Fatime Qosaj, March 5, 2003; Dr. Rrahman Hajdari, Clinical Director, Gjilan Hospital, Interviewed in Albanian by Fatime Qosaj, March 20, 2003; Dr. Refki Selaj, Internal Medicine Specialist, Prizren Hospital, Interviewed in Albanian by Fatime Qosaj, February 24, 2003.

a key mechanism for providing incentives for private-care providers to become a formal part of the healthcare system (IHSD, 2003b).

B. Secondary and Tertiary Care

The reform program proposed that the secondary level of the health system would receive patients upon referral only. Hospitals in Kosovo would improve their efficiency and effectiveness by reducing the number of beds, and future budget allocations to hospitals would be based on performance contracts and service agreements. By all accounts, however, efficiency and effectiveness in the hospital sector has not improved (IHSD, 2002a).

Hospital provision is compromised by poor facilities, lack of equipment, and a lack of adequately trained staff. In general, hospitals are overwhelmed with large numbers of inappropriate outpatients due to the lack of a referral system from PHC and self referral by patients themselves. Hospital capacity in Kosovo, measured by total bed numbers, is low by regional or European averages. However, the average length of stay is 12 days, and there is a low average bed occupation rate of 69.5 percent, suggesting inefficient use of existing resources. (Centre for Administrative Innovation in the Euro-Mediterranean Region, 2004)

Reform to the secondary and tertiary levels of the health system received significantly less attention and financial support than primary healthcare reforms. One specialist complained, “there is not enough information about the future of the secondary and tertiary levels of care. No strategic plan has been created to determine how reform should progress.”⁷¹ Efforts were made to improve the training of specialists with new curricula for post-graduate specialities of internal medicine, surgery, paediatrics, obstetrics and gynaecology, and radiology (HLSP, 2004). Hospital master plans were developed, but the funding to implement these plans was consistently lacking.

The Ministry failed to fully support the secondary and tertiary levels of healthcare in spite of the population’s continued reliance on hospitals. The health-sector budget in Kosovo was evenly split between primary and secondary care services, even though secondary and tertiary care were much more expensive (Zwi et al., 2001). Although budgetary allocation is an important lever of change, and this distribution supports the future of primary care, it leaves hospitals under-funded for their level of activity, with little resources to maintain hospital infrastructure.

⁷¹ Dr. Blerim Qosaj, Orthopaedic Surgeon, University Clinical Centre, Pristina, Personal Communication, March 24, 2003.

The referral system was not yet fully functioning. The Kosovar public still perceives primary care as a stopping point on the road to specialist care, not as a place to receive treatment.⁷² Therefore, some hospitals are still overburdened, but are comparatively under-financed and unable to secure resources to address historic under-investment or lead to rationalisation initiatives (Zwi et al., 2001).

Not enough attention was paid to the secondary sector, the critical interface between primary and secondary care is weak, and the effort to implement performance-related contracting has not been successfully implemented.

C. Financing

The Yellow Book did not outline a specific vision of a financing system for Kosovo, but contained a pledge that the financing alternatives would be studied. It speculated that the most likely form of financing would be some form of pre-payment system (voluntary or compulsory insurance) but other options would be examined including tax revenue, private insurance, and community insurance. Co-payments would remain in place, as an important source of income that could also support health-policy goals (such as the referral system). An essential-drug list was developed, and drugs on this list were to be provided free of charge. Informal payments made to staff were also prohibited.

In 2005, the health system continued to be funded out of the Kosovo Consolidated Budget. As more revenue was generated through taxation, the amount of money allocated to the health system gradually increased. The health system received 81 million DM in 2000, 94.6 million DM in 2001, 40.8 million Euro in 2002, and 44.4 million Euro in 2003 (Kosovo Ministry of Health, 2005). However, these amounts remained inadequate, and without significant donor resources, the low financial capacity of the Kosovo government threatens the sustainability of the reform process. According to the Ministry of Health, in 2005 Kosovo spent 6.4 percent of its GDP on health, with 2.4 percent from public resources (the Kosovo budget); 0.7 percent from donor resources, and 3.2 percent from private sources. Private expenditure through out-of-pocket expenses for private services and pharmaceuticals, co-payments, and under-the-table payments was higher than public expenditure. Total public-health expenditure was about U.S. \$28 per capita—in Croatia it is about U.S. \$400 per capita (Kosovo Ministry of Health, 2005).

⁷² Dr. Sami Rexhepi, District Health Officer, Pristina, Interviewed in Albanian by Fatime Qosaj, February 27, 2003.

These additional costs for individuals attempting to access the health system created barriers to healthcare. This inability to access care when needed undermined the equity of the system.

According to WHO, in principle all Kosovars have access to health care although in practise this is not the case. The most common barrier to health care access is the cost of the service. The most expensive items of expenditure for patients are drugs, including those required during hospital treatment, as well as more general expenses and informal payments made to staff in order to ensure access to health care. (Centre for Administrative Innovation in the Euro-Mediterranean Region, 2004)

While the majority of stakeholders interviewed stated that the reforms provided better access to healthcare for rural populations and women, they argued that the reforms had resulted in less access for poorer populations.⁷³

Significant challenges faced UNMIK in reforming healthcare financing.

Kosovo is a poor province, and providing effective healthcare in the face of resource constraints was an immense challenge. The World Bank funded a project designed to assess the most appropriate system and implement the basis for that system. Sadly, this project appeared to be flawed from the outset. The Bank greatly overestimated the capacity of the remnants of the Kosovo Health Insurance Fund (HIF), stating: “The top management is highly experienced, qualified, and motivated to resurrect Fund activities. We believe that the human capacity of the HIF could be easily and quickly mobilized if it were necessary” (World Bank, 2000a). This analysis could not have been further from the truth: former HIF officials were in Pristina, but the HIF was beyond repair or rejuvenation. Its building was almost destroyed; the HIF headquarters was too close to the headquarters of the police in Pristina, and suffered extensive collateral damage in the NATO bombing campaign. Its Serb staff had fled, while the Albanian staff had been out of the system for ten years. The HIF lacked the capacity to undertake basic administrative functions. In addition, the post-conflict environment was not appropriate for social insurance, as critical economic preconditions were not in place and government capacity to oversee the system was weak.

The World Bank project focused on several issues, including establishing a purchaser/provider split to heighten accountability in the system and build the foundation for a future health-insurance system. The Health Care Commissioning Agency (HCCA) was conceived as a forerunner to an insurance fund. The HCCA

⁷³ See Appendix Three, Question 31 a, b, and c.

would initially exist within the Ministry of Health, with plans to make it an independent entity in the future. The HCCA would establish the basis for the contracting of services, necessary to split the purchaser and provider functions. Performance contracts would be signed with municipalities for primary care, and with hospitals for secondary and tertiary care. The HCCA would essentially buy the services that these institutions provided, stipulating the type and quality of service.

Progress in establishing the HCCA was hampered by the absence of key inputs such as accurate data, information and management systems, and reward systems. The implementing agency contracted by World Bank to establish the insurance system expressed deep frustration:

Lack of data and information usable for management decision-making purposes; Absence of cohesive service contracts constructed on a partnership 'trust' basis between the Commissioning Agency and provider health care institutions; Inadequate local management powers and systems e.g. finance and human resources management within which Directors and their teams can operate; Serious continuing under-funding and poor reward system, and uncertainty about resource prospects for the future (IHSD, 2003b).

The lack of basic accounting practises also impeded progress. Budgeting systems were not detailed enough to hold institutions accountable. Until the summer of 2001, accounts with the Department of Health were done on Excel spreadsheets, which allowed for significant corruption (Percival, 2003). For example, the pharmaceutical budget was a single block allocation without separation allocations for hospitals, municipalities, and clinical services, and there was no coding structure for goods and services throughout the health sector.

The HCCA began two pilot projects on performance-related contracts, but the funding from the World Bank ended before this method of contracting could be extended to other regions. A health-insurance law has been prepared, but a general health-insurance system will not be introduced until at least 2006.⁷⁴

Problems with the co-payment system, small user fees designed to buttress the referral system and increase revenue, also indicated the weakness in the collection and accountability systems (IHSD, 2003b).

There is a lack of confidence in and commitment to the current system for returning co-payment and other income collected at the hospital level. A number of hospitals and municipalities reported having followed procedures in banking co-payment income but being unable to recover the funds when they

⁷⁴ Dr. Matthias Reinicke, Personal Communication, 26 January 2005.

sought to do so because they had been appropriated by other health care providers of for other health purposes. (IHSD, 2003c)

The HCCA was charged with the task of identifying the basket of health services that would be provided free of charge. This task was undermined by the lack of data on morbidity and mortality, weak health-system activity reporting systems, and the lack of basic financial data (IHSD, 2003c).

The development of any form of financing system, whether taxation-based or insurance-based can only prosper if basic operational systems are robust and well-developed. In particular, the health information systems which accounts for and measures financial resources used in achieving the activities (IHSD, 2003a).

The HCCA also suffered from staffing shortages, as they were unable to find appropriately trained personnel at the salary levels provided by the Ministry of Health. For many months after its inception, the HCCA existed with only one staff member (IHSD, 2003c). Frequent turnover of key personnel in hospitals and municipal structures impeded progress in building HCCA systems (IHSD, 2003c).

Thus, the emphasis of the World Bank project should have been on establishing the building blocks of a future health-financing system such as transparent accounting systems throughout healthcare institutions in Kosovo, the training of personnel to run these systems, and the gradual transferral to performance-based budgeting practises. Health-information and management systems were also critical foundations for a transparent and effective financing system, and they were sadly lacking.⁷⁵

D. Organisation and Governance

1. *The Central Level*

According to the health-policy framework, the Department of Health (which was transformed into the Ministry of Health) was responsible for policy, strategic planning, regulation and standard setting, monitoring to ensure adherence to regulations, human-resource planning, licensing, quality assurance, and budgeting. Municipalities became responsible for the management of primary care, but the Ministry of Health would work to ensure that they adhered to central guidelines and standards.

The Department of Health acted initially as the financier (purchaser) of healthcare services, the provider of these services, the regulator, and the institution that developed policy and programs. Although many governments undertake such tasks,

⁷⁵ The European Agency for Reconstruction funded a project to build a health-information system in Kosovo. However, this project ran into difficulty and serious issues of sustainability were raised.

most ministries have an institutional legacy on which to build. The Department of Health had no standardized procedures, was woefully understaffed, and those staff that were in place lacked experience working in a ministry of health. Occupying a single floor in a dilapidated building in the centre of Pristina, it struggled even to administer the chaotic healthcare system. Daily challenges included oversight of service provision, setting budgets and providing payroll to health institutions, management of co-payments, procurement of capital goods and drugs, and coordination of non-governmental actors in the health sector. They were also forced to address complicated issues such as coordination of donors, UN procurement rules, assessing human-resource challenges, building financing systems, and dealing with emerging health issues such as outbreaks of infectious disease.

By the summer of 2001, the Department of Health faced three main tasks. First, it had to continue to administer the health system. Second, it had to build the foundation for a future Ministry of Health that was to be established after the province-wide elections in the fall of 2001. This required building managerial and technical capacity within the Department of Health, establishing a regulatory framework for the future Ministry of Health, developing a health-financing strategy, establishing human-resource policies, exercising quality control, oversight of the pharmaceutical sector, and regulating the quickly growing private sector. And third, it had to implement the health-reform program described above.

After the central elections in November 2001, the Provisional Institutions of Self-Government (PISG) were established and the Ministry of Health was put in place. Under the Constitutional Framework, the PISG holds almost full authority in the health sector. The Ministry of Health has the mandate to monitor the health situation and implement appropriate measures to prevent and control healthcare problems, develop policies and implement legislation, coordinate activities in the health sector including the management of healthcare infrastructure, develop and implement norms and standards, and oversee adherence to such standards. It was staffed by civil servants and led by an official appointed by the Prime Minister. Internationals were transformed from positions of authority within the Ministry to advisory roles (see Figure Eleven).

The Constitutional Framework also guaranteed that representatives from minority communities would be awarded Ministries—one Ministry for someone from the Serbian community and one Ministry for someone from non-Serb minorities. The

Ministry of Health was awarded to a representative of a non-Serb minority party.⁷⁶ This sparked criticism from donors, who saw a critical Ministry in which they had invested millions awarded to a Minister on the basis of ethnicity, rather than on the basis of qualifications for the difficult task of overseeing and reforming the health sector.

There is no real harm in appointing a minister according to political (or even ethnic) criteria when the public service is well established. But Kosovo has a small, low paid public cadre, relatively inexperienced in public administration, and such a policy can be harmful. And, in a ministry run by an acting minister and an interim (international) permanent secretary, any attempt to build sustainable capacity is at risk. International donors invested nearly €80 million in the public health sector between 1999 and 2002. This investment is at risk and needs to be secured. The authorities (the Government and, where and when necessary, UNMIK) must ensure that users of public health facilities can expect to get out of these facilities in better condition than when they enter. (Reinicke, 2003)

In the first year of its existence (2002), the Ministry was wracked by political disputes. The first Minister was dismissed, as he did not fully respect the Ministry's hiring procedures and had made political appointments to the civil service. His cooperation with donors was minimal and sometimes hostile, and he obstructed some key developments such as the appointment of the Permanent Secretary—the highest civil servant within the Ministry of Health.⁷⁷ The dismissal of the Minister invoked a political crisis, which further disrupted the already slow progress in fully establishing the Ministry.

In the summer of 2003, the Ministry was poorly organized, with a lack of leadership and management capacity. It had few monitoring or enforcement mechanisms to ensure that laws were implemented and ministerial directives followed. Moreover, the Ministry lacked basic internal structures. There were few formal staff meetings and planning sessions. Key members of the Ministry remained 'out of the loop' on major policy decisions (International Crisis Group, 2003b).

Partly as a result of these disruptions, there was little activity in the Ministry of Health on implementing the Yellow Book program for reform. Apart from ongoing donor initiatives such as training of family-medicine physicians and the establishment of a health-insurance system, little attention was paid to the Yellow Book. The

⁷⁶ The Constitution Framework stipulated that one Ministry be held by a member of a non-Serb minority. *Constitutional Framework*, Chapter 9.3.5 (a).

⁷⁷ The position of Permanent Secretary is the highest rank in the civil service.

Ministry was preoccupied with keeping itself afloat amidst scandal and a lack of leadership.

In 2005, the capacity of the Ministry was growing. Staffing of key positions was complete, and key members of its national staff were internationally trained, with significant experience working in international organisations.

2. *The Local Level*

Responsibility for primary healthcare passed from the central level to the municipalities after municipal elections were held in October 2000. To ensure that this did not result in a deterioration of services, the Department of Health (later Ministry of Health) took three steps. First, the Department established six District Health Authorities to provide support, monitoring, and control for the municipalities. These offices were located in Pristina, Mitrovica, Peja, Prizren, Gjakova, and Gjilan and monitored, supervised, and supported secondary healthcare institutions, as well as primary healthcare institutions. The district authorities also ensured coordination between primary and secondary healthcare services (Kosovo Ministry of Health, 2004).

Second, the Department negotiated with the Central Fiscal Authority and the Department of Public Services an agreement that defined the rights and duties of the municipalities. Under this agreement, the municipalities have to provide health promotion and education, health prevention, immunisation, basic curative services, oral health, mental health, supply of essential drugs, safe drinking water and sanitation, and food safety and nutrition. And third, to help build the capacity of municipalities, the Department of Health developed model organisational charts for the Municipal Health Directorates and model job descriptions for primary care personnel (Kosovo Ministry of Health, 2005).

The results of decentralisation are mixed. In some municipalities with strong leadership and where politics are less contentious, decentralisation has not resulted in a deterioration of primary care services. Municipal control of primary care has led to closer observation over health services to ensure that they are more responsive to local needs. In other areas, where the capacity of municipal councils is weak, critics allege that that decentralisation has led to heightened corruption and reduced access to healthcare, particularly for minority communities (International Crisis Group, 2003a). The majority of stakeholders believed that the decentralisation of primary care services

had either made no change or had worsened the delivery of care.⁷⁸ One stakeholder stated, “Municipalities do not have the capacity to take on these responsibilities. The centre does not have the capacity to monitor municipalities and they are left to themselves.”⁷⁹ Some stakeholders believed that responsibilities should have been transferred gradually, when municipalities developed management capabilities.⁸⁰

E. Other Key Reform Objectives

1. Public Health

The health-policy document outlined a vision for public health. The Institute of Public Health (IPH) would be modernized, shutting down duplicative regional operations and upgrading its laboratory and health-systems capacity. Reform would concentrate on three areas: communicable disease control, health promotion, and water and food safety. The IPH would act as the technical arm of the Ministry of Health, providing it with timely and accurate information on public-health issues. In addition, the IPH would guide and supervise public-health activities at the district and municipal levels. The World Health Organization undertook a capacity-building project at the IPH to assist in transforming its role.

Progress has been made. Public health was made a municipal responsibility, and municipal public-health inspectors have been hired. Responsibility for immunisation was transferred from the IPH to primary care facilities (Kosovo Ministry of Health, 2005). While technical capacity at the IPH undoubtedly improved, its ability to provide analysis on key public-health issues to the Ministry has been impeded by the failure to establish a health-information system. The Ministry of Health has stated that:

A good quality information system is essential for the monitoring of the health strategy. Therefore, continuous development of a functional and unique Kosovo Health Information System will have one of the highest priority places in the Ministry of Health’s agenda. The monitoring strategy will include the evaluation of existing data, the collection of additional data if necessary, data analysis and interpretation with result-based policy formulation. The Ministry of Health will actively support the development and implementation of new information technologies into the health sector and in particular in the Kosovo health information system. The Ministry of Health recognizes the poor current situation in respect to the lack of reliable information, the poor information flow and the quality of information generation, it is essential to embrace new

⁷⁸ See Appendix Three, Question 35.

⁷⁹ Fakrije Hasani, Development of Nursing Program (NGO), Pristina, Interviewed in Albanian by Fatime Qosaj, March 5, 2003.

⁸⁰ Dr. Sami Rexhepi, District Health Officer, Pristina, Interviewed in Albanian by Fatime Qosaj, 27 February 2003.

and affordable information technologies in order to establish functional health information systems. (Kosovo Ministry of Health, 2005)

Efforts to put in place this health-information system have been plagued with problems.

In 2002, a health-management information system became operational, and is functioning in thirty facilities.⁸¹ Analysts at the IPH have been provided with software and have been trained in its use. However, it is not clear how the information will be taken from the Health Information System by the IPH and transformed into information suitable for policy and decision making at the Ministry of Health (HLSP, 2004). Moreover, a consultant assessing the health-information system found gaping holes in the system. Basic information about the system was missing, such as how the system functions, how the processes work, how to fix user problems, how to use specialized tools for support of information systems, how to install and deploy the application, how to import and export data into the central database, how to design reports, and how to perform quality control of the imported data. No comprehensive checklists were designed to maintain the processing system. And crucial documentation needed to maintain the system was not available (Dataguard, 2005). While the original consultant working on the system challenged these findings, he did acknowledge that the health information system was developed in too short a time span to ensure a sustainable system was established (Reinicke, 2005). Moreover, the majority of stakeholders believed that the decentralisation of primary care services had made no change or had worsened the delivery of care.⁸²

2. *Mental Health*

The foundation of Kosovo's mental-health program was community-based mental-health care, organized out of family-medicine centres. For acute cases, inpatient psychiatric care would be provided in hospitals. By 2005, community mental-health facilities had been established in many cities in Kosovo and mental-health staff had been trained (Simpson and Maxhuni, 2003, Kosovo Ministry of Health, 2005).

However, Mental Disability Rights International found that serious concerns remain with the treatment of mental illness in Kosovo. The program to build community-based mental-health care was very slow to be established. More

⁸¹ Dr. Matthias Reinicke, Personal Communication, 26 January 2005.

⁸² See Appendix Three, Question 36.

disturbing, the report documented serious physical and sexual abuse that was taking place at Kosovo's main psychiatric institute (Rosenthal and Szeli, 2002).

F. Impact on Health Status

Available indicators suggest that by 2005 Kosovo had experienced gains in health status. Maternal health had improved: In 1999, 23 women died per 100,000 live births; between 2000 and 2002, the Kosovo Obstetric and Gynaecological Association estimated the average rate at 21 deaths per 100,000 live births (Kosovo Ministry of Health, 2005). Perinatal mortality, which includes stillbirths and deaths of live-born infants during the first seven days of life, decreased steadily to 28.7 per 1,000 births in 2001, and 27.1 per 1,000 in 2002 (Kosovo Ministry of Health, 2005).

The fight against communicable diseases had also been relatively successful. In 2002, the WHO estimated that immunisation against measles was only 67 percent coverage. A vaccination campaign in 2003 raised that to 99-percent coverage for children aged 1 to 15 (Kosovo Ministry of Health, 2005). With the introduction of Directly Observed Treatment for Tuberculosis (DOTS), the annual incidence rate of tuberculosis dropped by 11 percent between 2001 and 2002. Kosovo's treatment success rate of 87 percent exceeded the WHO goal of 85 percent (Kosovo Ministry of Health, 2005).

Non-communicable diseases were more challenging. Cardiovascular diseases were the leading cause of death, accounting for about 48 percent of total mortality (Kosovo Ministry of Health, 2005). Cancer was the second leading cause of death, and the most common causes of cancer-related deaths were lung and stomach cancer in men and stomach and breast cancer in women (Kosovo Ministry of Health, 2005).

Despite these gains, in 2005 health status in Kosovo remained among the worst in Europe, and the lack of a fully functioning health-information system meant that continual monitoring of health status was extremely difficult.

II. REFORM OUTCOMES: MEETING THE OBJECTIVES OF HEALTH REFORM?

Table Nine outlines the objectives of health reform as presented in the Yellow Book, and summarizes progress made towards meeting these objectives.

Table Nine: Progress in Meeting Health-Reform Goals

	Reform Objectives	Reform Progress
Primary Care	<ul style="list-style-type: none"> • Location and services offered by family-medicine centres would be based on population. • Family doctors would have 	<ul style="list-style-type: none"> • The WHO established a facility master plan based on capitation, which guided rehabilitation and staffing. In minority areas, some facilities

	Reform Objectives	Reform Progress
	<p>patient lists, and be responsible for diagnoses and curative care, reproductive, maternal and child health, and emergency care and stabilisation. Family doctors would be responsible for coordinating specialist and tertiary-care services.</p> <ul style="list-style-type: none"> • Private practise would be allowed, and physicians would be allowed to practise in both the public and private sectors, but institutions must be approved and regulated and oversight established to prevent abuse. 	<p>were opened that were not included on the master plan.</p> <ul style="list-style-type: none"> • Family-medicine training established with a two-year specialisation program. Nurses are also trained in family medicine. • Serious impediments exist: patient registration is not universal, gate-keeping role of primary care underdeveloped, and resistance from specialists. • Ministry lacks the capacity to regulate the private sector, and there are accounts of physicians redirecting patients from the public sector to their private clinics.
Secondary and Tertiary Care	<ul style="list-style-type: none"> • Patients would receive specialist care and hospitalisation upon referral only, except in emergencies. • Hospital Master Plans will establish a vision for increasing the efficiency of hospitals. 	<ul style="list-style-type: none"> • Patients often bypass the primary care level to receive direct treatment by specialists. Analysts have estimated that up to eighty percent of patients at Pristina University Hospital could have been treated at the primary care level. This means that hospitals are overburdened. • While Master Plans were developed, the Ministry has lacked the resources and commitment from donors to implement these plans.
Mental Health	<ul style="list-style-type: none"> • Foundation of community-based mental-health care organized out of family-medicine centres. Inpatient psychiatric care for acute cases. 	<ul style="list-style-type: none"> • Community mental-health centres have been established throughout Kosovo. • Mental Disability Rights International has been critical of the slow pace of the establishment of community mental-health facilities and documented physical and sexual abuse in Kosovo's main psychiatric institute.
Public Health	<ul style="list-style-type: none"> • The Institute of Public Health would focus on communicable disease 	<ul style="list-style-type: none"> • Oversight of public health was transferred to municipalities, and public-health inspectors

	Reform Objectives	Reform Progress
	<p>control, health promotion, and water safety.</p> <ul style="list-style-type: none"> • The institute would operate as the technical arm of the Department of Health, providing it with information on public-health issues. 	<p>operate at the municipal level. Responsibility for immunisation was transferred to primary care.</p> <ul style="list-style-type: none"> • The ability of the Institute of Public Health to provide timely and accurate analysis to the Ministry of Health has been impeded by the lack of a functioning information system. While a health-information system exists, its sustainability is questionable.
Healthcare Financing	<ul style="list-style-type: none"> • No commitment was made to any financing system, but a pledge was made to study the merits of various alternatives. Some form of pre-payment system would be established through compulsory or voluntary insurance. Co-payments would be maintained. 	<ul style="list-style-type: none"> • Equity is marred by the significant private expenditures (including under-the-table payments) that the public has to make to access healthcare. • System continues to be funded out of the Kosovo Consolidated Budget, but a precursor to a social-insurance system, the Health Care Commissioning Agency (HCCA), has been established and is beginning the process of establishing performance-based contracts. • The establishment of the HCCA and performance-based contracting has been undermined by the absence of accurate data, information and management systems, and reward systems. Moreover, the failure to establish a transparent accounting system prior to the HCCA has slowed efforts to implement health-financing reforms. • The HCCA struggled to identify the basket of health services that would be provided free of charge.
Organisation and Governance	<ul style="list-style-type: none"> • The Ministry of Health would be responsible for policy, strategic planning, and regulation and standard 	<ul style="list-style-type: none"> • The UNMIK-led Department of Health was expected to administer the health system, prepare for the transition from

	Reform Objectives	Reform Progress
	<p>setting.</p> <ul style="list-style-type: none"> • Responsibility for primary care would be decentralized to municipal level. 	<p>international to local control, and manage the reform process. It faced serious capacity shortfalls.</p> <ul style="list-style-type: none"> • The Ministry has been undermined by political turmoil, including changes of Minister and controversy surrounding the appointment of the most senior civil servant. This turmoil undermined its capacity to implement reforms. • Oversight for primary care became the responsibility of the municipalities in 2001. Municipalities were slow to establish oversight structures, and capacity of municipalities varies. Ministry of Health set up District Health Authorities to monitor municipalities, creating animosity and confusion.

III. THE MINISTRY OF HEALTH STRATEGY: IMPLEMENTATION PLAN?

Table Nine clearly demonstrates that by 2005 many objectives of reform had not been met, and the health system continued to suffer from inequity and variable quality of care. Moreover, the Ministry of Health was unable to make much progress on implementing the reform program.

To focus the efforts of the Ministry of Health on reform, in early 2005 the Ministry released an ambitious strategy document. This strategy was an effort to establish an implementation plan for the health-reform process. Below we assess the strategy released by the Ministry of Health.

A. Objectives of the Ministry of Health

The Ministry of Health established seven goals, with several objectives for each goal, which are outlined in Table Ten. As seen in this table, the goals, objectives, and targets set for these objectives are highly ambitious.

Table Ten: Ministry of Health 2005 Strategy: Goals and Objectives

Goal	Objectives (by 2014)
1. Reduce the incidence and adverse impact from major communicable and non-communicable diseases.	<ul style="list-style-type: none"> a. Reduce the incidence of infectious diseases including TB (by 40%) and AIDS (halt spread) and reduce their impact; b. Reduce the incidence and impact of cardiovascular diseases (reduce mortality by 15%); c. Reduce the incidence and impact of cancer (reduce death rate by 10% and late diagnosis by 25%); d. Reduce the incidence and impact of diabetes (halve increase of type II diabetes); e. Improve oral health (stabilize incidence of cavities).
2. Enhance child and mother health.	<ul style="list-style-type: none"> a. Reduce under-five mortality and morbidity (by two thirds); b. Reduce maternal mortality and morbidity (by 50%); c. Improve immunisation (coverage rates of 95% for mandatory vaccines).
3. Strengthen health-promotion activities and advance healthy lifestyles.	<ul style="list-style-type: none"> a. Reduce smoking (by 10%); b. Improve nutrition (decrease prevalence of vitamin A deficiency and anaemia by 50%); c. Increase levels of physical activity; d. Prevent drug addiction and risky behaviours, with special emphasis on youth.
4. Reduce inequalities in health status.	<ul style="list-style-type: none"> a. Ensure accessible and appropriate health services for people from lower socio-economic groups; b. Ensure accessible and appropriate health services for minority populations.
5. Improve mental health.	<ul style="list-style-type: none"> a. Halt and begin to reduce the incidence and impact of mental illnesses; b. Stabilize the incidence rate of suicides and suicide attempts.
6. Support a healthy environment and injury-prevention program.	<ul style="list-style-type: none"> a. Enhance healthy physical environment; b. Enhance healthy social environment; c. Reduce the incidence rate of accidents.
7. Introduce institutional reforms and improvement of management practises in healthcare services.	<ul style="list-style-type: none"> a. Strengthen primary healthcare services through family-medicine approach; b. Improve public-health services through reorganisation of public-health institutions; c. Improve management of human resources; d. Improve financial management; e. Strengthen legal and regulatory framework; f. Improve management of drugs and medical supplies; g. Strengthen policy and planning capacity research and quality of healthcare services; h. Integrate health services in minority areas.

Source: (Kosovo Ministry of Health, 2005)

The Ministry of Health also issued a primary care strategy document in September 2004. In this strategy, the Ministry committed itself to ensuring that eighty to ninety percent of healthcare needs are addressed at the primary care level. The primary care strategy acknowledges that for the primary care system to function effectively, more work is needed to develop basic infrastructure for the system. Items essential to the functioning of a healthcare system are lacking, such as basic medical records, patient registration with a family physician, the referral system, and a quality-improvement system (to ensure minimum standards in healthcare are met, including clinical management, clinical guidelines, quality assurance, and licensing and re-licensing (Kosovo Ministry of Health, 2004). The strategy also acknowledges that more information is needed on the numbers and qualifications of healthcare workers, and continuing professional education is required, including continuing training in family medicine for both doctors and nurses.

The strategy emphasizes that the Ministry of Health is working to identify and update the basic package of health services, develop human resources, improve infrastructure and equipment, identify and develop needed regulation, and develop sustainable financing (Kosovo Ministry of Health, 2004). The Ministry intends to utilise financial incentives through contracting of services with municipalities to ensure that the system of family medicine is maintained and supported. The Ministry also acknowledges that further financial resources are required to support primary care (Kosovo Ministry of Health, 2004).

B. Strengths and Weakness of the Healthcare Strategies

The development and publication of these strategies was critically important. It was the first time since the release of the Yellow Book in 2001 that the Ministry had outlined any strategic vision. Moreover, these strategies were the product of the Kosovo government, not the international community, and were written primarily by experts from Kosovo. They reflected the continuation of the vision of a primary care-based system outlined in the Yellow Book and the development of analytical and strategic capacity within the Ministry of Health. With these strategies, the Ministry attempted to provide a focused plan to implement the health-policy vision outlined within the Yellow Book and ensure the sustainability of that vision.

Moreover, the two strategy documents accurately reflect the healthcare issues facing Kosovo. Controlling both communicable and non-communicable diseases, improving mother and child health, and addressing variable access to healthcare and

variable quality of care are all critical healthcare problems. The Ministry of Health's overarching strategy outlines specific targets that the Ministry should meet by 2014, as well as initiatives that the Ministry will undertake to meet those targets, which are important steps towards developing accountable and transparent institutions.

However, these documents suffer from some serious weaknesses. First, the strategy outlines too many priorities for the Ministry of Health while not providing information on how the Ministry will develop the capacity to address these problems. For example, the Ministry commits itself to developing action plans for all of the objectives identified in the health strategy, and twenty-seven such objectives exist. Developing and enacting twenty-seven action plans is a difficult task for any institution, let alone a Ministry of Health only four years old.

Second, the strategy identifies priorities without supporting evidence. For example, countering diabetes is identified as a key objective for the Ministry (see Table Ten: goal 1, objective d), but there is no specific data outlining the incidence rate of diabetes, the risk factors for the disease, and why it is a priority for the Ministry. In its effort to address inequalities in health status, the Ministry also strays into policy areas outside its mandate such as reducing income disparities between socio-economic groups, reducing unemployment, supporting community development, and promoting equal opportunities in education (Kosovo Ministry of Health, 2005). Socio-economic policy has an important impact on public health, however the Ministry should focus on areas within its purview and address factors over which it has some influence and control.

The ability of the Ministry to meet these targets is questionable, and few specific strategies are offered. It commits to reducing mortality rates from cardiovascular diseases by fifteen percent (see Table Ten, goal 1, objective b), but is that realistic in the absence of information and analysis of factors driving these diseases? The Ministry also pledges to reduce by two-thirds the under-five mortality rate (see Table Ten goal 2, objective a), yet provides little evidence of the causes of high mortality rates in this age group. It identifies some specific initiatives, such as implementing Integration Management of Childhood Illnesses (IMCI) and Promoting Effective Perinatal Care (PEPC); establishing early breastfeeding in delivery units; developing and applying clinical guidelines and protocols for child care; and regular monitoring of growth and development for children in Primary Health Care (Kosovo Ministry of Health, 2005). However, some of the initiatives are very vague, including

a promise to develop specific policies and strategies for child and adolescent health. It is unclear whether these interventions are appropriate without an accurate diagnosis of the causes of under-five mortality.

Critical gaps also plague these strategy documents. As part of its injury-prevention program, the Ministry would like to stabilize and reduce the rate of accidents, accident-related deaths, and disabilities (see Table Ten, goal 6, objective c.) (Kosovo Ministry of Health, 2005). The leading causes of accident morbidity and mortality are not identified—i.e. vehicle accidents, workplace accidents, or other causes. The initiatives to meet this target do not include simple, cost-effective solutions such as public health initiatives to promote seatbelts and speed limits. The Ministry also does not identify partners within the government and civil society with whom they will work to meet these goals.

This lack of attention to injury prevention is particularly critical for child health. In other countries in South Eastern Europe, injury is the most common cause of death among children. In the whole of Central and Eastern Europe, the childhood death rate from injuries is 2.5 times higher than in the EU, and the two most common causes of childhood death are traffic injuries and drowning. Studies in Bosnia and Macedonia demonstrate that children's knowledge of traffic rules and dangers from traffic are very low (Rechel and McKee, 2003). The health strategy misses this crucial area of cost-effective interventions, such as the promotion of child car seats, water safety, and injury-prevention initiatives in the home.

Initiatives regarding maternal health—another key health-status issue in Kosovo—are also poorly developed and not based on data or evidence. The strategy for primary care states that the Ministry of Health will, "...increase information regarding family planning methods, especially for women, considering family planning as one of the most effective methods of improvement of mother and child health" (Kosovo Ministry of Health, 2004). While the general strategy for the Ministry of Health pledges to develop and apply clinical guidelines to reduce maternal mortality by fifty percent, efforts to identify the barriers to accessing pre-natal and antenatal care are not outlined. The strategy does not address critical issues such as mother and child nutrition and raising awareness of the risks of smoking and alcohol consumption during pregnancy.

The critical question of how the Ministry of Health will finance these activities is also not examined. While the strategy commits to improving financial management

systems, the issue of healthcare financing is not addressed. The strategy is also silent on the initiative to separate purchaser and provider functions in the Ministry through the contracting of services via the Health Care Commissioning Agency. No information is provided on how health-financing mechanisms, such as performance-related contracts, will be utilized to meet these objectives (Kosovo Ministry of Health, 2005). The strategy states that oncology services should be supported with diagnostic and treatment equipment, but does not identify revenue sources to pay for this expensive treatment.

While the strategy commits to the importance of a health-information system, it remains unclear that this information will be used to enhance decision-making. The Ministry commits to specific health targets, but it is unclear how these targets were identified in the absence of a fully functioning health-information system, or how information systems will be used to monitor progress in achieving these goals.

The Ministry of Health has not reflected on why Kosovo has failed to make progress in implementing the health-reform program. Reform objectives have been stymied by political turmoil, economic weakness, and serious capacity problems. Moreover, the foundation for ambitious reform efforts such as family medicine, health financing, and public health was not established prior to these reforms being attempted. The weakness of the health-information system, the failure to put in place a patient-registration system, and the failure to have sufficiently robust and transparent accounting in place prior to the establishment of the Health Care Commissioning Agency have undermined the ease and speed of the reform process.

Therefore, while the Ministry of Health's strategy is a step in the right direction, there is a danger that it ignores some of the basic hurdles that the Ministry needs to overcome to implement health reform. Below we evaluate what went right in Kosovo's health-reform program, as well as what went wrong.

IV. THE CONCEPTUAL FRAMEWORK: A SUMMARY

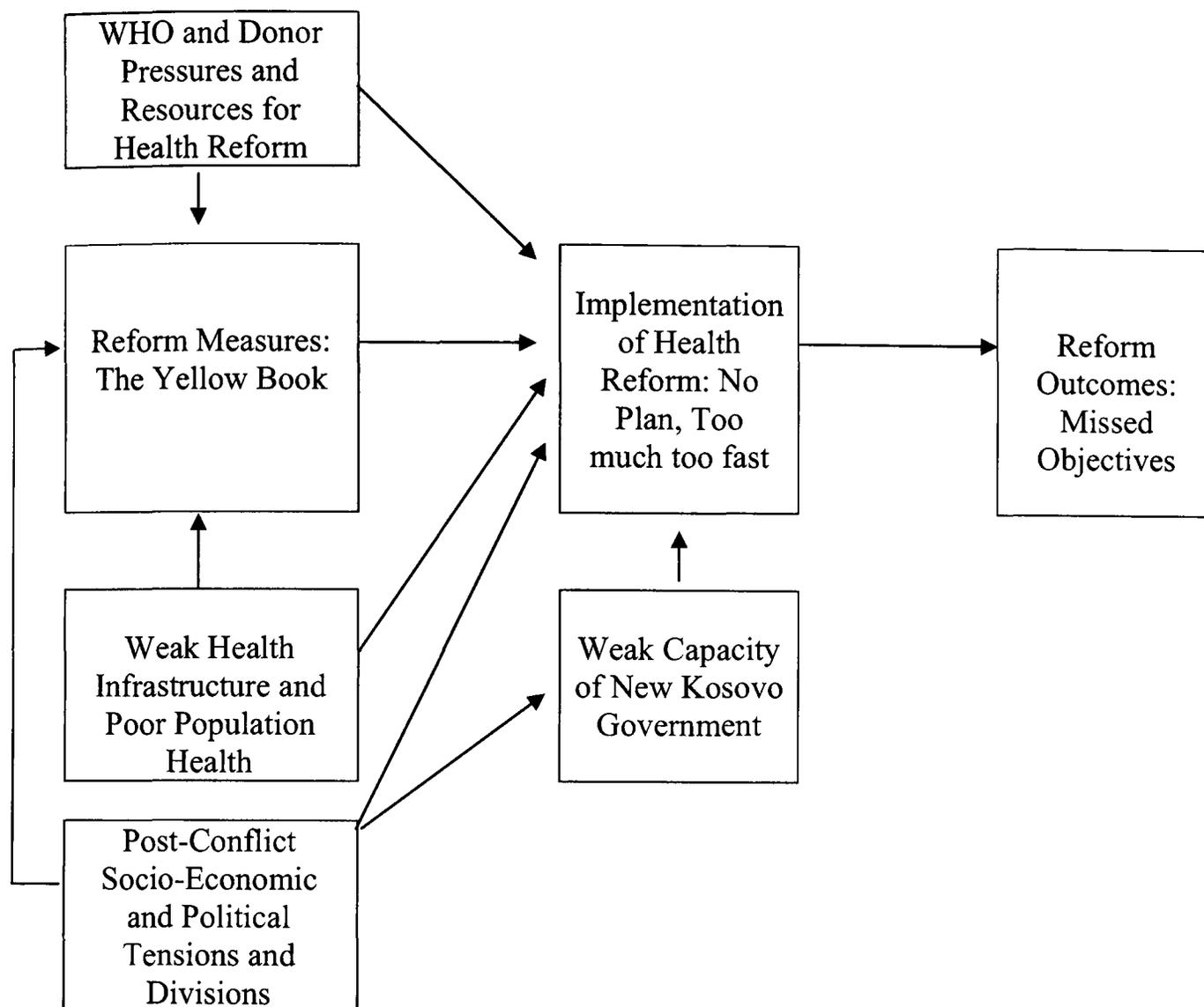
Some progress has been made in implementing Kosovo's health policy: the Ministry of Health has maintained the overarching objectives of reform in its strategy documents, family doctors have been trained, responsibility for primary care has been transferred to the municipal level, immunisation coverage has increased, and some maternal and child health indicators have improved. Moreover, the Ministry has developed a strategy outlining the objectives of reform.

Yet there is also cause for concern. As outlined above, some key reform initiatives, such as building the strength of primary care and establishing an effective health-financing system, have been problematic. Moreover, the Ministry of Health strategy to implement health reform contains serious flaws, and there is little indication that it has adequately identified the barriers to reform.

It is still too early to fully judge Kosovo's health-reform program, and not enough data is available to assess the judiciousness of certain reform decisions, such as the establishment of the Health Care Commissioning Agency. Health reform is a complex undertaking, and it can take years of resources and effort to produce meaningful change. Yet trends in health reform can be evaluated, i.e. what elements of the reform program have gone well, what has been problematic, and how effectively the Ministry of Health is overcoming obstacles to reform.

The conceptual framework applied to Kosovo clarifies the reform process as well as reform outcomes, enabling analysis of the factors shaping the reform measures and their implementation. Figure Fifteen applies the conceptual framework for health reform to the Kosovo case.

Figure Fifteen: Application of the Conceptual Framework to Kosovo Case



The reform measures as outlined in the Yellow Book were selected to reflect population-health challenges and to address the dilapidated infrastructure of the public health system. However, as outlined above, these measures were also driven by external pressures and resources from the WHO and international donors. The socioeconomic and political context—namely the ambitious efforts of the international community to build liberal-democratic institutions as part of their post-conflict peacebuilding efforts—also shaped the reforms. The implementation of the reform measures was impacted not only by these three factors (the health context, the external pressures for reform, and the socio-economic and political context), but, importantly, by the weak capacity of the Kosovo Ministry of Health. All of these factors impacted on the ability of the reforms to meet their objectives of establishing a primary care-based system with functioning family-medicine teams, referral to the secondary and tertiary levels of care, community-based mental-health care, an Institute of Public Health that operates as the technical arm of the government, sustainable healthcare financing, and governance structures that reflected the European Union’s principle of

subsidiarity with a Ministry of Health-provided policy, strategic planning, and regulation and standard setting.

CONCLUSION: PROVING THE HYPOTHESIS AND IMPLICATIONS FOR OTHER HEALTH-REFORM EFFORTS

The research hypothesis—generated after the development of the conceptual framework and an analysis of the failures of health reform in Central and Eastern Europe—tested in this thesis is that the post-conflict social, economic, and political context and its impact on state capacity, the externally driven nature of the health-reform process, and the compressed timeframe for reforms together impact on the ability of post-conflict health-reform programs to achieve their objectives. This conclusion summarizes the analysis above to prove that this hypothesis is correct, and assesses the implication for future research. The successes of the Kosovo reform effort are highlighted below.

I. WHAT WENT RIGHT

Important lessons from other post-conflict contexts were applied in the case of Kosovo. The WHO assumed a coordination function and established a strategic-planning document (the Blue Book) to guide investments in the health sector. A facility master plan guided the rehabilitation of health facilities. Weekly coordination meetings were held. These important developments took place in a difficult context with a multiplicity of donors and NGOs and a weak government in the form of UNMIK.

Moreover, Kosovo's health policy provided all stakeholders in the health sector, donors, international agencies, non-governmental organisations, and Kosovo health professionals with an opportunity to outline a shared vision for the health sector. The WHO was wise to begin formulating health policy soon after the conflict ended. Donor funds were then used to build the foundation for health reform.

The vision of the reform process, first articulated in the Yellow Book and repeated in the strategy of the Ministry of Health, has traction within Kosovo. Despite the pessimism generally expressed by stakeholders, all were optimistic that in fifteen years the health system would reflect the vision outlined in the health-policy document.⁸³ The health policy has guided donor responses and ensured a degree of coherence in rehabilitation and reform efforts. After the authority for the health sector was passed from UNMIK to the Kosovo provisional government, the Ministry of Health maintained adherence to these policy goals in its strategy documents. Training

⁸³ See Appendix Three, Question 37.

of family doctors has begun, family-medicine centres have been established, some community mental-health services have been created, and the Health Care Commissioning Agency was established to act as the precursor to a health-insurance fund. And responsibility for primary care and public health has been decentralized to the local level. While much has been accomplished, reforms largely failed to meet their objectives.

II. WHAT WENT WRONG: PROVING THE HYPOTHESIS

A. External Pressures for Reform

Kosovo's donors generously provided more than one hundred million Euros to rehabilitate and reform the health sector. Without this assistance, many health facilities would have remained in a state of disrepair and bereft of equipment. Physicians were trained in family medicine, specialists upgraded their skills, and public-health infrastructure was upgraded.

However, donors made several critical errors. First, donors did not commit to a sector-wide approach early in the process, and donor coordination was more often like competition. Donors often undertook their programming based on their own national objectives rather than on a solid assessment of needs on the ground. Second, donors overestimated the window of opportunity for reform and the indigenous capacity within Kosovo to achieve reform objectives. And third, donors did not focus enough attention in the critical early stages of the reform process on the crucial problem of the state's capacity to undertake reform efforts.

B. Post-Conflict Political and Socio-Economic Context

As described above, the health system was politically charged. Many of Kosovo's leading politicians are physicians. The health sector was a key battleground for Kosovo's autonomy, and Albanians were justifiably proud of their accomplishments in establishing a parallel health system and medical school during the 1990s. After the international community arrived in Kosovo, the health system continued to be an important arena for political struggle. The KLA appointed heads of hospitals and primary clinics immediately after the war, but many of these appointments were changed after the rival LDK won elections at the municipal level. After the central elections in 2001, the new Minister of Health introduced political appointments in the Ministry and throughout the health system, which resulted in his dismissal. This politicisation distracted Kosovo officials from the reform program and impeded progress towards meeting reform goals.

Kosovo also suffered from extreme economic weakness. While billions of dollars poured into the province, with approximately a hundred million Euro given to the reform effort, this money was quickly absorbed by the need to refurbish and equip health facilities and training programs. Resources were not sufficient to provide adequate financial incentives to support reform goals, and the reforms did not generate a financing strategy effectively to address Kosovo's resource challenges.

C. Weak Government Capacity

The United Nations Department of Health, and later the Kosovo Ministry of Health, was expected to undertake three objectives: first, coordinate donors and NGOs during the rehabilitation program; second, oversee the administration of the health system; and third, implement an ambitious program of reform. The Department was expected to meet these three goals with few resources. It was initially short-staffed and completely overstretched. While international staff provided competent technical advice on public-health issues, they lacked experience working within government and could not guide the transformation of the Department into a government ministry. Because of these weaknesses, the Department lacked the capacity to exercise a strong planning role. There was no sector-wide planning approach, and no implementation plan for the Yellow Book was developed.

When the Department of Health was transformed into a Ministry, political problems undermined the transition process. The first Minister of Health was dismissed for incompetence, and the most senior civil-servant post in the Ministry—the Permanent Secretary—remained unfilled for many months. This political instability also contributed to slowing down the implementation of reforms.

While there are promising signs that the Ministry of Health has overcome some of these difficulties, the strategic-planning documents released by the Ministry to guide the reform process have key weaknesses, outlined above. Weaknesses include a multiplicity of objectives with few specific strategies on how these objectives will be achieved, targets and priorities identified without supporting evidence, critical gaps in the areas of child and maternal health, and no information on financing and payment systems.

D. Compressed Nature of the Reform Process

Donors and the WHO argued that an important window of opportunity existed for reform. This window existed for two reasons: first, there was little resistance from stakeholders eager to block reform, and second, there was a massive influx of donor

resources. However, the capacity needed for this type of radical change was seriously underestimated. According to the agency attempting to implement the health-insurance system, the rate of change was too much for these weak institutions.

The health system has experienced constant change especially at the centre.... The rate of change has created significant pressures on the Ministry of Health and its capacity to set policy and manage the health system. The lack of capacity within the Ministry, turnover of key personnel, delays to the appointment of staff in the permanent secretary post and within the HCCA and lack of basic systems for producing health information and financial data, as well as the lack of financial accounting and management capacity across health institutions, have been significant barriers to the implementation of financing reform. (IHSD, 2003b)

Stakeholders shared this concern that the rate of change was too fast. One doctor stated, "The health system changed too quickly from one system to another, and such dramatic change was impossible with all the post-war problems."⁸⁴

The problems posed by the compressed time frame for reform were exacerbated by the failure to undertake effective policy planning. While the policy document (the Yellow Book) was developed in consultation with donors and health professionals, no similar process took place to develop an implementation plan. One stakeholder complained that, "there were no preparations for implementation, no assessment of financial, human or management resources."⁸⁵ As a result, there was little reflection about the possible impediments to reform, and the necessary steps to achieving reform objectives. Health reform cannot be effectively built on a weak foundation.

An implementation plan could have identified the need to establish the necessary building blocks of reform. In primary care reforms, efforts to establish patient registration, clinical guidelines, the gate-keeping role of the primary care sector, and the interface between the primary and secondary care sectors could have created a more solid foundation for family medicine. Instead family physicians were trained and returned to a health system where family medicine still had not gained full acceptance. Efforts to implement financing reforms also experienced similar problems:

⁸⁴ Dr. Lumturije Gashi-Luci, Chief Pathologist, Pathology Clinic, Pristina University Hospital, Interviewed in Albanian by Fatime Qosaj, February 24, 2003.

⁸⁵ Dr. Sebahudin Ahmeti, Health Consultant, Interviewed in Albanian by Fatime Qosaj, March 13, 2003.

Basic conditions and systems necessary to support an insurance based system do not exist: payroll tax collection system; patient identification system; a health information system to support transaction system; costing/pricing management accounting systems; licensing, registration, and accreditation systems. (IHSD, 2002b)

The weak health-information system has meant that accurate and reliable data are not available to evaluate the progress and impediments to health reform.

III. SUMMARY: FACING THE CHALLENGE OF REFORM

The need to improve the healthcare system in Kosovo is clear. Kosovo's health indicators are among the poorest in Europe. The system is not currently effective or equitable. However, the context for implementing the health-reform program in Kosovo is daunting. Important health issues must be addressed: high rates of infant and maternal mortality, serious child-health concerns, and risk factors for both communicable and non-communicable diseases. Demand for healthcare is high, but the health system is crumbling, financial barriers to access exist, and there is a physician shortage. The highly fragmented nature of Kosovo's politics, the low administrative capacity of the government, and economic weakness undermine Kosovo's capacity to implement reform.

Kosovo was the first of a new kind of international intervention, where the international community contributed sufficient troops and resources to undertake a massive reform of political, social, and economic institutions. As part of the effort to avert a return to war, these reforms had the objective of transforming Kosovo into a liberal democracy characterized by a free and open political system, the legal and institutional protection of human rights, including minority rights, and an economy driven by the private sector. In the healthcare sector, the international community's objective was to improve the efficiency, equity, and effectiveness of Kosovo's health system. While the objectives were noble, the reality has fallen far short of the grand vision outlined in the Yellow Book. And if the trends outlined in Chapter Seven persist, Kosovo will continue to struggle to implement its reform goals.

Below, the predictive and explanatory value of the literature on health interventions in situations of conflict, health reform, health reform in Central and Eastern Europe, and peacebuilding is reviewed. The additional lessons learned from the Kosovo case study are examined, particularly the importance of state capacity and the need for an implementation plan outlining realistic reform goals. The chapter concludes by outlining a research agenda for post-conflict health reform.

IV. PREDICTIVE AND EXPLANATORY VALUE OF LITERATURE

A. Health and Conflict

There are three stages of health interventions after a conflict has ended: the humanitarian, rehabilitation, and reform stages. While the humanitarian phase is focused on addressing threats to population health, critics contend that coordination is often lacking and agencies neglect the necessary building of local capacities. The international community focuses on repairing infrastructure during the rehabilitation phase, but analysts have argued that a longer-term health strategy should be developed during this time period to ensure that resources are focused on sustainable projects. While little assessment has been made of the effort to undertake reforms as part of post-conflict peacebuilding operations, an evaluation of East Timor claimed that these were really development activities, being implemented with short time horizons.

In Kosovo, the international community learned important lessons from mistakes made in previous post-conflict operations. Coordination systems were established, a facility master plan to guide rehabilitation was released, and a policy document was written to ensure that investment was channelled in sustainable directions. Moreover, the decision by the WHO to establish a policy direction helped channel the substantial donor resources available in the post-conflict period into sustainable interventions. The problem with the health policy was in its implementation.

B. Health Reform

Health reform was described in Chapter One as “sustained, purposive change to improve the efficiency, equity, and effectiveness of the health sector with the goal of improving health status, obtaining greater equity, and obtaining greater cost-effectiveness for services provided” (Basch, 1999).

A major analysis of how to design and implement health-reform programs identifies tasks critical to produce effective reform. These tasks are to clarify goals; carry out an honest diagnosis of problems within the health sector; develop a reform plan with the participation of key stakeholders; embrace politics; focus on implementation; and build in evaluation systems to learn from mistakes (Roberts et al., 2004). In Kosovo, the health-reform effort clarified the goals of reform, i.e. to provide a more effective and equitable system; diagnosed—to the extent possible—the problems within the health sector; and undertook stakeholder consultations to establish a reform plan. However, they failed either to focus effectively on implementation or to create an evaluation system to identify and correct problems undermining reform.

This examination also outlines ‘five control knobs’ for health-sector reform. However, the state must have the capacity to turn these ‘control knobs’ to affect change. In the case of Kosovo, this capacity did not exist. Moreover, these control knobs require institutional infrastructure, such as health-information and financial accounting systems. These building blocks of reform were not established prior to the attempted implementation of systemic changes.

C. Reforms in Central and Eastern Europe

Many Central and Eastern European countries began radical health-reform programs after the collapse of communism in the early 1990s. These programs were strikingly similar—the reorientation of the health system to primary care, the introduction of family medicine, efforts to make the secondary and tertiary sectors more efficient, the introduction of financing reforms in the form of social insurance, efforts to strengthen public-health systems, and decentralisation. These reforms have been undermined by economic instability, the lack of political will and general political instability, and unhealthy lifestyles. The reforms themselves have also been problematic. Change was introduced too quickly, the implementation of the reforms was not planned, there was little enthusiasm for family medicine, governments had little capacity to introduce and manage change, health-financing reforms suffered from a shortage of funds and problematic efforts to split the purchaser and provider functions, and data collection was weak.

Key lessons emerged from this examination of health reform:

- Careful attention should be paid to the political, social, and economic environment to ensure that the reform effort is in harmony with these external factors.
- The implementation of reforms should be planned, ambitious reforms should not be attempted without building concomitant government capacity, and care should be taken that the economy is strong enough to support the reform program.
- Efforts to introduce a system focused on primary care must address the problems of a lack of enthusiasm, the weak interface between primary and secondary care, training, and weak data collection.

The health-reform program in Kosovo was very similar to reform programs throughout Central and Eastern Europe, and suffered from many of the same problems. Economic weakness and political instability created a difficult environment in which to implement reforms. Little capacity existed to implement change, and data-collection systems were weak. Health professionals as well as the general public had little enthusiasm for family medicine and the reorientation of the system to primary care. While health planners in Kosovo had successfully applied key lessons from analysis of

humanitarian and rehabilitation programming, they neglected to examine the problems associated with the implementation of similar reform measures elsewhere in Europe.

D. Post-Conflict Peacebuilding

The international community undertakes widespread, radical reforms in post-conflict states to create liberal democracies and prevent a return of hostilities. It attempts to compress development in post-conflict states, believing the environment is favourable for radical change. Critics warn, however, that the international community takes functioning states for granted, and fails to build state institutions prior to holding multi-party elections and introducing radical socio-economic reforms. Moreover, peacebuilding missions are often characterized by a failure to prioritize critical interventions, the lack of local ownership of the reform program, and the pace of reform being driven by external agendas and timetables.

The international community undertook sweeping reforms to build a liberal democracy in Kosovo. Donors strongly believed that the environment favoured radical change. The international community held administrative authority and could put in place legislation and regulations reflecting European standards. Donors generously contributed resources for the reconstruction and reform program. Billions of dollars were committed to this small province of two million people.

However, Kosovo was haunted by its past. Investment in Kosovo's infrastructure had been minimal, and the highways, the electrical grid, the water system, and public buildings were all crumbling. Albanians had been shut out of government and public institutions for ten years. And while the conflict was of short duration, displacement and destruction were significant.

Kosovar society emerged from the war weakened and deeply divided. No functioning state institutions existed, and the United Nations built a civil administration from scratch. However, despite this lack of local institutional, administrative, and managerial capacity, the international community pushed ahead with a complex reform effort. The duration of reform projects and their ongoing sustainability was determined by donor deadlines and availability of funding sources, not by any objective sense of the time it would take to implement these reforms in the post-conflict environment, or the ability of the Kosovar government to manage them into the future. In the health sector, building blocks of reform such as health-information systems, patient registration, and transparent financial accounting systems were not identified.

V. THE ADVANTAGES OF THE CONCEPTUAL FRAMEWORK FOR HEALTH REFORM

The conceptual framework applied here provides a strong analytical tool to assess post-conflict health reform. It situates the effort to reform health systems within an analysis of the post-conflict peacebuilding initiatives of the international community to build liberal democratic states. It integrates the key findings from the literature examining the impetus to reform health systems post-conflict with the literature that assesses health reform more generally. The framework guides analysts of health reform by demonstrating the issues of key importance to their analysis.

Applying this framework, analysts can assess the various stages of the reform process, and focus on external and internal pressures for reform. The framework also assesses the pressures shaping health reforms—external pressures, as well as the health context. The quality of the health-reform measures is evaluated, and the factors impacting on the implementation of reforms investigated. In addition, analysis also focuses on the process of implementation of the reforms and addresses the outcomes of reforms. The key value-added of this framework is its focus on the capacity of the state to implement reform measures.

Using this framework, this thesis was able to test and prove the hypothesis that post-conflict health reform in Kosovo was largely unable to meet its objectives as a result of the externally driven nature of the reform process, the tumultuous post-conflict socio-economic and political context, the weak capacity of the state, and the compressed nature of the reforms.

As outlined in the Methods section, the objective of case study research is to find “the conditions under which specified outcomes occur, and the mechanisms through which they occur, rather than uncovering the frequency with which those conditions and their outcomes arise.” (George and Bennett, 2005, p.31) While single case studies have value for testing hypothesis and identifying new variables, the generalizability of their conclusions are limited. Therefore, this framework should be applied to similar cases of post-conflict health reform (after the formal cessation of hostilities, where the international community has significant control). Through these cases studies, the generalizability of this hypothesis and the framework could be tested.

VI. FUTURE AREAS TO EXPLORE TO STRENGTHEN FRAMEWORK

As the objectives of peacebuilding have expanded, health reforms have become an important component of socio-economic transformation implemented as part of peacebuilding programs. However, few assessments have been done of the efforts to

implement health reforms in post-conflict settings. The study of Kosovo therefore provides important insight into the challenges of implementing wide-ranging health reforms in a post-conflict environment. Two key lessons emerge: the critical importance of building state capacity to implement reforms, and the need for a realistic implementation plan for health reform. These factors, outlined below, require further exploration through a series of case studies on post-conflict health reform.

A. State Capacity: The Need for a Visible Hand

The World Health Organization's Annual Report in 2000 examined health systems and argued that government 'stewardship' is the most critical input to establish functioning health systems, because "the ultimate responsibility for the overall performance of a country's health system must always lie with the government" (WHO, 2000b). The report defines stewardship as a "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the population" (WHO, 2000b).

While the WHO emphasis on stewardship was welcome, the state's capacity to provide that stewardship is assumed. The WHO argues that states have not provided such stewardship because they have been myopic, overly focused on legislation, and have turned a blind eye to the evasion of health regulations. The WHO outlined how governments could effectively provide this stewardship:

To discharge [stewardship] requires an inclusive, thought out policy vision that recognizes all principal players and assigns them roles. It uses a realistic resource scenario and focuses on achieving system goals. Intelligence requires a selective information system on key system functions and goal achievement, broken down into important population categories, such as income level, age, sex and ethnicity. Stewardship also calls for the ability to identify the principal policy challenges at any time, and to assess the options for dealing with them. Influence requires regulatory and advocacy strategies consistent with health system goals, and the capacity to implement them cost-effectively. (WHO, 2000b)

The WHO assumes the existence of strong capacity to provide such stewardship.

However, states do not automatically possess such skills. In post-conflict settings state power is often contested and society deeply fragmented. In most cases healthcare systems have been shattered by conflict, while the effect of the conflict on overall population health means that the demand for health services escalates. Governments are forced to coordinate donors and NGOs while attempting to re-establish health services. The capacity of the state is weakened by war, while the

demands on the state at all levels and from all quarters—population, donors, and NGOs—increase. While developing a health-policy vision or strategy is important to ensure that donor resources are channelled toward long-term objectives, if the state does not have the capacity to implement reforms, the sustainability of the health-reform process will be undermined.

While the weak capacity of the state to implement health reforms has been cited as a reason for reform failure, state capacity has not been defined or explained. What is state capacity? How can this concept be operationalised? Recall that to function effectively, the state requires the following elements:

- **Human Capital:** A sufficient number of well-trained civil servants.
- **Enforcement Capacity:** The ability of the state to develop policy guidelines and implement this policy.
- **Coherence:** The state's ability to implement reform measures in a reasonably equal fashion throughout its territory.
- **Fiscal Resources:** Sufficient financial resources to administer the system and implement reform programs.
- **Reach and Responsiveness:** The reform vision of the state should be accepted by key stakeholders, and the state should be responsive to their views and inputs.
- **Legitimacy:** The moral authority of the state to govern should be recognized by social groups. (Homer-Dixon, 1996)

While this is a useful schematic, the key question remains: how to build capacity?

Traditional approaches to capacity building include training, technical assistance, the development of guidelines and manuals, and study tours to foreign countries to see how health systems elsewhere operate. Skills such as financial management, legal drafting, and economics are best acquired through formal training. But research has found that many of the skills needed to implement reforms cannot be taught and are learned through process of trial and error. Therefore, reform programmes need to build in opportunities for reformers to assess experience and learn from mistakes. (Mills et al., 2001)

States could be able to build capacity through the process of *successfully* implementing health-reform programs, but this area needs further research.

B. Decompressing the Time Frame for Reform

This thesis demonstrated that in the Kosovo case study, the speed at which the health reform program was implemented was extremely problematic. But is there an alternative to 'compressed development' in post-conflict environments? Further research on this question - the speed at which health reform can successfully be implemented and the necessary building blocks for reform - may benefit from an examination of the effort to build health systems in developing countries.

A development project that was implemented at the same time as the international community was undertaking health reform in Kosovo provides some

important lessons in the time frame necessary for successful health reform. In Tanzania, a project sponsored by the Canadian International Development Research Centre (IDRC) contributed to lowering child mortality rates by a dramatic forty percent in one district (Savigny et al., 2004).

This project tested the hypothesis that healthcare spending should be directed toward cost-effective interventions targeting the most significant local health issues (the largest contributors to the local burden of disease). The project first gathered demographic data on local health issues. Policy makers were then provided with health-information tools to interpret this data and profile the local burden of disease. In the districts where this project was implemented, the major causes of mortality were malaria and a cluster of childhood illnesses.

The local health authority was provided with accounting tools better to manage resources in their districts. They were able to focus slightly more resources (less than two U.S. dollars per person) on these illnesses. To ensure that the resources were spent effectively and to create synergies throughout the health system, the project built capacity at primary care clinics. Clinicians were provided with training (specifically the Integrated Management of Childhood Illnesses) to provide better treatment and care (Savigny et al., 2004).

The Tanzania project is a good example of building the foundations for reform at the same time as efforts are made to improve the system. The use of health-information and financial-management systems was a critical precondition for improving the effectiveness and efficiency of the health systems. This example from Tanzania also illustrates the effectiveness of planning the implementation process of health reform.

VII. THE RESEARCH AGENDA

This heuristic case study which applied a conceptual framework of post-conflict health reform to Kosovo highlighted key factors impacting on the implementation of reforms, namely the pitfalls associated with a post-conflict transformational change agenda, the importance of state capacity, and the dangers of a compressed timeframe for reform. However, many issues remain to be further explored. Similar health reforms are being implemented in many post-conflict settings. Why have these particular reform measures risen to prominence? How appropriate are these healthcare strategies? What is the evidence for their success? Further investigation is needed into state capacity. What are the most effective

methods for building this capacity? Are sector-wide programming approaches preferable? How can reform programs be implemented in states that are corrupt or pernicious? What can other disciplines, such as change management, teach us about the implementation of health reform? And what are the long-term consequences of failed health-reform efforts for equity? Given the spate of international engagements in East Timor, Afghanistan, and Iraq, moving beyond this heuristic case study to a “plausibility probe”⁸⁶ that undertakes a structured focused comparison of case studies on post-conflict health reform could further investigate these issues to refine the conceptual framework and provide a foundation for a theory on post-conflict health reform.

The international community is expanding its activities in post-conflict zones, and significant resources are being committed to health reform in these contentious environments. While laudable, the results of the Kosovo case study demonstrate that much remains to be learned about undertaking dramatic social change in countries scarred by war.

⁸⁶ Recall that a plausibility probe tests theories on a limited number of cases to assess its generalizability. See GEORGE, A. & BENNETT, A. (2005) *Case Studies and Theory Development in the Social Sciences*, Cambridge, MIT Press..

APPENDIX ONE: KEY FINDINGS OF ANALYSIS OF HEALTH-REFORM EFFORTS IN CENTRAL AND EASTERN EUROPE

I. FACTORS CONTRIBUTING TO HEALTH REFORM

A. Problems within the Health System

As parts of the former Soviet Bloc, the pre-transition healthcare systems in countries throughout the region were remarkably similar (Ensor, 1993, Rechel and McKee, 2003). These systems were based on the Semashko model, where the central government operated both as the purchaser and the provider of healthcare services (Hinkov et al., 1999, Hlavacka et al., 2000, Hocevar, 1996). Polyclinics, located in major towns and/or municipalities, were theoretically the first point of contact for patients. General practitioners, dentists, paediatricians, and gynaecologists all practised at these clinics, and physiotherapy and basic diagnostic services were also available (Busse, 2000, Karski et al., 1999, Svab, 1995, Hinkov et al., 1999, Vulic and Healy, 1999). Many factories and other places of work also had health clinics, which treated substantial numbers of patients (Mihalyi, 2000). Budgets for primary care facilities were determined by hospitals; therefore resource allocation favoured hospital care over primary care (Ensor, 1993, Svab, 1995). The main role of primary care physicians was to control absence from work due to sickness and act as referral agents to the hospital sector (Figueras et al., 2005). Many patients bypassed the primary care system, and specialists gradually became the practitioners of choice (Mihalyi, 2000, Shuey et al., 2003, Svab, 1995).

The Semashko model initially led to impressive health gains by tackling common infectious diseases through state-led public-health initiatives such as immunisation and increasing access to healthcare through the proliferation of health services. The government expanded the number of health facilities, including clinics in workplaces and more hospitals (Figueras et al., 2005, Mihalyi, 2000). However, the claims of socialist countries that they provided free healthcare access for all were exaggerated. Certain groups received priority treatment, including factory workers, students, and politicians. Those who were self-employed such as farmers often lacked coverage under social-insurance schemes (Mihalyi, 2000).

This model of delivering healthcare suffered from several weaknesses, which became more apparent over time as advances in medicine pushed healthcare costs higher, and the economy weakened. The healthcare system was under-funded and inefficient (Fister and McKee, 2005, Figueras et al., 2005). The system was focused

on secondary and tertiary services; while hospitals suffered from excess capacity, primary care was underutilised and under-funded. Physicians placed a high value on specialist training that mirrored the emphasis that the healthcare system placed on hospital and curative care. Nurses were marginalized and received very little training. Few incentives were in place to ensure high-quality, efficient services that responded to the needs of patients. Public-health services focused on immunisation, with little attention paid to health education and promotion efforts, environmental health, and occupational risks (Basch, 1999).

B. Poor Health Status

Partly as a result of problems within the health system, and partly a result of economic problems as well as environmental and lifestyle factors, the health of the population was worse in Central and Eastern Europe than in the rest of the continent. The region was characterized by high smoking rates, poor diet, high alcohol intake, and high rates of non-infectious diseases, such as cardiovascular disease, cancer, and diabetes. Infectious diseases, including tuberculosis, were also on the rise (Field and Twigg, 2000, Rechel and McKee, 2003). The deterioration of population health and the general corrosion of healthcare services signalled that these health systems desperately needed to change (Fister and McKee, 2005, Ensor, 1993). These factors combined with the political and economic winds of change sweeping across Europe to contribute to the impetus for sweeping health reform.

C. Political and Economic Forces Contributing to Reform

As communism gave way to liberal market economies throughout the region, international agencies such as the World Bank, the International Monetary Fund, and the European Union provided significant resources to the newly elected democratic governments to reform and modernize government institutions. This reform effort included the badly tarnished health sector.

The key international players that supported the development and implementation of reform programs remained remarkably constant throughout the countries of the region. These players were the World Health Organization, the World Bank, and the European Community's PHARE⁸⁷ program (Hinkov et al., 1999, Vulic and Healy, 1999, Nuri and Healy, 1999). The focus of the EU's PHARE program was to prepare countries for accession to the European Union (Rechel and McKee, 2003).

⁸⁷ The PHARE program is the main channel for the European Union's financial and technical cooperation to develop pre-accession strategies.

These agencies advocated the implementation of similar health-reform programs across the region—i.e. an emphasis away from secondary- and tertiary-based systems towards primary care, and reforming public health away from the traditional emphasis on immunisation. While these reforms were designed to ensure that the health systems of Central and Eastern European countries met European standards and were cost-effective, reforms also had an ideological basis. Health reform was part of the liberalisation of these economies.

II. HEALTH-REFORM MEASURES IMPLEMENTED

Most countries in the region have introduced similar reform programs, albeit with varying starting dates and pace of implementation. Reformers focused on four of the five mechanisms outlined earlier. Efforts were made to change the organisation of the system, reform the system of financing, as well as the mechanism through which payments were delivered to health professionals, and put in place new regulations. Less emphasis was placed on influencing individual behaviour. Typical reform measures, outlined in detail below, included reorganizing the system, which included a reorientation of the health system to primary care, reforming secondary and tertiary care, upgrading training for healthcare staff, decentralizing responsibilities for some healthcare services to the local level, and modernizing the public health system. Reforms also restructured the financing of the healthcare system.

A. Reorganizing and Regulating the Healthcare System

1. Reorientation to Primary Care

Much of the focus of reforms was on healthcare restructuring, supported with regulatory changes. Since the Declaration of Alma Ata in 1978, donors and international organisations have emphasized the health benefits and cost-effectiveness of primary care-based health systems. Common to all reforms in Eastern Europe is the reorientation of health services toward primary care (Gaal et al., 1999, Saltman and Figueras, 1997, Saltman and Figueras, 1998, Saltman et al., 1998, Ensor, 1993).

In primary-care systems, patients' first point of contact in the healthcare system is with general practitioners or family-medicine specialists who act as 'gate-keepers,' coordinating further health-related services, if required, for the patient. These doctors also provide public-health activities such as immunisation and ensure that basic health-promotion messages are communicated to their patients. This provides better tracking of patient health and ensures that higher-cost resources—such as specialists, lab testing, and hospitals—are used efficiently.

2. *Reform of Secondary and Tertiary Care*

The Semashko model of healthcare delivery favoured secondary and tertiary levels of care, and therefore hospitals received more funding than primary care. However, despite the preferential treatment granted to hospitals, they suffered from similar problems of inefficiency and poor management that plagued primary care.

Hospital care under the Semashko model was highly fragmented. Hospitals were classified according to diseases they treated as well as the occupations of their patients. This produced many different hospitals—or hospitals with several separate buildings—but with few horizontal linkages. This system resulted in a duplication of services and highly vertical programs. While secondary and tertiary hospitals often had too much capacity given the population size, closing facilities was highly problematic. In the absence of community programs in mental health, geriatric care, and occupational health, these facilities became the main providers of social care (McKee, 2004, McKee and Fidler, 2004).

As part of the reform effort, countries in the region attempted to upgrade the organisation, efficiency, and performance of hospital services. Management was decentralized, hospital beds were cut, the average length of stay for patients reduced, and facilities were amalgamated to increase the cost-effectiveness of the system (Figueras et al., 2004).

3. *Strengthening Public Health*

Under the Semashko system, public health was organized according to the San-Epid model. San-Epid institutions undertook monitoring, public-health inspections, prevention, and research. Departments in San-Epid institutions included environmental health, general health, occupational health, nutrition and food hygiene, child and adolescent health, and communicable disease control. While this system was reasonably successful at vaccination and communicable disease control, it failed to address issues such as environmental pollution, occupational hazards, and non-communicable diseases (Bobak et al., 2004). Moreover, these institutions rarely provided policy guidance to governments.

Proposed reforms had the objective to ensure that public-health institutions were better able to respond to public-health challenges. They included decentralisation of some public-health functions to the local level, transferring public-health initiatives such as immunisation to primary care institutions, modernizing health-information systems, and strengthening health-promotion activities (Bobak et al., 2004).

4. *Human Resources and the Quality of Care*

Many countries undertook human-resource planning to create or upgrade skills in family medicine, public health, and management expertise. Continuing education programs were developed to ensure professional skill sets were maintained and enhanced, while professional standards and accreditation mechanisms were put into place. Reforms also included accreditation of physicians and the establishment of professional associations for health professionals (Borowitz et al., 2004).

5. *Decentralisation*

While pre-transition health systems were highly centralized, reforms followed the European Union principal of subsidiarity, meaning that activities should be undertaken by the lowest competent authority. As a result, reforms made local levels of government responsible for significant areas of the health sector such as primary care, hospital oversight, and public health.

There are two main forms of decentralisation. Deconcentration is when administrative responsibilities are transferred to local levels within the central bureaucracy (civil service). Devolution, a more extreme form of decentralisation, is when decision-making is transferred to the local level of government. The central government relinquishes decision-making authority to organisations outside their direct control.

Decentralized institutions allow local communities greater involvement in the management of their healthcare. These institutions should benefit from faster decision-making processes, ensure that local concerns are taken into consideration in these decisions, and be more innovative in their responses to changing circumstances on the ground. Through decentralisation, local institutions should have higher morale, more commitment, and greater productivity, as workers have more control over decisions that impact on their organisation. Moreover, the central administration is released from operational responsibilities and is able to concentrate on the role of policy development and coordination (Hunter et al., 1998).

B. *Healthcare Financing and Payments*

Prior to the implementation of health-financing reforms, health systems in the region were largely funded using social insurance, with little distinction between purchaser and provider. The insurance fund received revenue from state-owned enterprises, supplemented by tax revenue from the government. The main objective of these funds was to track absences from work (Mihalyi, 2000). Social-insurance funds

were not independent from the government, and the Ministries of Health or Finance controlled the insurance organisation. Money channelled to healthcare was the outcome of political negotiations, and healthcare was often not prioritized. As a result, a steady revenue stream for the health sector was not guaranteed (Dixon et al., 2004); (Field and Twigg, 2000).

Many countries in the region introduced decentralised, contract-based social health insurance, complemented by voluntary insurance. The objective of the reforms was to protect the amount of healthcare funding available, split the purchaser and provider functions so the government was not both the owner and financer of health services, and prompt greater efficiency and responsiveness to local needs (Figueras et al., 2004). While national pooling was maintained to ensure equity between rich and poor regions, international advocates of reform pushed for regional purchasers to issue performance-related contracts as part of an effort to reform “payments” and enhance the quality and efficiency of interventions. Such contracting would theoretically improve efficiency by making providers more accountable for their resources and increase the responsibility of individuals for their own healthcare (Dixon et al., 2004).

While the split between purchaser and provider functions reflected ideological concerns about the role of the state, it also supported the effort to heighten cost-effectiveness of health interventions. Population-health priorities can be built into healthcare payments—purchasing decisions—allowing the health system to be more responsive to health trends. Purchasers have financial levers and other incentives to improve performance of providers, including outlining explicit targets for providers. Contestability or competition among providers can be introduced, also increasing efficiency and introducing patient choice (Dixon et al., 2004).

Performance-related purchasing was a distinct shift from historical line-item budgeting and included capitation for primary care services and new hospital payment systems linked to defined units of hospital outputs. However, for such contracting to be effective, it requires information on performance outcomes, which are available from information systems. Unfortunately, such information systems were often not operational (Dixon et al., 2004, Figueras et al., 2004).

C. Behaviour

The health-reform programs emphasised reorganisation of the system. Little attention was paid to broad public-health messages designed for behavioural change to reduce individual risk factors for poor health.

III. THE OUTCOMES OF THE HEALTH-REFORM PROGRAM

The impact of reforms on population health as well as the degree to which the reform program was successfully implemented is considered below.

A. The Organisation of the Healthcare System

1. Reorientation to Primary Care

Under the Semashko model, patients relied on specialists for the majority of medical treatment. The transition from a specialist-oriented system to a primary care-based system has proven difficult. Specialists have resisted the changes, budgets have not necessarily provided primary care with sufficient resources, and primary care does not necessarily have the human resources to make it function properly. In Moldova, primary care facilities are so under-resourced that they are frequently unable to provide the minimum package of free medical assistance (MacLehose, 2004).

As a result of these problems, the referral system often does not function as it should. Many patients are referred to specialists with conditions that could be treated in a primary care facility (McKee and Fidler, 2004). In Albania, fees imposed on those who bypass the referral system have had little impact, and the referral system does not function adequately. As doctors receive under-the-table payments, specialists have incentives to discourage patients from using the primary care system (Tragakes, 2003). In Romania, the frequency of primary care consultations has decreased, and the referral system is also often bypassed. The number of hospital admissions is higher than in most European countries, as patients are directly admitted to hospital without the proper care at the primary care level (Vladescu, 2002).

Discharge from hospitals is also problematic, with patients often returning to the community without proper medical oversight in place (McKee and Fidler, 2004). Even in Slovenia, whose health system functions reasonably well, primary and secondary levels of care do not cooperate fully on case management (Albrecht, 2002).

Strengthening primary care requires long-term human-resource planning. Physicians have been retrained and introduced to the concept of family medicine (Busse, 2000, McKee and Fidler, 2004, Nuri and Healy, 1999). However, simply retraining general practitioners or specialists has not produced the required shift in mentality. Doctors at the primary care level should be addressing the majority of patient complaints, but instead they often act as referral agents to the secondary level of care (McKee and Fidler, 2004). Therefore, complete training in family medicine is required, and medical schools throughout the region have established family-medicine

specialist programs. In Bulgaria, undergraduate medical training includes ninety hours of teaching in family medicine (Koulaksazov et al., 2003).

For primary care physicians to act as effective gatekeepers and for the system to operate cost-effectively, the range of functions and services provided at the primary care level should be expanded (McKee and Fidler, 2004). Some countries, such as Bulgaria, guarantee citizens free choice of family doctor, and eighty-seven percent of Bulgarians have chosen a family physician for primary care (Koulaksazov et al., 2003). However, in other countries like Macedonia, “primary care” includes specialists working at local health centres such as paediatricians, gynaecologists, and obstetricians, among others. Thus, while the reform program focuses on reorienting the system towards primary care, much of this is accomplished by labelling specialists as primary care providers (Hajioff, 2002).

2. *Reform of Secondary and Tertiary Care*

Despite the efforts of reform programs to reorient the health system to focus more on primary care, secondary and tertiary medicine continues to dominate health systems in many countries.

As part of its reform program, Albania closed many hospitals and converted them into primary care centres. In 1992, Albania had 160 hospitals, while it now has only fifty-one. Hospitals were consolidated, with some district hospitals being upgraded to regional hospitals to provide a more complete range of secondary services (Tragakes, 2003). The hospital restructuring program in Moldova resulted in many hospitals being closed, but occupancy rates for remaining hospital beds remain very high. This suggests that the tradition of excessive hospitalisation continues (MacLehose, 2004). In other countries, such as Bulgaria, the number of hospital beds remains high, and inpatient services are often a substitute for social care for the infirmed (Koulaksazov et al., 2003).

Because reform programs throughout the region focused much of their attention on primary care and financing issues, secondary levels of care were often neglected. Hospitals are not efficient, while quality of care is often sub-optimal. In Macedonia, hospitals do not practise economies of scale with regions offering every specialty possible. Programs to rationalize healthcare delivery have not been established. Moreover, hospital directors lack management skills and financing of hospitals remains based on line-item budgeting (Hajioff, 2002).

Secondary care remains out of reach in some areas, despite being publicly funded. Patients in Macedonia have to pay ‘hotel’ charges, which can reach almost U.S. \$150 per month (Hajioff, 2002). In Albania, patients often cannot afford to make the under-the-table payments for medical care, and even drugs on the essential-drugs list are often available only through private pharmacies. Combined with poor quality of care and unsanitary conditions, patients are discouraged from hospitalisation (Tragakes, 2003).

3. *Strengthening Public Health*

Population-health indicators in Central and Eastern Europe compare unfavourably to Western Europe or North America. The region’s high rates of mortality, morbidity, and disability undermine economic prosperity (Bobak et al., 2004).

At the end of the 1990s, the difference between the European countries with the highest and lowest life expectancies at birth was more than 10 years in both men and women; virtually all countries with low life expectancy are in the CEE/NIS [Central and Eastern Europe/Newly Independent States]. Even at age 45, there is an eight-year difference in male life expectancy between the best and the worst European countries (data from WHO health for all database). (Bobak et al., 2004)

Most of this difference is caused by high disease incidence, not substantially higher case-fatality rates (Bobak et al., 2004). High smoking rates, poor nutrition, including a high intake of saturated fats, low levels of physical activity, and a high prevalence of obesity contribute to poor health. In addition, the dramatic social and economic changes that took place in the 1990s, where unemployment rose and inequalities worsened, contributed to lifestyle choices—such as substance abuse—which increased mortality rates (Bobak et al., 2004).

Prioritizing public health in Eastern Europe has proven difficult. While attempting to modernize public-health practise, decentralisation of some public-health responsibilities has removed public health from the various ministries’ radar screens, and public-health activities subsequently have not receive the funding needed. Health-information systems were not fully functioning, and the quality of data was often low, impeding the capacity of public-health specialists to provide policy advice to governments. Medical schools also failed to prioritize public-health training, and maintained their traditional focus on communicable disease control. Health promotion remained responsive, not focusing on lifestyle issues that seriously undermined population health (Bobak et al., 2004).

Public health continues to emphasize control of communicable diseases through vaccination, rather than prevention of diseases and injury (Rechel and McKee, 2003). These vaccination programs are quite successful—in Albania, over ninety percent of children are immunized against a range of infectious diseases (Tragakos, 2003). However, health-promotion activities such as programs to reduce childhood injury and death are not prioritized. Improvement of road safety and programs to teach children to swim are cost-effective mechanisms to reduce childhood mortality. Enforcement of speed limits, ensuring that children wear seatbelts or child restraints, establishment of pedestrian crossings, and strict enforcement of drinking-and-driving rules are examples of important public-health initiatives largely absent in Central and Eastern Europe (Rechel and McKee, 2003).

4. *Human Resources and the Quality of Care*

The challenge of reform is to put evidence-based guidelines into routine clinical practise, so that health interventions reflect the best scientific evidence available (Figueras et al., 2004). However, reform measures have predominantly focused on increasing financing and improving efficiency without sufficient focus on quality of care delivered. Ineffective treatments and inefficient use of human resources continue to undermine the quality of care (Borowitz et al., 2004). While clinical guidelines have been produced, they have not always been implemented, as little incentive exists to put these guidelines into practise. Reforms have not included incentives to change behaviour at the patient-practitioner level. A legacy of underinvestment and the lack of resources in the healthcare system have worked to undermine the quality of health care (Borowitz et al., 2004). One analyst summarized the situation:

...the promotion of high-quality care in the CEE and NIS is made difficult by the lack of resources, the failing infrastructure and inappropriate management structures inherited from the communist models. Nevertheless, even allowing for these constraints, it is apparent that the quality of care provided is often much worse than it need be (Figueras et al., 2004).

In Albania, most doctors working in primary healthcare facilities are not trained family doctors. There is no accreditation system for physicians, and no provisions for continuing medical education. Nurse numbers have been declining, despite the creation of a Faculty of Nursing and a College of Nurses. In addition, emigration is causing a brain drain, which is impacting on the ability of the health system to provide quality care (Tragakos, 2003).

5. *Decentralisation*

For decentralisation to function well, local levels of government must have administrative and managerial capacity to manage their new responsibilities. Countries with successful local government administration of healthcare typically have had it for a long time. Moreover, decentralisation can lead to fragmented services, weakened central health departments, political manipulation to favour particular interests, and a weakening of the public sector (Hunter et al., 1998).

Decentralisation can also increase inequity by limiting the sharing of resources—both human and financial—among regions and contributing to regional imbalances. Healthcare requires significant revenue, while the possibilities for local government to raise this revenue are limited. Decentralisation can impede adequate pooling of resources, with some rich areas reluctant to allocate resources to poorer areas (Dixon et al., 2004). In Bulgaria, municipalities became responsible for most healthcare provision following decentralisation in 1992, and continued to provide financing for hospitals after the social-insurance system was established in 1999. The regional distribution of healthcare funds was often inequitable and lacked transparency and accountability (Koulaksazov et al., 2003).

In many Central and Eastern European countries, decentralisation only took place on paper. Albania's Ministry of Health remains the main funder and provider of healthcare services. Efforts to decentralize have been slow, with the creation of the Tirana Regional Health Authority in 2000 to manage primary care and public health services (Tragakes, 2003).

6. *Regulation*

While reformers attempted to put in place regulations supporting the reform effort, constant turnovers in government and in the civil service undermined the reform process. In addition, reform analysts neglected to assess governance capacity for implementing reforms. States lacked the capacity to implement these regulations.

B. Reforming Healthcare Financing and Payment Systems

Health-insurance systems have been hindered by weak economies with low employment levels and little formal activity within labour markets. As a result, social-insurance schemes in most countries have a narrow revenue base. While a large informal economy exists in most countries, those operating within it evade contributions. Insurance schemes have been further undermined by the inability of unemployment and pension funds to transfer the required resources to health

insurance. High levels of corruption within the insurance organisations have also hindered progress (Dixon et al., 2004, Figueras et al., 2004). In Macedonia, revelations of corruption in the health-insurance fund contributed to the government being voted out of office in 2002 (International Crisis Group, 2002c).

As a result of these factors, in most countries in Eastern Europe social insurance has failed to generate enough revenue to finance the health system. Healthcare is instead funded by a combination of taxation, social insurance, voluntary insurance, and out-of-pocket payments. The income of the Bulgaria National Health Insurance Fund was limited by the low tax base, and is only able to fund outpatient care, outpatient pharmaceuticals, and twenty percent of inpatient care (Koulaksazov et al., 2003). In Albania, the Health Insurance Institute was established in 1995, but still receives the majority of its funding from the state budget (Tragakes, 2003).

The limited success in implementing social insurance has generated serious equity issues. While entitlement is theoretically universal, there are substantial differences between the ability of certain population groups, including the poor, rural communities, and some ethnic groups such as the Roma, to access services (Dixon et al., 2004). Bulgaria has institutionalized co-payments to buttress the referral system, but also to provide additional funds to the health sector. Such cost-sharing has had an impact on equity, as co-payments are not affordable for lower-income groups (Koulaksazov et al., 2003).

Under-the-table payments are common throughout Central and Eastern Europe. Informal payments are highest for inpatient (hospital) care. They are a result of cultural practises, the lack of a cash economy, poor salaries, lack of drugs and basic equipment, and weak governance (Dixon et al., 2004). A household survey in Albania estimated that private payments to providers, including under-the-table payments, to be just under twenty-five percent of total out-of-pocket expenditure (Tragakes, 2003).

Expenditure for private healthcare is also significant in some countries in Central and Eastern Europe. The existence of private clinics siphons resources away from the public sector. Moreover, some countries are unable to regulate these clinics, effectively leading to quality-control issues.

While some countries in the region have made efforts to identify a distinct package of health benefits, this has been a difficult process. In Bulgaria, the National Health Insurance Fund guarantees the financing of basic health services, but the scope of these services is subject to annual revision (Koulaksazov et al., 2003).

Governments struggle to clarify what should be publicly funded for several reasons. Information about the cost-effectiveness of health interventions is not available due to the weakness of health-information and management systems. Citizens also see healthcare as a right, and do not want any cuts in benefits. Providers also oppose any cuts in entitlements (Dixon et al., 2004). As a result of this failure to define a basic benefits package, the boundaries between public and private insurance are not clear (Dixon et al., 2004).

Efforts were made to increase efficiency by discontinuing line-item budgeting and implementing performance-based contracts in most regions, yet some countries have been unable to implement this system. In Ukraine, financing has retained the Soviet tax-based approach, and budget allocation remains based on a list of permitted line items, determined on the basis of hospital capacity (Lekhan et al., 2005).

In performance-based systems, budgets of primary care facilities are often established through a capitation system, with some countries experimenting with fee-for-service and other incentives to attract physicians to rural placements. In secondary-care facilities, performance-based systems are based on *per diem* and per-case or fee-for-service payment. These methods of financing secondary care have sometimes driven up the volume of cases admitted. Under some fee-for-service models, perverse incentives can exist for secondary facilities to treat patients, costing purchasing organisations too much money and also undermining efforts to enhance primary care. In Croatia, a capitation system was utilized at the primary care level, while specialists were paid on the basis of a fee-for-service system. As a result, both primary care physicians (who received funding based on the amount of people they had on their patient list, not for the services they provided) and specialists (who received money for services provided) had an incentive to manage patients at the secondary level (Dixon et al., 2004).

The establishment of contracts has often proven difficult. Without functioning health-information systems, the data necessary to establish these contracts is just not available. Technical and management skills to implement these contracts are also lacking. Moreover, the inadequate and unpredictable funding flowing from social-insurance organisations means that insurers cannot pay all providers' bills. In Bulgaria, the National Health Insurance Fund does establish performance-based contracts with hospitals, but only has the resources to cover twenty percent of inpatient care (Koulaksazov et al., 2003). With so many actors allocating funds and attempting

to control these funds (the social-insurance organisation, commercial insurers, central and local authorities) resource pooling is fragmented, and establishing performance-based contracts and planning service delivery is undermined (Dixon et al., 2004).

C. The Impact of Reform on Population Health

There is much regional variation in population health throughout Central and Eastern Europe. While deaths from injuries and violence increased across the region, mortality from communicable and non-communicable diseases varied dramatically by region. While some countries such as the Czech Republic experienced improvements in life expectancy, in others life-expectancy rates fell and a health crisis unfolded (McKee and Fidler, 2004, McKee, 2004).

One of the objectives of health reform is to improve population health. By that measure, the reform process received failing grades in the states of the former Soviet Union. In 1993, Russia was the first industrial nation to experience a sharp decrease in its population for reasons other than war, famine, or disease epidemic (Field and Twigg, 2000). By the year 2000, life expectancy for men in Russia was two years lower, while for women it was three quarters of a year lower than life expectancy in 1980 (Field and Twigg, 2000). Russia was not alone. In Bulgaria, life expectancy for women dropped from 75.1 years in 1989 to 74.6 years in 2000, while male life expectancy fell from 68.6 years in 1989 to 67.6 years in 2000. Mortality from chronic conditions increased, caused by unhealthy lifestyles, unbalanced nutrition, poor environmental conditions, and increased poverty (Koulaksazov et al., 2003).

The MONEE project [Monitoring in Central and Eastern Europe] estimates that 'excess mortality' in the region over 1990-99 totalled some 3.26 million deaths. These are the deaths that would not have occurred if mortality rates had stayed at the 1989 levels (taking into account the changes each year in the age structure and size of the population). Of these deaths, 72 percent were to males, and three-quarters to persons aged over 25 and under 60—the crisis has predominantly been one affecting adult men. (The Monee Project, 2001)

Several factors contributed to this mortality crisis. The transition from communism to liberal democracy caused significant social and economic stress. Higher rates of unemployment and the dismantling of the social safety nets caused lower household income and higher poverty. The resulting psychosocial stress contributed to higher rates of cardiovascular disease and increased substance abuse (The Monee Project, 2001). Smoking rates, alcoholism, and other forms of substance abuse rose dramatically. Increased rates of injection drug use contributed to the spread of HIV/AIDS. Although infant mortality appeared to fall, malnutrition rates among

children were alarmingly high. And an increase in violent crime led to more deaths from homicide, while suicide also became more prevalent (The Monee Project, 2001, Field and Twigg, 2000, McKee and Fidler, 2004, McKee, 2004).

Thus the social contract that was struck between the state and the people under the communist regime has been to a large extent abrogated, leading to what some have called ‘state desertion’ and leaving millions of people stranded in despair, poverty, and destitution. It has been estimated that the top 10 percent of the population possesses half of the nation’s wealth, and the bottom 40 percent less than 20 percent of that wealth. Somewhere around 40 or more million people live below the poverty line, currently defined at about \$30 per month. Privatisation has also led to a flight of capital abroad estimated at \$200-500 billion, paralleling a stark decrease in production, both industrial and agricultural, and thus a decline of the gross domestic product. The famous, and now notorious ‘shock therapy’ became more shock than therapy, leading to political instability, corruption, and criminalisation at the highest levels of government. (Field and Twigg, 2000)

While many factors external to the healthcare system impacted on population health, the deteriorating state of the health system—and the failure of the health-reform process—should also be considered a contributing factor.

Deaths from causes amenable to health care have been falling faster than overall mortality in Western Europe since the mid-1960s. In contrast, in the USSR, deaths from these causes remained steady, contributing to the widening mortality gap with the west. (McKee, 2004)

The lack of access to pharmaceuticals as well as the failure to implement evidence-based medicine reduced the ability of the health system to provide timely and appropriate interventions (McKee, 2004).

The poor state of the health system also undermined the response to public-health issues such as rising tuberculosis cases and the spread of HIV/AIDS. The incidence of tuberculosis rose by about fifty percent in the region in the decade following 1989. The worst outbreaks were found in Kyrgyzstan, while Russia also experienced rising case numbers. The situation was compounded by the appearance of drug-resistant strains of tuberculosis. Economic recession, poverty, social upheaval, malnutrition, overcrowded prisons, and increased homelessness, combined with the lack of appropriate drug therapy, contributed to drug resistance (The Monee Project, 2001).

The response to the rising incidence of HIV/AIDS was similarly inadequate (Rechel and McKee, 2003). The region has the fastest growth in HIV cases in the world. In most countries of Central and Eastern Europe, risk factors exist for a devastating epidemic of HIV/AIDS. High rates of intravenous drug use and unsafe sex

practices among the heterosexual population are driving the epidemic. Women are accounting for an increasing share of new HIV infections, increasing the risk of mother-child transmission. Because of cultural attitudes towards men who have sex with men, there are fears of hidden epidemics among that population (UNAIDS, 2004). Yet the response from governments is slow: Ukraine, the country with the highest per-capita prevalence of HIV infection within Europe, lacks a public-health information service and sex education in schools, and has no national dissemination strategy for prevention of HIV/AIDS (DeBell and Carter, 2005).

Inequity has also risen, with barriers to access for poor and minority groups as a result of under-the-table payments and general discrimination (Rechel and McKee, 2003).

Since informal payments bypass the official system, they in effect reinforce their cause: the scarcity of public financial resources. They also interfere with incentives to provide health care more efficiently and effectively. If unofficial payments make up a significant proportion of the incomes of doctors and others working in the health sector, then the effect of any reform in the official wage system is diluted. In some cases, incentives could even be contradictory. (The Monee Project, 2001)

While current trends are not promising, it has been little more than a decade since the beginning of the transition period. Reform, particularly the retraining of physicians and the restructuring of health centres, is a lengthy process. Years may pass before widespread health benefits are seen.

APPENDIX TWO: THE PATH TO WAR IN KOSOVO

Kosovo lies in the heart of the Balkans and at the crossroads between Europe and the Middle East. Although only 10,686 square kilometres in size (smaller than Connecticut), Kosovo was historically important as a trading route, as well as a critical source of natural resources. Economic migration and various wars ensured that its population was heterogeneous, including Albanians and Serbs, with smaller numbers of Turks, Roma, and Jews. While Serbs and Albanians lived peacefully together for much of the last several centuries, their coexistence has also been marred by periods of bitter violence.

Kosovo has been the site of many conflicts over the centuries, including the infamous battle of 1389 on the fields of Kosovo Polje (also known as the Field of Blackbirds) between a Serbian-led coalition and the Ottoman Empire. The defeat of the Serbian army during this battle marked the beginning of over five hundred years of Ottoman rule, an occupation marked by periods of revolt, but which lasted until 1912 when Serbian armies reclaimed Kosovo. After the end of the First World War, Serbian control over Kosovo was consolidated (Malcolm, 1998, Judah, 2000).

Kosovo is symbolically important to both the Serbian and Albanian populations. It contains many historically significant Serbian Orthodox sites, such as the Gračanica Monastery, the Pec Patriarchy, the Decani Monastery, and the Monastery of the Holy Archangels in Prizren. Serbs undertook repeated uprisings against Turkish domination, and the Serbian religion and culture withstood centuries of Ottoman rule. This survival in the face of adversity attained mythical status, and as result Kosovo became a rallying cry for Serbian nationalists as a symbol of the resilience of Serbian culture (Malcolm, 1998, Judah, 2000).

For Albanians, who now form the significant majority of the province's population, Kosovo has been their home for centuries. Under the Ottoman Empire, many previously Catholic Albanians converted to Islam, and over time the Albanian aristocracy received important administrative positions and some rose to prominence in the Ottoman bureaucracy. In the 1800s, Albanians in Kosovo began to struggle for recognition of their cultural, linguistic, and religious rights within the Ottoman Empire. This struggle continued as Kosovo became part of the Kingdom of Serbs, Croats, and Slovenes after World War One, and as part of the Socialist Federal Republic of Yugoslavia after World War Two. While Josip Tito, the leader of Yugoslavia, did not grant Kosovo the status of a republic, Kosovo became an autonomous province of the

Republic of Serbia under the 1974 Yugoslav Constitution. This meant it could write its own Constitution and have its own Parliament. As a result, Albanians gained political tools to protect their language and culture, opening an Albanian language university in Pristina (Malcolm, 1998, Judah, 2000).

I. WHERE IT STARTED AND ENDED: KOSOVO AND THE DISSOLUTION OF YUGOSLAVIA

Josip Tito died in 1980, and his death was a harbinger for the break-up of Yugoslavia. Kosovo was the place where the dissolution of Yugoslavia began (in 1989), and where it will most likely end, if Kosovo achieves its independence.

In 1981, Yugoslavia was in a period of economic decline. Real incomes had fallen, as inflation skyrocketed. Between 1979 and 1989, inflation averaged 123 percent annually (Kunitz, 2004). The standard of living of ordinary citizens was declining precipitously. In Kosovo, many Albanians felt that despite the province's autonomous status, power rested with Serbs or with pro-Serb Albanians. Kosovo was the poorest region in the Yugoslav federation with a 1979 annual per capita income of only \$795, while the Yugoslav average was \$2,635. Unemployment among the Albanian population ran high. Serbs and Montenegrins, who formed fifteen percent of the population, held thirty percent of the jobs (Malcolm, 1998). A student protest over the poor quality of food that began in the canteen of Pristina University (in the capital city) transformed into days of street demonstrations, unleashing pent-up Albanian frustration. Demonstrators demanded that Kosovo become its own republic or unite with Albania. Authorities panicked, and a severe crackdown on the protestors ensued. While casualty figures were never released, hundreds were injured and dozens killed. More than two thousand were arrested and given sentences ranging from one month to fifteen years. Top officials in the communist party in Kosovo were dismissed from their posts (Malcolm, 1998). The lasting legacy of these demonstrations was the resurgence of overt ethnic enmity between the Serbian and Albanian communities.

Partly because of the poor state of the economy and partly because of tension with the Albanian community, many Serbs were leaving the province. Serbian nationalists began to publish accounts of harassment of Serbs in Kosovo, and cited the exodus of Serbs from the province as the result of ill treatment. This culminated in a 1986 *Memorandum* written by the Serbian Academy of Arts and Sciences, which claimed that two hundred thousand Serbs had been forced from Kosovo in the 1970s and 1980s, and which argued that Albanians had literally declared war on Serbs (Judah, 2000).

Slobodan Milosevic, who rose to become the head of the Serbian Communist Party in 1986 and officially became President of the Serbian Republic in 1989, exploited the grievances of Kosovo's Serbs as part of his political ambitions. In 1987, he told Serbian demonstrators who were clashing with Albanian police officers outside Pristina (a demonstration he had organized) that, "no-one dare beat you." In March 1989, he arranged for the Kosovo Parliament to rescind Kosovo's autonomy. And in June 1989, on the six hundredth anniversary of the Serb defeat against the Turks in 1389, he addressed a million Serbs gathered at the site of the battle, stating, "After many decades, Serbia has her state, national, and spiritual integrity back.... Six centuries later, we are in battles and in quarrels. They are not armed battles, though such things should not yet be excluded" (as quoted by (Judah, 2000)).

A spate of laws was passed in the early 1990s that further curtailed Albanian rights. To stem the exodus of Serbs from the province, a prohibition on land sales from Serbs to Albanians was introduced. Many Albanians who worked in state institutions and state enterprises (including teachers, doctors, and factory workers) lost their jobs, Belgrade imposed its curriculum on schools, and publicly funded primary and secondary education was provided only in Serbian. Pristina University became a Serbian-language institution.

Albanians reacted furiously to these measures. However, unlike their neighbours in Slovenia, Croatia, and Bosnia, they did not immediately take up arms against the Serbian government. Instead, they began a campaign of passive resistance. The political party known as the Democratic League of Kosovo (LDK) was formed, whose leadership was composed mainly of Albanian intellectuals. In 1991, Albanians held a referendum on independence for Kosovo. The vote was not recognised by Serbian authorities, but was not blocked, either. Voters overwhelmingly chose the option of independence. In 1992, Albanians held a second vote to form a parallel government and elected Ibrahim Rugova as president. A parallel education system was established, including primary, secondary, and university education; basic healthcare was provided by the Mother Theresa network; and a taxation system collected funds to support this parallel government and social structures. Throughout this difficult time, remittances from Albanians living outside the province financially supported both the government as well as Albanians who had lost their jobs (Judah, 2000).

While the campaign of passive resistance avoided war, the political objectives of independence or even autonomy were not realized. And the situation in Kosovo was far from calm. Serbian authorities regularly accused Albanian extremists of attacks against police. Human-rights organisations reported human-rights abuses ranging from intimidation of Albanian political activists to police attacks on Albanian civilians. Impatience with the status quo grew. After the issue of Kosovo was not addressed at the Dayton Peace Conference in 1995, many Albanians believed that the international community was not rewarding Kosovo's peaceful approach. Albanian support for the campaign of passive resistance eroded, and animosity grew between those who wanted to continue resisting peacefully and those who wanted to oust Serbian rule by force (Judah, 2000).

II. FROM SIMMERING CONFLICT TO ALL-OUT WAR

The Kosovo Liberation Army (KLA) was formed in 1993, aligned with a political party with Marxist leanings known as the LPK (the Popular Movement for Kosovo). The KLA lacked a central command structure and its various regional commanders operated semi-autonomously. They remained relatively unknown, with little military might until the collapse of the pyramid schemes in Albania in 1997. One of the results of the chaos that accompanied the collapse of these schemes was the opening of government arms caches. Albania became awash with Kalashnikovs, and the KLA acquired from Albania the weapons that they needed to scale up their guerrilla activities. Therefore, in 1998 the KLA emerged as a significant if uncoordinated guerrilla force, undertaking frequent strikes on Serbian police and army checkpoints (Judah, 2000).

The Serbian army reacted harshly, undertaking brutal retaliatory attacks on villages where KLA members were suspected of hiding. Paramilitary units were also established. In one important turning point in March 1998, police attacked the "Jashari" family compound, whose patriarch, Adem Jashari, was a member of the KLA. In total, fifty-eight people were killed, including eighteen women and ten children under the age of sixteen (Judah, 2000). The village in which they lived was razed to the ground. The period of intense civil strife began with the deaths of the Jashari family.

The most intense fighting was in Central Kosovo (known as Drenica) and Western Kosovo. The pattern of the conflict was similar in many villages across Kosovo. KLA members undertook attacks on Serbian police and military checkpoints.

attempted to gain control of the territory, and intimidated the local Serbian civilian population (often by kidnapping or killing civilians suspected of Serbian paramilitary activity) in an effort to get them to leave. The military responded with brutal retaliatory attacks on Albanian villages, resulting in civilian deaths and a flood of internally displaced people. In one such attack on January 15 in Racak, forty-five Albanian civilians were killed in an apparent Serbian police raid.

As the conflict intensified, so did the divide in the Albanian community between those who supported the KLA and those who supported the campaign of non-violent resistance led by the LDK. Those who were associated with the KLA tended to be rural-based, while those associated with the LDK were more urban.⁸⁸ This divide continues to haunt Kosovo.

III. THE NATO INTERVENTION

Efforts to broker a peace agreement between the Kosovo Liberation Army and the Yugoslav government collapsed, with Yugoslavia's failure to sign the Rambouillet Agreement, which had outlined an arrangement for autonomous self-government in Kosovo. On March 24, 1999, a NATO-led coalition began a 78-day aerial bombing campaign. The objective, as outlined by President Clinton, was as follows:

We act to protect thousands of innocent people in Kosovo from a mounting military offensive. We act to prevent a wider war; to diffuse a powder keg at the heart of Europe that has exploded twice before in this century with catastrophic results. And we act to stand united with our allies for peace. By acting now we are upholding our values, protecting our interests and advancing the cause of peace. (Clinton, 1998)

NATO fully expected the air campaign to last only a few days, seriously underestimating the Serbian commitment to Kosovo. Milosevic anticipated that the bombing campaign would be short, believing that the coalition would break down, underestimating NATO's commitment to winning the war.

With the initiation of aerial bombardments by NATO, the Yugoslav army and paramilitary forces initiated a campaign of ethnic cleansing in Kosovo known as "Operation Horseshoe."⁸⁹ Over a million Albanians were driven from their homes, with 800,000 refugees fleeing to neighbouring countries and an estimated 400,000

⁸⁸ In the face of the assault on Albanian villages by the Serbian military, the LDK eventually sponsored its own army, known as FARK (Armed Forces of the Republic of Kosova). FARK was unable to operate effectively, and many of its members joined the KLA. JUDAH, T. (2000) *War and Revenge*. New Haven, Yale University Press.

⁸⁹ There is controversy over whether or not this was an official plan by the Serbian government. Little proof existed of this plan beyond western intelligence information presented during the bombing campaign.

displaced within Kosovo (Leaning, 2003). Politicians, human-rights activists, and other prominent Albanians were abducted and killed. An estimated 10,500 Albanians died at the hands of both paramilitary and military forces (American Bar Association and AAAS, 2000).

Albanian houses were also destroyed as part of this campaign of ethnic cleansing. The European Commission reported that out of a housing stock of 250,000 houses, almost half (approximately 120,000 homes) sustained war-related damage. Out of the 120,000 damaged houses, 41,000 were not seriously damaged, or sustained moderate damage (5 to 40 percent damage); 32,000 were badly damaged (41 to 60 percent damage); while 47,000 were effectively destroyed with only the foundation remaining (61 to 100 percent damage). The houses of approximately 500,000 people fell into IMG damage categories III and IV (European Agency for Reconstruction, 1999).

Several factors led to the end of the bombing campaign. The aerial bombardments were taking a toll on the civilian infrastructure in Serbia, and the Yugoslav government's appetite for continuing the war was fading. Milosevic was indicted for war crimes on May 24, 1999, and he realized that unless he agreed to a peace deal his days in power would be numbered. The KLA were continuing their offensive in Kosovo, and combined with NATO bombing, the Yugoslav army was suffering casualties. NATO countries began preparing for a ground offensive, which Milosevic knew would drive him from office. And the international community feared the consequences of failure, sending mediators Victor Chernomyrdin and Marti Ahtisaari to begin a process of mediation using a G8 gathering in Cologne to outline the basic principles of a settlement (Judah, 2000).

APPENDIX THREE: STAKEHOLDER INTERVIEWS

I. THE QUESTIONNAIRE

The objective of the stakeholder interviews was to gather and examine data to test the hypothesis that the following three factors would impact on the reform process:

- *External pressures* for reform, and the extent to which this impacts on the *legitimacy* of the health-reform process;
- The socio-economic and political environment that weakened the *capacity* of the state to oversee reforms;
- Compressed nature of the reform process, which impacted on the *progress* and *sustainability* of reform.

Stakeholder questions were therefore designed to assess the following factors:

- *External pressures* for reform, which impact on the *legitimacy* of the reform process;
- The *capacity* of the state to oversee and implement the reform process, including the ability of the government to communicate its vision for reform and respond to concerns;
- The *compressed time frame for reform*, impacting on the progress of reform and perceived sustainability of the reform process;
- Information on the *progress of health reform* was also gathered.

The results of stakeholder interviews were to be combined with health data and management data to ascertain the degree to which health reform had been implemented, the capacity of the state to oversee the health sector and implement the reform process, and the degree to which key stakeholders agreed with the reform process.

The interviews and data gathered would also investigate regional differences in reform implementation, focusing on three regions: Pristina (Central), Gjilan (South East), and Prizren (South West). These three regions were selected as they were the least damaged by the war and lacked the minority politics that plagued other regions. Please refer to the Kosovo map in Appendix Four.

The questionnaire was tested on three people prior to interviewing stakeholders: two international and one Albanian. Closed questions were developed, with an open question at the end to provide for clarification of response and explanations of position. The questionnaire was translated into Albanian and then backtranslated for verification. Stakeholders provided consent for the interviews and were interviewed by one physician in Albanian, without the author present to reduce bias. The author met with the physician conducting the interview regularly during the interview process to ensure that the interviews were going smoothly. The results of these interviews were translated into English.

II. INFORMATION SHEET AND CONSENT FORM

The following information sheet and consent form were provided to stakeholders participating in the study.

INFORMATION SHEET

Study Title: Analysis of Health Reform in Kosovo
Investigator: Valerie Percival
number: (+377) 044 161 215
email: val_percival@hotmail.com
Purpose of Study: Research for a Doctorate in Public Health
London School of Hygiene and
Tropical Medicine

Objective of Study:

This study will analyse the ambitious health reform program that the international community is undertaking in Kosovo. The study will focus on how to evaluate health reform, the capacity of the government to implement reforms, and how the reform program has impacted on minority communities.

Key stakeholders will be interviewed, including Kosovars working in the Ministry of Health, the Institute of Public Health, the District Health Offices, and in health facilities. Internationals working with the Ministry of Health, the World Health Organization, and other United Nations Agencies will also be interviewed.

The goal of these interviews is to understand both international and Kosovar opinions on the reform process. During this interview, you will be asked for your opinion on key issues such as how the international community has discussed the process of reform with Kosovars, why the reform process is happening, how the reforms are being implemented, how the provision of health care has changed since the reform program began, and whether the reforms have improved the delivery of health services.

This research is not for profit. It is hoped that the results of the study will facilitate the health reform process in other countries.

Confidentiality:

During the interview, answers to questions will be recorded on the questionnaire. Before the interview begins, you will be asked to read sign a consent form. This form signifies that you understand the purpose of the interview and that you agree to have your comments used in written articles. *If you require or prefer confidentiality*, your comments will be cited but no reference will be made to your name or your position.

CONSENT FORM

Study Title: **Analysis of Health Reform in Kosovo**

Investigator's Name: **Valerie Percival**

Contact Number: **(+377) 044 155 675**

Contact email: **val_percival@hotmail.com**

I have read the information sheet concerning this study and I understand that the opinions expressed during my interview will be recorded on paper.

If I agree to have my name cited, I understand that my name may appear in the thesis or in other articles resulting from this research. If I do not agree to have my name cited, I understand that my comments may be included in the thesis and other articles resulting from this research, but **no** reference will be made to my name or my position.

I give/ do not give (please circle one) my consent to have my name cited in any articles or written work arising from this study.

Valerie Percival has answered my questions concerning this study.

I understand that at any time I may withdraw from this study by contacting Val Percival at the contact number/email address above. I understand that after July 1st, 2003, Val Percival will no longer be living in Kosovo and I will contact her by email.

I agree to take part in this study.

Signed:

Date:

III. SELECTION OF STAKEHOLDERS

Stakeholders were selected based on the following criteria:

- Active involvement in the health sector;
- Senior positions in the health sector; and
- Impacted by the reform process.

An effort was made to incorporate regional perspectives to ensure that the results were representative, and not skewed in favour of the capital region.

A. List of Stakeholders

1. *Central Level Stakeholders*

1. Dr. Pleurat Sejdiu, Permanent Secretary (most senior civil servant), Kosovo Ministry of Health (February 24, 2003). Shortform in transcript below: Sejdiu.
2. Fetije Huruglica, Head of Nursing, Kosovo Ministry of Health, (March 7, 2003). Shortform in transcript below: Huruglica.
3. Dr. Ferid Agani, Head of Strategic Planning, Kosovo Ministry of Health (March 7, 2003). Shortform in transcript below: Agani.
4. Fekrije Hasani, Development of Nursing Program (NGO), Pristina (March 5, 2003). Shortform in transcript below: Hasani.
5. Dr. Driton Ukmata, Head of Mission, Handicap International (NGO), Pristina (March 17, 2003). Shortform in transcript below: Ukmata.
6. Dr. Naser Ramadani, Epidemiologist, National Institute of Public Health, (March 27, 2003). Shortform in transcript below: Ramadani.
7. Dr. Lumturiye Gashi, Chief Pathologist, Pathology Clinic, Pristina University Hospital (February 24, 2003). Shortform in transcript below: Luma.
8. Dr. Sebahudin Ahmeti, Health Consultant (Member of Health Law Working Group), March 13, 2003. Shortform in transcript below: Ahmeti.
9. Dr. Ilir Begolli, Head of Social Medicine Department, National Institute of Public Health (March 24, 2003). Shortform in transcript below: Begolli.
10. Dr. Genc Ymerhalili, Director of Family Medicine Development Centre, Kosovo Ministry of Health (Pristina) (February 28, 2003). Shortform in transcript below: Ymerhalili.

2. *Regional Stakeholders*

11. Dr. Sami Rexhepi, District Health Officer, Pristina (February 27, 2003). Shortform in transcript below: Rexhepi.
12. Dr. Erdina Kabashi, Public Health Coordinator, Prizren (February 24, 2003). Shortform in transcript below: Kabashi.
13. Dr. Sadije Sllamniku, Family Medicine Specialist, Gjilan (March 20, 2003). Shortform in transcript below: Sllamniku.
14. Dr. Hajriz Shaqrir, Family Medicine Specialist, Gjilan (March 19, 2003). Shortform in transcript below: Shaqrir.
15. Dr. Myrvete Ajete, Family Medicine Specialist, Pristina (March 4, 2003). Shortform in transcript below: Ajete.
16. Dr. Fadil Bajraktari, Family Medicine Specialist, Prizren (February 24, 2003). Shortform in transcript below: Bajraktari.
17. Dr. Hajriz Ibrahim, Family Medicine Specialist, Director, Gjilan Family Medicine Centre (March 20, 2003). Shortform in transcript below: Ibrahim.

18. Dr. Abdullah Hoti, Family Medicine Specialist, Director, Pristina Family Medicine Centre (March 5, 2003). Shortform in transcript below: Hoti.
19. Dr. Blerim Qosaj, Orthopaedic Surgeon, University Clinical Centre, Pristina (March 24, 2003). Shortform in transcript below: Qosaj.
20. Dr. Rrahman Hajdari, Clinical Director, Gjilan Hospital, (March 20, 2003). Shortform in transcript below: Hajdari.
21. Dr. Refki Selaj, Internal Medicine Specialist, Prizren Hospital (February 24, 2003). Shortform in transcript below: Selaj.
22. Dr. Uke Tahirukaj, Paediatrician, Pristina Family Medicine Centre (March 4, 2003). Shortform in transcript below: Tahirukaj.
23. Arijeta Bicku, Nurse, Main Family Medicine Centre (February 24, 2003). Shortform in transcript below: Bicku.
24. Blerina Morina, Headnurse, Main Family Medicine Centre, Prizren (February 24, 2003). Shortform in transcript below: Morina.
25. Myrvete Sopi, Main Nurse, Main Family Medicine Centre, Pristina (March 3, 2003). Shortform in transcript below: Sopi.
26. Hanife Hoxha Telaku, Headnurse, Family Medicine Centre Prizren (February 24, 2003). Shortform in transcript below: Telaku.

IV. PROBLEMS ENCOUNTERED

Generally, the interviews were too long and the questions too complicated, and the same questions should have been given to all stakeholders. Moreover, some of the questions about health-system performance were ambiguous, particularly questions 30 and 31, as it was not clear to what the reformed healthcare system should be compared—the war-time health system, the health system in the 1990s (either the Serbian health system or the Mother Theresa Network), or the health system in the 1980s. In Question 34, the option of continuing the health reform was not included.

Health data and management data were largely unavailable in 2003. Data was only available for a limited number of centres involved in pilot projects with the European Agency for Reconstruction.

Given this lack of health data, the original objective of assessing regional variations in health-reform implementation was not possible.

V. ANALYSIS OF RESULTS

A. The Process

Transcribed: The interviews were conducted in Albanian by one interviewer, and were transcribed into English by a second interpreter. The interview results were then consolidated and formatted by the author.

Coding: The following codes were used:

- External Pressures
- Legitimacy
- Capacity
- Communicate/Respond
- Compressed Time Frame
- Progress

- Sustainability

Discarded Results: Interviews were conducted with patients at various health facilities. These interviews were discarded because the patients did not demonstrate sufficient knowledge of the health-reform process.

Significance: Responses were deemed significant in a majority of cases. If the majority response was gained with only with one or two stakeholders, the responses were judged to be split, and not significant.

Lessons Learned: The interviews were too long and complicated, attempting to gather too much data. The questionnaires should have contained no more than twenty questions.

B. The Results

External Pressures for Reform:

- Question 4: All central stakeholders identified post-conflict political pressure or economic reasons as driving reform.
- Question 4b: Regional-level stakeholders identified health issues as driving the reform process.
- Question 4c: The majority of regional stakeholders believed international donors and UNMIK/WHO were behind the reforms.
- Question 9: Most stakeholders indicated that Kosovars had moderate input; in their verbal comments they expressed concern that reforms were ready-made.
- Question 10: Almost half of stakeholders indicated that the opinions of Kosovars surrounding the reform process did not significantly alter the Health Policy. They argued again that the reforms had been ‘ready-made’ by internationals.

The Legitimacy of the Reform Process:

- Question 4: The fact that external pressure drove the reform process may have undermined its legitimacy.
- Question 9: Because Kosovars had moderate input into the reform process, its legitimacy may have been undermined.
- Question 10: As the views of Kosovars did not significantly alter the Health Policy, this may have undermined the legitimacy of the reforms.
- Question 11: The majority of stakeholders stated that information was provided in the correct language. Most regional-level stakeholders stated that only ‘sometimes’ was the information provided in the correct language. This perhaps indicating the differential resources available for translation in the regions.
- Question 13: Most central-level stakeholders expressed doubt as to the level of commitment from Kosovars to the reform process.
- Question 14: Most stakeholders believed that the international community was only somewhat or not very committed to the reform process, undermining its legitimacy. Stakeholders expressed concern that the international community is not committed for the long-term.
- Question 24: The majority of stakeholders believed that the concept of family medicine has only been “tolerated,” not received enthusiastically.

The Capacity of the State to Oversee and Implement the Reform Process:

- Question 12: The majority of stakeholders believed that the Ministry of Health did not act sufficiently to implement reforms. This view was particularly marked among central-level stakeholders.
- Question 17: Most stakeholders believed that national standards for professional qualifications in primary care health facilities are enforced.
- Question 21: All stakeholders indicated that national standards reflect the objectives of the reform program.
- Question 22: All but three stakeholders agreed that the state was not able to enforce its standards in private clinics.
- Question 23: The majority of stakeholders believed that the services available at primary care health facilities did not meet the guidelines set out in Kosovo's health-policy document.
- Question 25a: The majority of regional stakeholders stated that family-medicine teams did not function in their areas of responsibility.
- Question 27: When asked an open-ended question about the problems faced in the implementation of family medicine, six of seven central-level stakeholders who answered this question mentioned human resource-related issues—lack of trained doctors, the need for more training.

The Ability of the New Kosovo Government to Communicate Its Vision for Reform and Respond to Concerns:

- Question 5: The majority of stakeholders indicated that discussion of the reforms with Kosovo health professionals was moderate or infrequent. The majority of stakeholders expressed concern with the lack of discussion surrounding reforms—particularly after the initial Yellow Book consultation.
- Question 6: In female-dominated health sectors (nurses and midwives), all but one stakeholder indicated that discussion had been moderate or infrequent.
- Question 7: Stakeholders agreed that the reforms were not sufficiently communicated to the public; however, some stakeholders argued that this was all that was possible or necessary at the time.
- Question 11: The majority of stakeholders stated that information was provided in the correct language. Most regional-level stakeholders stated that only 'sometimes' was the information provided in the correct language.

The Compressed Timeframe for Reform:

- Question 3: While stakeholders were divided in their opinions of whether or not reform had been introduced too quickly, only two of eight central-level stakeholders who responded to the open-ended question provided positive feedback. The others stressed that change was too rapid, the system was in chaos, insufficient data existed to take reform decisions, and there were no preparations for reform implementation.

The Progress of Reform:

- Question 22: All but three stakeholders agreed that the state was not able to enforce its standards in private clinics.
- Question 23: The majority of stakeholders believed that services available at primary care health facilities did not meet the guidelines set out in Kosovo's health-policy document.
- Question 25a: The majority of regional stakeholders stated that family-medicine teams did not function in their areas of responsibility.

- Question 27: When asked to identify three main problems faced in the implementation of family medicine, the one factor commonly referred to was human resources—mentioned by six out of seven stakeholders.
- Question 31a: Most stakeholders believed that rural populations were better served after the reforms.
- Question 31b: Most stakeholders believed that the poor were not served as well after the reforms.
- Question 31c: Most stakeholders believed that women were better served after the reforms.
- Question 35: Most stakeholders believed that decentralisation of primary care responsibility has made no change or worsened the delivery of care.
- Question 36: Most stakeholders believed that decentralisation of public-health responsibility has made no change or has worsened the delivery of care.

Perceived Sustainability of the Reform Process:

- Question 13: Most central-level stakeholders expressed doubt as to the level of commitment from Kosovars to the reform process.
- Question 14: Most stakeholders believed that the international community was only somewhat or not very committed to the reform process, undermining its legitimacy. Stakeholders expressed concern that the international community is not committed for the long term.
- Question 15: All stakeholders clearly believe that, without the active involvement and financing of the international community, the reform program will not succeed.
- Question 16: The majority of stakeholders did not believe that Kosovo has the necessary funds to implement the reform program.
- Question 24: Stakeholders indicated that there is not much support for family medicine—a response particularly marked among regional stakeholders.
- Question 26: Stakeholders were all optimistic for the future of family medicine under the right conditions.

Regional Differences:

There were no discernable differences in the responses from stakeholders from different regions (i.e. Gjilan and Prizren). On some questions—namely the driving force behind reforms and the use of the appropriate language to deliver health-reform information—there were differences between central-level and regional stakeholders.

VI. STAKEHOLDER QUESTIONS AND RESPONSES

Note: CS=Central Stakeholders; RS=Regional Stakeholders

<p>Question 1a: <i>Regional-Level Stakeholders Only</i></p>	<p>In the fall of 1999, the World Health Organization began the process of reforming the Kosovo health system to a primary care-based system. Do you understand the process of healthcare reform that is occurring in Kosovo?</p> <p>a. Understand it completely. b. Understand some elements. c. Confused by the process.</p>			
<p>Indicator/Analysis</p>	<p><i>A</i></p>	<p><i>B</i></p>	<p><i>C</i></p>	<p>Comments</p>
<p><u>Communicate/Respond</u> Validity problem: the verbal comments do not match the multiple-choice answer. There may have been a bias in response—to impress the interviewer.</p>	<p>9</p>	<p>5</p>	<p>1</p>	<ul style="list-style-type: none"> • I was informed late about the reform. (Kabashi) • Internationals working in Kosovo were working for very short periods of time; they did not know the culture, traditions, and problems in this country. Though they were experienced, they did not know what can be implemented and accepted in Kosovo. (Rexhepi) • Nurses at smaller facilities were not informed of the health policy. (Sopi) • Some levels of reform are not clearly defined. (Morina) • I was not interested, as I am a specialist in secondary care. (Selaj)
<p>Question 1b:</p>	<p>In the fall of 1999, the World Health Organization began the process of reforming the Kosovo health system to a primary care-based system. In November 2000 they published a policy document. Have you read the health-policy document?</p> <p>a. Yes. b. No.</p>			
<p>Indicator/Analysis</p>	<p><i>A</i></p>	<p><i>B</i></p>	<p><i>C</i></p>	<p>Comments</p>
<p><u>Communicate/Respond</u> The majority of those interviewed had read the health-policy document—not necessarily significant given that all those interviewed were in relatively senior positions.</p>	<p>19 CS: 11; RS: 8</p>	<p>6 CS: 1; RS: 5</p>		
<p>Question 2:</p>	<p><i>Did you attend any discussions about the reform or implementation of the health program?</i></p>			

	a. Yes. b. No.			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<p><u>Communicate/Respond</u> Most had attended discussions, but this is not necessarily significant given that all those interviewed were in relatively senior positions.</p>	19 CS: 10; RS: 8	6 CS: 2; RS: 4		
<p>Question 3: <i>Central-Level Stakeholders Only</i></p>	<p>In your opinion, was the idea of reform: a. too quickly introduced? b. introduced in timely fashion? c. too slowly introduced? Why?</p>			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<p>Indicator: <u>Compressed Time Frame</u> Analysis: Significant. While stakeholders divided in their opinion, some of the comments provide insight into stakeholder reactions to the reform timeline.</p>	6	4		<ul style="list-style-type: none"> • Changed too quickly from one system to another—not possible with post-war problems. (Luma) • There were no preparations for implementation—i.e. financial, human, and management resources. (Ahmeti) • There was an emptiness in the health sector, and it was the right time to do the job. (Begolli) • They should have taken more time to analyse the data. (Ukmata) • The post-war was the right time to try and reorganize the health system. It was a reasonable, timely attempt and positive attempt. (Hasani) • There was no constitution; the system was in total chaos, so we didn't know what is a good system. (Sedjiu) • There was not enough data to take reform decisions in health. Population and health staff were not informed enough about the benefits of reform. It was the post-war period, and people were surviving economically, trying to find incomes, having vital problems, and most of the people were oriented in business and privatisation. (Huruglica) • People did not know about the concept of family medicine. (Ymerhalil)

Question 4a: <i>Central-Level Stakeholders Only</i>	In your opinion, what was the driving force behind the reform?			
Indicator/Analysis	A	B	C	Comments
<u>External Pressure Legitimacy</u> Analysis: Significant. All stakeholders identified either political pressure or economic reasons as the driving factors behind reform.				<ul style="list-style-type: none"> • Driving force behind reforms was political pressure from the United Nations, economic. (Luma) • Economic and political reasons. (Ahmeti) • Post-war situation and Kosovars' enthusiasm. (Begolli) • After the war, there was political momentum, and the inherited communist healthcare system had to be advanced to prepare for regional and European integration. (Ukmata) • Economic reasons. (Hasani) • Politics after the war. (Agani) • Attempt to distance from previous system. (Sedjiu) • Economic reasons, as services were reorganized to be cost-effective. (Huruglica) • Economic reasons—the services are reorganized to be cost-effective (Ymerhalil)
Question 4b: <i>Regional-Level Stakeholders Only</i>	These reforms are happening for: a) Economic reasons. b) Health reasons. c) Political reasons.			
Indicator/Analysis	A	B	C	Comments
<u>External Pressure</u> Significant. Interesting that the key reason for reform given by regional stakeholders—health reasons—was not mentioned by central stakeholders.	6	10	2	<ul style="list-style-type: none"> • To offer better services to the patients. (Kabashi) • To improve Kosovo health system quantitatively and qualitatively. (Rexhepi) • All three reasons: Treatment of patients will be cheaper, one doctor from the beginning. (Sopi) • All three reasons—economic reasons—treatment with family medicine is cheaper for the state. (Bajraktari)
Question 4c: <i>Regional-Level Stakeholders Only</i>	Who do you believe is behind the reforms? a) International donors. b) UNMIK and WHO. c) Kosovars. Why?			

<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<p>External Pressure Significant. The majority of regional stakeholders indicated that internationals (donors or UNMIK/WHO) were behind the reform process.</p>	7	10	5	<ul style="list-style-type: none"> • Because of the experience of the WHO in other states, and the situation in Kosovo after the war. (Kabashi) • We have something that internationals do not have—experience here in Kosovo, lots of courage, and are very self-confident. (Rexhepi) • UNMIK, donors and Kosovars are all behind the reforms. (Bicku) • Kosovars were only workers for the internationals. (Tahirukaj) • Donors were the initiators of reform. (Hajdari) • Without Kosovars you cannot implement reforms. (Bajraktari)
<p>Question 5:</p>	<p>In your opinion, discussion of the reforms with Kosovar health professionals has been:</p> <p>a. frequent.</p> <p>b. moderate.</p> <p>c. infrequent.</p> <p>Why?</p>			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<p>Communicate/Respond Analysis: Significant. In their verbal comments, the majority of stakeholders expressed concern with the lack of discussion—particularly after the initial Yellow Book consultation. This indicates that the ability of the government to ‘share its vision’ was weak, and the legitimacy of the reforms was undermined.</p>	3 CS: 1; RS: 2	13 CS: 7; RS: 6	8 CS: 4; RS: 4	<ul style="list-style-type: none"> • Kosovars critical of reform progress, didn’t engage, and response of local experts was weak. (Luma) • All healthcare professionals were not included, just more accredited ones. (Ahemti) • All actors such as NGOs and full representation from the National Institute of Public Health were not included. (Ramadani) • It was the maximum amount of dialogue possible at the time. (Begolli) • Although the internationals were the minority in health discussions, they were able to dominate discussions with nationals. That is my experience as representative of Handicap International. (Ukmata) • There were discussions, but they were not enough. When I talk to Regional Health Officers I have the impression that they do not know the policy and the non-family medicine specialists oppose this strategy as it is based in family medicine. This is due to a conflict of interest—less patients for specialists. (Hasani) • There were no conferences organized—no feedback conferences. (Agani) • The changes should start from the ground level to the top people—but they thought that this would take too much time. They didn’t recognize how important are these changes, so they didn’t want to be involved in the reforms in the beginning. (Sedjiu)

				<ul style="list-style-type: none"> • There were discussions, but many personnel changes have occurred, and appointments were made after the central and local elections. More discussions needed to be held. (Huruglica) • People were passive at that time. It was the immediate post-war period, and people had other economic problems, and more time was needed to introduce that policy. (Ymerhalil) • They still have started implementation, and the media has not done anything to help. People are still going to their family doctor, and asking for a paediatrician. (Kabashi) • We were informed through the press. (Tahirukaj) • Not enough contact has been made with Kosovo health professionals, especially in the last year. (Ibrahimi) • We did not hear anything about reforms before the health-policy document was released. (Shaqiri)
Question 6:	Discussion of the reforms with Kosovars in female dominated health sectors (i.e. nurses and midwives) has been:			
	<ul style="list-style-type: none"> a. frequent. b. moderate. c. infrequent. 			
	Why?			
Indicator/Analysis	A	B	C	Comments
<u>Communicate/Respond</u> Analysis: Significant. Most stakeholders felt that the discussion with female-dominated health sectors was infrequent.	1 CS: I; RS: 0	10 CS: 5; RS: 5	9 CS: 5; RS: 4	<ul style="list-style-type: none"> • Professional associations of nurses were quite weak—were not organized, and had not political support. (Luma) • It would prolong the process. (Ahmeti) • Post-war situation and they were unorganized. (Begolli) • They were listened to as much as was needed, the reforms were imposed for our (Kosovars') benefit. (Ukmata) • They are not well organized associations. (Agani) • Most of them did not understand the strategy, and they were not well organized. (Sedjiu) • During a presentation at the health-policy conference, the nurses agreed with the policy, but emphasized that the nurses should have academic education. This was incorporated into the Yellow Book. (Huruglica) • Only head nurses have been informed. (Kabashi)

				<ul style="list-style-type: none"> • They were not so organized. (Rexhepi) • At the time of discussions about health reform, nurses were not organized. Our superiors did not inform us of the policy. If discussions had been frequent, I would have heard about it. (Sopi) • They didn't find it necessary to inform us (nurses). (Morina)
Question 7:	Discussion of the reforms with the Kosovar public has been:			
	<ul style="list-style-type: none"> a. frequent. b. moderate. c. infrequent. 			
	Why?			
Indicator/Analysis	A	B	C	Comments
<u>Communicate/Respond</u> Analysis: Significant. Stakeholders agreed that the reforms were not sufficiently communicated, which reflects on the legitimacy of the reforms and the ability of the government to share its reform vision.		7	16	<ul style="list-style-type: none"> • Kosovo society not accustomed to public debates. (Luma) • I cannot say that the public was not consulted, but it was moderate consultation, and the maximum amount possible for that time considering the post-war situation and donor pressure to have a policy in place. (Begolli) • It was a post-war situation, and the key issues were survival and rapid decision-making. (Ukmata) • Population does not understand the concept of family medicine and the services that they can get. The Ministry did not promote this policy enough to the population. (Hasani) • Lack of initiative from the Department of Health. (Agani) • There was not enough interest in the media, and the public was occupied with the election. (Sedjiu) • The time that the document had to be finished did not allow for extensive discussion. (Huruglica) • Health workers did not take any initiative to discuss it—people were not used to say openly what they think and this is inherited from the previous system. (Ymerhalil) • The media had some information about reforms, but this did not continue. (Kabashi) • It was difficult for the media to have much interest in such issues—the people in the media were no so specialized, professionally. Health was presented in media mainly because of the lack of equipment and daily problems, but not for their health strategy. (Rexhepi) • Media have to inform about other problems. (Morina)

				<ul style="list-style-type: none"> • There was little information in the media. (Selaj) • Absence of education—we didn't offer the public much information, and they didn't take initiatives to find out information. (Hajdari) • The media did not inform public about the reforms—they focused on political problems. (Qosaj)
Question 8:	<p>Discussion of the reforms with the Kosovar minority population has been:</p> <p>a. frequent.</p> <p>b. moderate.</p> <p>c. infrequent.</p> <p>Why?</p>			
Indicator/Analysis	A	B	C	Comments
<u>Communicate/Respond</u> Many did not answer this question—therefore, no clear findings.	3 CS: 2; RS: 1	5 CS: 3; RS: 2	7 CS: 3; RS: 4	<ul style="list-style-type: none"> • Serbs are not interested to be part of this society. (Luma) • WHO went to see Serb health representatives, but unclear what happened. (Begolli) • In the nursing project of the Ministry of Health, Serbs are included in training and they received a lecture on the Kosovo Health Strategy. (Hasani) • Lack of political will from the Serbian side. (Agani) • Efforts were made, and at the beginning Serbs participated, but stopped as they had pressure from Belgrade. (Huruglica) • They rejected invitations to discuss reforms. (Ymerhalili) • With minorities, except the Serb minority. (Kabashi) • I had contacts, but not enough. They (Serbs) have shown resistance more for political rather than professional reasons. Once we tried, they made contacts impossible. Internationals did not trust Albanians to make contacts with Serbs. If the locals were trusted, we could find some common language—at least at the professional level. (Rexhepi)
Question 9:	<p>In discussions of health reforms, in your opinion Kosovars had:</p> <p>a. significant input.</p> <p>b. moderate input.</p> <p>c. insignificant input.</p> <p>Why?</p>			
Indicator/Analysis	A	B	C	Comments
<u>Legitimacy</u>	2	19	2	<ul style="list-style-type: none"> • During some discussions, Kosovo health professionals were able to push their

<p><u>External Pressure</u> Analysis: Significant. Most stakeholders indicated that Kosovars only had moderate input, and in their comments they expressed concern that the reforms came ‘ready-made.’</p>	<p>CS: 1; RS: 1</p>	<p>CS: 10; RS: 9</p>	<p>CS: 1; RS: 1</p>	<p>points/influence some decisions. (Luma)</p> <ul style="list-style-type: none"> • Even if we were better prepared with proposals, the policy framework was ready and we were brought into the final act. (Begolli) • I think that reforms and decision making for Kosovars was something new, and therefore Kosovars cannot blame the internationals. Though I am sure that there was need for greater influence, but Kosovars aspirations are high—and we would propose the space shuttle. (Ukmata) • The content was defined by internationals and the decision makers were internationals. This is not something wrong—it was positive, as we did not have a brighter vision. We were isolated for a decade. (Hasani) • Executive power is still in the hands of the internationals, four years after the war. (Agani) • There was much discussion at the experts’ level and not at the institutional level, maybe because the institutions did not show enough interest. That is one of the reasons why we have so many problems in post-wartime period. (Sedjiu) • The policies were developed by internationals and the consultation time was too short—we did not have enough time to give our inputs. The biggest pressure came from donors. NGOs come and implement their programs for a certain period of time, and they have to spend that money no matter how it is implemented, the quality is not important. It was the same with policy. (Huruglica) • If Kosovars had shown more interest, been more active, and taken more responsibility, then they could have more significant input. (Ymerhalili) • There are now working groups for reforms. (Kabashi) • I insisted and it did not happen—I said that the strategy should be presented to the population, but the internationals said first we have to make a policy, then present it. Strategy formulation did not start well. But there are also other problems that bothered people at that time. People were not able to evaluate whether the old or new system is better for them, as they were not informed about how the old system functioned. (Rexhepi)
<p><u>Question 10:</u></p>	<p>In your opinion, Kosovar input:</p> <ol style="list-style-type: none"> a. was taken seriously, and altered the Health Policy. b. was listened to, and incorporated into the Health Policy. c. was listened to, but did not significantly alter the Health Policy. 			

<i>Indicator/Analysis</i>	Why?			<i>Comments</i>
	<i>A</i>	<i>B</i>	<i>C</i>	
<u>Legitimacy</u> <u>External Pressure</u> Analysis: Significant. Stakeholders again indicated that the views of Kosovars were incorporated, but did not significantly alter the health policy. Moreover, in their verbal comments they expressed concern that the health policy came ‘ready-made,’ and that their input was minimal.		15 CS: 8; RS: 7	13 CS: 3; RS: 10	<ul style="list-style-type: none"> • If internationals did not accept some ideas, they didn’t incorporate them into the health policy, and nobody can change that. (Luma) • The health policy was 80% determined outside of the working group. (Ahmeti) • In the first group, local experts were listened to more as the working group was smaller and was more effective. In the second working group, local experts’ suggestions were not considered as much as they had been previously. (Begolli) • I know that Mr. Ahmeti’s proposals were incorporated. (Ukmata) • Kosovars lacked knowledge in health policy, so they listened more. If we found the health-policy ideas reasonable, we accepted them, but we were not able to implement the reforms. (Sedjiu) • If Kosovars had made more effort and had more experience, they would have had more input. (Ymerhalili) • They adapted the reform to the situation—but there is some confusion, as the Ministry continues to give new specialisations. (Kabashi) • Most internationals came here with their prejudice, and they were preoccupied to realize the project, and less implement it. Once you gave a suggestion, internationals were afraid they would be lost. The internationals planned the strategy before. (Rexhepi) • It was previously prepared and served to us, more or less. (Selaj) • Most of the important work was done by international experts, because we didn’t have enough experience.... Nothing is prepared special for our conditions. (Qosaj)
Question 11:	During discussions and communications about health policy and health reform: <ol style="list-style-type: none"> a. an effort was made to communicate this information in the appropriate language. b. sometimes the information was communicated in the appropriate language. c. the information was rarely communicated in the appropriate language. 			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Legitimacy</u> Analysis: Significant. The majority of respondents indicated that the information was communicated in the	13 CS: 6; RS: 7	9 CS: 5; RS: 4	1 CS: 1; RS: 0	

correct language.				
Question 12:	<p>Since the introduction of the health-reform program by the WHO, the Department/Ministry of Health is responsible for its implementation. In your opinion, did the Ministry:</p> <ol style="list-style-type: none"> attempt to implement the program? pay only lip service to implementation? ignore reforms? <p>Why?</p>			
Indicator/Analysis	A	B	C	Comments
<p><u>Capacity</u> Analysis: Significant. Most felt that the Ministry of Health did not act sufficiently to implement reforms. This response was particularly marked among central stakeholders.</p>	9	13	1	<ul style="list-style-type: none"> Ministry did not develop a plan of action, which is the first step to implementation, but nothing is done. (Luma) Each office at the Ministry had an international and local professional and they could not implement the policy either because they did not know or were not interested. (Ahmeti) I think that the Ministry murdered its own reforms as it signed 700 specialisations other than family medicine. (Begolli) They did not have capacity or will to implement the policy. They have designed administrative instruction as they needed, or as the things came up, they did not have any systematic plan in promoting health policy officially. The right people were not in the right places. (Ukmata) According to a study, the nurses trained were going back to their facilities and worked in the manner they used to work. A nurse trained in family medicine works in the laboratory. The ministry did not do anything to systematize through an administrative instruction those nurses to work together with a family-medicine doctor. Earlier it was more difficult, but now it is easier, as almost all directors are trained in family medicine and they support us more. (Hasani) No technical capacity, lack of human resources. (Agani) The structures have to implement reforms, as well. (Sejdiu) The Ministry is always trying to contribute to the five health-policy goals through its programs and offices. (Huruglica) Based on this policy, the ministry formed structures, established the PHC unit at the Ministry, and family-medicine development centre. (Ymerhalil) They said one thing, and then did something else. (Kabashi) The Ministry is different from the UN Department of Health –who was very

				<p>dedicated to implementing the health policy. The new minister was very political and attempted a different strategy. Also problem with civil servants, who should serve in Ministry—not be political. (Rexhepi)</p> <ul style="list-style-type: none"> • While they made many trainings, trained personnel came back to the same old positions with the same way of work. (Sopi) • They signed nurses' licenses, but for other aspects of the reforms, I do not know. (Bicku) • Nobody from the Ministry ever came to see us to ask what our problems are. (Tahirukaj) • Unclear if the Ministry had the competence to do the implementation. Also there were political influences in the Ministry. (Selaj) • Except for one program about organisation in hospitals, we didn't have any further support from the Ministry. (Hajdari)
<p>Question 13: <i>Central-Level Stakeholders Only</i></p>	<p>How committed are Kosovars working in the health system to the implementation of these reforms?</p> <p>a. Committed. b. Somewhat committed. c. Not very committed.</p> <p>Why?</p>			
Indicator/Analysis	A	B	C	Comments
<p><u>Legitimacy</u> <u>Sustainability</u> Analysis: Significant. Most stakeholders expressed doubt as to the level of commitment from Kosovars to the reform process.</p>	2	6	3	<ul style="list-style-type: none"> • In the first year, Kosovars were very committed. Since then, their enthusiasm has dropped and they start to care only about personal interest. (Luma) • Reforms are crucial for financial security in the health sector. (Ahmeti) • They said yes to reforms, but when it came to work, they do not do much. (Ramadani) • Kosovars wanted the reforms, but they did not have the capacity and time to understand them, they just followed them. (Ukmata) • We are a poor country and we are trying to implement with all our knowledge and forces. The main reason that we are doing this is that we believe the system will serve the population, but we are lacking motivation. (Hasani) • They put individual interest higher than collective interest, they did not understand the reforms, and did not know the strategy. (Sejdiu) • We look to doctors as the main driving force in the health sector, and they are more interested in private practise. (Huruglica) • Lack of incentives. (Ymerhalili)

<p>Question 14: <i>Central-Level Stakeholders Only</i></p>	<p>How committed is the international community working in the health system to the reform program?</p> <p>a. Committed. b. Somewhat committed. c. Not very committed.</p> <p>Why?</p>			
<p>Indicator/Analysis</p> <p><u>Legitimacy</u> <u>Sustainability</u> Analysis: Significant. Most stakeholders believed that the international community was only somewhat or not very committed. Stakeholders expressed concern that the international community is not committed for the long term.</p>	<p>A</p> <p>3</p>	<p>B</p> <p>5</p>	<p>C</p> <p>1</p>	<p>Comments</p> <ul style="list-style-type: none"> • The international community came, and did what they wanted to do, but did not care if the reform program was sustainable. (Luma) • Some internationals were not qualified for the work they did and did not have experience working at the governance level. There was no coordination at the Ministry level. (Ahmeti) • There was no continuity among the international community besides the institutions. Donors were very dynamic and it was impossible to cope with all of this. (Ukmata) • They are waiting for more initiatives from Kosovars and Kosovar institutions (Hasani) • Some donors wanted to do something, but were in the long run indifferent. Most of them were in Kosovo to undertake one project, without a broad perspective. (Sejdiu) • Donors are always available and interested. They give money, but when the memorandum cannot be signed, the donor cannot do much. EAR was going to give money for a nursing college. This has not happened since 2001. The donor has made the best out of it, and gave money for licensing nurses and nursing conferences. (Huruglica)
<p>Question 15: <i>Central-Level Stakeholders Only</i></p>	<p>How important is donor commitment to the reforms?</p> <p>a. Very important. b. Important. c. Not very important.</p> <p>Why?</p>			
<p>Indicator/Analysis</p> <p><u>Sustainability</u> Analysis: Significant Clear that stakeholders believe that without the involvement of the</p>	<p>A</p> <p>9</p>	<p>B</p>	<p>C</p>	<p>Comments</p> <ul style="list-style-type: none"> • Kosovo needs more economic and professional support for the reform program. (Luma) • Hospital investments and technical support is needed. (Ahmeti) • The reforms are positively imposed by the international community, and their financial and technical support is really important. (Ukmata)

international community, the reform process will not proceed.				<ul style="list-style-type: none"> • Only if we are organized will donors provide money. (Hasani) • There is little budget resources for capital investments. (Agani) • Without financial aid, we cannot incorporate as a region. (Sejdiu)
Question 16:	Does the health system have the funds necessary to implement the reform program?			
	a. Yes. b. No.			
Indicator/Analysis	A	B	C	Comments
<u>Sustainability</u> Analysis: Significant. Most stakeholders believe that Kosovo does not have money for reforms.	6 CS: 3; RS: 3	17 CS: 8; RS: 9		<ul style="list-style-type: none"> • Kosovo's budget is very small, we don't have enough funds. (Luma) • The reforms should save money and not increase the expenditures of the budget. If people were interested, they could save money. (Ukmata) • Funds are not available due to bad financial management. (Hugulica) • Although the budget is small, if we are smart and efficient with this budget, I think we can have more. (Kabashi) • The health budget is too low, and we still need donor support. (Sopi) • Lack of equipment, low motivation among patients, specialists are moving to the private sector. (Hoti)
Question 17:	Are national standards for professional qualifications in primary care health facilities enforced?			
	a. Yes. b. No. Why?			
Indicator/Analysis	A	B	C	Comments
<u>Capacity</u> Analysis: Significant. Most believed that these standards are enforced.	13 CS: 4; RS: 9	8 CS: 6; RS: 2		<ul style="list-style-type: none"> • There are no standards—no law, no implementation. (Luma) • No enforcement capacity for standards. (Ahmeti) • Kosovo is a small country and people know each other. (Ukmata) • There are regulations, but no one respects them. (Sedjui) • The licensing process is going on with Nurses Association and the Ministry of Health. (Huruglica) • Licensing of doctors is done in all of Kosovo, through the Kosovo Medical Association and Ministry of Health. (Ymerhalili) • They licensed doctors and nurses. (Kabashi) • Every nurse has graduated and has a diploma. (Sopi) • While licensing has been conducted, more rigorous control is necessary. (Hoti)

Question 18:	Do national facility standards exist? a. Yes. a. No.				
Indicator/Analysis	A	B	C	Comments	
<u>Capacity</u> Analysis: While most stated that facility standards exist, some gave mixed responses as to their implementation. Significance unclear.	14 CS: 6; RS: 8	8 CS: 4; RS: 4		<ul style="list-style-type: none"> Partially. (Ukmata) For primary care health centres. (Huruglica) Some standards exist, but not all. (Kabashi) 	
Question 19: <i>Central-Level Stakeholders Only</i>	Are they enforced in primary care health facilities? a. Yes. b. No.				
Indicator/Analysis	A	B	C	Comments	
<u>Capacity</u> Analysis: Divided responses. Significance unclear.	3	4		<ul style="list-style-type: none"> Partially implemented—no enforcement capacity. (Ahmeti) Partially. (Ukmata) 	
Question 20:	Are there any impediments to enforcing national facilities standards? If yes, is it due to: a. Lack of equipment? b. Funding? c. Training? d. Enforcement capacity?				
Indicator/Analysis	A	B	C	D	Comments
<u>Capacity</u> Analysis: Insufficient response.	6 CS: 0; RS: 6	7 CS: 1; RS: 6	6 CS: 0; RS: 6	8 CS: 5; RS: 3	<ul style="list-style-type: none"> All. (Luma) All. (Agani) All. (Sedjiu) Budget lines are not allowing anything to be done well, and organisation is not so good. (Kabashi) Lack of legislation is also problematic. (Rexhepi) Lack of motivation. (Morina) Lack of education/training to support reform. (Tahirukaj).

				• All of these things impede reforms. (Ibrahimi)
Question 21: <i>Central stakeholders only</i>	Do these national standards reflect the objectives of the reform program? a. Yes. b. No. Why?			
Indicator/Analysis	A	B	C	Comments
<u>Capacity</u> Analysis: Significant . All respondents indicated “yes.” However, if the standards are not implemented, it does not matter if they reflect the reforms.	6			<ul style="list-style-type: none"> • The same reforms as other states in transition and European standards. (Ahmeti) • The standards are dedicated to family-medicine centres—these standards should be enforced from the municipalities, and the municipalities do not have any clue. (Huruglica)
Question 22:	Are national standards for professional qualifications and facility qualifications enforced in private clinics? a. Yes. b. No. Why?			
Indicator/Analysis	A	B	C	Comments
<u>Capacity</u> Analysis: Significant . Clear that standards are not enforced in private clinics.	3 CS: 0; RS: 3	17 CS: 10; RS: 7		<ul style="list-style-type: none"> • There is no control, no human capacities. Corruption is present in institutions and the private sector. (Ahmeti) • There is no legislation and no control. Pharmacies are a disaster. (Ukmata) • No regulation for the private sector has been approved. (Agani) • There is no legislation, and nobody checks the private clinics. (Sejdiu) • No inspection or other controls have been organized. (Kabashi) • Standards are not respected. (Selaj) • The private sector is not controlled. (Hajdari) • There is no legislation to control the private sector. (Hoti) • There is no control of the private sector. I know doctors without license who are working privately. (Shaqiri) • There have been inspections in the last four to five months. (Silamniku)
Question 23:	Do the services available at primary care health facilities generally meet the guidelines set out in Kosovo’s health-policy document? a. Yes.			

					• All of these things impede reforms. (Ibrahimi)
Question 21: <i>Central stakeholders only</i>	Do these national standards reflect the objectives of the reform program? a. Yes. b. No. Why?				
Indicator/Analysis	A	B	C	Comments	
<u>Capacity</u> Analysis: Significant. All respondents indicated “yes.” However, if the standards are not implemented, it does not matter if they reflect the reforms.	6			<ul style="list-style-type: none"> • The same reforms as other states in transition and European standards. (Ahmeti) • The standards are dedicated to family-medicine centres—these standards should be enforced from the municipalities, and the municipalities do not have any clue. (Huruglica) 	
Question 22:	Are national standards for professional qualifications and facility qualifications enforced in private clinics? a. Yes. b. No. Why?				
Indicator/Analysis	A	B	C	Comments	
<u>Capacity</u> Analysis: Significant. Clear that standards are not enforced in private clinics.	3 CS: 0; RS: 3	17 CS: 10; RS: 7		<ul style="list-style-type: none"> • There is no control, no human capacities. Corruption is present in institutions and the private sector. (Ahmeti) • There is no legislation and no control. Pharmacies are a disaster. (Ukmata) • No regulation for the private sector has been approved. (Agani) • There is no legislation, and nobody checks the private clinics. (Sejdiu) • No inspection or other controls have been organized. (Kabashi) • Standards are not respected. (Selaj) • The private sector is not controlled. (Hajdari) • There is no legislation to control the private sector. (Hoti) • There is no control of the private sector. I know doctors without license who are working privately. (Shaqiri) • There have been inspections in the last four to five months. (Silamniku) 	
Question 23:	Do the services available at primary care health facilities generally meet the guidelines set out in Kosovo’s health-policy document? a. Yes.				

<i>Indicator/Analysis</i>	b. No. Why?			<i>Comments</i>
	<i>A</i>	<i>B</i>	<i>C</i>	
<p><u>Capacity</u> Analysis: Significant. Majority of stakeholders did not feel that services available at primary care health facilities reflect the reform guidelines. Clear concern in regard to quality.</p>	7 CS: 3; RS: 4	16 CS: 7; RS: 9		<ul style="list-style-type: none"> • Some of the centres function well, but the villages still don't have doctors and patients need to travel. (Luma) • Human resources planning has failed, there is lack of motivation among doctors. (Ahmeti) • While the services meet guidelines, much is needed to improve quality of care. (Ukmata) • There is no control and enforcement. (Hasani) • Still not enough family-medicine doctors. (Agani) • Services have just started to meet these guidelines. (Huruglica) • Lack of legislation, doctors, lack of health cards, lack of functioning referral system. (Ymerhalili) • We have a lack of equipment and human resources. (Kashi) • We don't have enough resources—not enough doctors, and no incentives to get them. In some municipalities in Gjilan region, doctors are going to the private sector. (Rexhepi) • There is no definition of catchment area, no continuity of patient follow-up, patients come and get the referral from the family-medicine doctor and just go to the specialist. (Sopi) • We don't know the healthcare zones, and don't have continuity to follow up on patients. (Bicku) • There is no organisation, no catchment areas, no essential drugs in pharmacies, no health cards. (Tahirukaj) • There are not enough doctors to implement primary care health care like in the document, and training on how to implement the health-policy document is also not provided. (Qosaj) • The main problem is to follow the patient and at the moment we do not know how to register all patients. (Hoti) • The population is not registered, so we don't know the real numbers of people. People don't have insurance, the health-information system is bad. We have started with health cards for patients, but this is in an initial phase. (Shaqiri)

<p>Question 24:</p>	<p>One of the foundations of the health-reform process is the concept of family medicine. This concept has been received in Kosovo:</p> <ol style="list-style-type: none"> a. Enthusiastically. b. Tolerated. c. Resented. <p>Why?</p>			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<p><u>Legitimacy</u> <u>Sustainability</u> Analysis: Significant. Stakeholders indicate that there is not much support for family medicine—particularly marked among regional stakeholders.</p>	<p>5 CS: 4; RS: 1</p>	<p>14 CS: 5; RS: 9</p>	<p>2 CS: 1; RS: 1</p>	<ul style="list-style-type: none"> • It put doctors who had been isolated from the system back into the system. (Luma) • Some doctors were enthusiastic, while others resented it. (Ahmeti) • People did not understand it. (Ukmata) • Young doctors are enthusiastic, but old doctors resent it. (Hasani) • Family is the main value/resource of Kosovo society. (Agani) • At the beginning, the concept of family medicine was received enthusiastically, but now people say that the Ministry has left us without doctors in rural areas by sending them into family-medicine specialisation. Villages are left without doctors. (Huruglica) • Young doctors have embraced family medicine. (Ymerhalili) • In the beginning, people did not understand that one doctor can do everything. (Kabashi) • Specialists feel endangered that they will lose their patients. Population also does not respect the referral process, and the concept of one family doctor. They are used to specialists. (Rexhepi) • The population does not know what reform means, and its importance. (Sopi) • Some understand it, and some do not. (Morina) • It is unclear how the family-medicine concept functions—specialists have reservations about the concept of family medicine. (Bicku) • Those that participated in family-medicine training admitted that they are not sure that they can resolve these issues with six months or one year of training. (Tahirukaj) • People do not understand the family-medicine concept—public-information campaign is missing. (Hajdari) • Most of the older-generation doctors are not interested in these reforms because they are afraid to lose patients. (Qosaj)

				<ul style="list-style-type: none"> Specialist doctors have opposed the concept of family medicine. (Hoti)
Question 25: <i>Regional-Level Stakeholders Only</i>	In your area of responsibility, do family-medicine teams function? a. Yes. b. No.			
Indicator/Analysis	A	B	C	Comments
<u>Capacity</u> <u>Progress</u> Significant. Regional stakeholders did not believe family-medicine teams were functioning.	2	12		<ul style="list-style-type: none"> We defined the teams, but we have an absence of family-medicine doctors. (Kabashi) Lack of enforcement—family medicine is a new concept that has to be implemented in old facilities, which are not appropriate for the concept of family medicine. There is a lack of protocols. There is no confidence that the concept of family medicine is sustainable in Kosovo. (Rexhepi) The population is not informed what services it can get—there are no patient and health cards, no motivation. (Sopi) We have to coordinate the work between doctors and nurses. (Ibrahimi)
Question 26: <i>Central-Level Stakeholders Only</i>	Do you think that the family medicine can be implemented in Kosovo? a. Yes. b. No. Why?			
Indicator/Analysis	A	B	C	Comments
<u>Sustainability</u> Analysis: Significant. Stakeholders all optimistic for the future of family medicine under the right conditions.	9			<ul style="list-style-type: none"> With hard work. (Luma) Standards should be set, with a law supporting these standards—teamwork should be promoted. Specialists should work in hospitals. (Ahmeti) Only with outside investment. (Begolli) There is a need, and both the infrastructure and tradition are there. (Ukmata) Need time—in other countries it took ten years. (Sedjiu) Because of enthusiasm and financial support from the Ministry of Health, the Family Medicine Development Centre was established. (Huruglica)
Question 27: <i>Central-Level Stakeholders Only</i>	What are the three main problems that you face in the implementation of the concept of family medicine?			
Indicator/Analysis	Comments			
<u>Capacity</u> <u>Progress</u> Analysis: The one commonly	<ul style="list-style-type: none"> 1) <i>Referral system</i> does not function; 2) health-service <i>financing and accessibility</i> of healthcare facilities is a problem; 3) lack of <i>legislation</i>; 4) lack of <i>human resources</i>—family-medicine concept has been 			

<p>referred to factor/issue was human resources—mentioned by six out of seven stakeholders. Significant.</p>	<p>imposed by the U.K.—the medical faculty was not involved. Implementing family medicine requires human-resources planning and citizen understanding. (Ahmeti)</p> <ul style="list-style-type: none"> • 1) <i>Sustainability</i> of the program. Family medicine is similar to general medicine—the concept is not bad, but the medical faculty and the dean and vice-dean are not doing anything. This program is led by some people who think they are qualified to do so, but are not collaborating with relevant institutions. (Ramadani) • 1) Lack of doctors; low motivation of medical doctors to specialize in family medicine and low MOH capacity to attract doctors to specialize in family medicine; the family-medicine program is not serious enough. (Ukmata) [Coded under ‘human resources.’] • 1) No catchment areas defined; 2) no health cards; 3) no standards/protocols; 4) no job descriptions that describe the competencies of doctors and nurses. (Hasani) [Coded as ‘lack of infrastructure.’] • 1) Absence of law; 2) training of staff; 3) misunderstanding of family medicine from public and professionals; 4) weak referral system. (Sejdiu) [Training coded as ‘human resources.’] • 1) Doctors do not want to work in rural areas—this has to be done through incentives and regulations; 2) trained nurses should come back to work in places where they can implement their training; 3) human-resources management. (Huruglica) [All coded under human-resource management.] • 1) Lack of legislation; 2) lack of administrative and management staff; 3) low salaries. (Ymerhalili) [Lack of administrative and management staff coded as ‘human resources.’]
<p>Question 28: <i>Central-Level Stakeholders Only</i></p>	<p>What causes these problems?</p>
<p>Indicator/Analysis</p>	<p>Comments</p>
<p>Open-ended question designed to see if stakeholders mentioned any common factors. They did not.</p>	<ul style="list-style-type: none"> • The program did not start as it should have at the University of Pristina and Medical Faculty. (Ramadani) • There are many programs in the health sector, but there are not many dedicated to the Ministry that would enable it to deal with all these programs. (Hasani) • 1) Absence of human capacities; 2) absence of law; 3) no motivation; 4) no foundation for work. (Sejdiu) • 1) Population does not know what family medicine is, and does not understand its cost-effectiveness; 2) lack of legislation; 3) low commitment of health workers because of low payments. (Huruglica)
<p>Question 29: <i>Central-Level Stakeholders Only</i></p>	<p>What do you think is needed to be support the concept of family medicine?</p>
<p>Indicator/Analysis</p>	<p>Comments</p>
<p>Open-ended question</p>	<ul style="list-style-type: none"> • Defined status of stakeholders in health sector; consolidation of the Ministry of Health; health law;

designed to see if stakeholders mentioned any common factors. They did not.	<p>promotion of the concept of family medicine among health workers and citizens. (Ahmeti)</p> <ul style="list-style-type: none"> • Learn from neighbouring countries—when there is the will to implement, it can succeed. (Ukmata) • Health-information system so the ministry can develop services that are appropriate to patients. (Hasani) • The law and development of professional capacities. (Sejdiu) • The public needs to be educated about the concept of family medicine. (Huruglica) • Secondary and tertiary level of healthcare should see family medicine as something useful; self-initiative and more actively involved municipalities, and a health-information system. (Ymerhalili) 			
Question 30: <i>Central-Level Stakeholders Only</i>	In your opinion, have reforms increased or decreased the ability of Kosovo to provide healthcare services to its population? Why?			
Indicator/Analysis	Comments			
<u>Progress</u> Two out of five stakeholders indicated that the performance of the health system has been weakened. Problematic question, because the reference point was not made clear in the question—should they compare to the pre-1990 or post-1990 health system?	<ul style="list-style-type: none"> • Decreased—poor services in primary care, bad functioning of referral system, weakens the reforms. (Luma) • Decreased—lack of motivation among health workers, weak health financing, and incorporation of private activities in public sector. (Ahmeti) • Increased—in comparison with healthcare system during Serbian rule. (Ukmata) • Increased—due to training of doctors and nurses. (Hasani) • Increased—they have incorporated some levels of the healthcare system that did not work before. (Sejdiu) • Increased—through training the awareness of health workers has increased and they provide services that are accessible to the population. (Huruglica) • Increased—through better access. (Ymerhalili) 			
Question 31a:	Have the reforms: <ol style="list-style-type: none"> Provided more access to healthcare for rural populations? Provided less access for rural populations? Why?			
Indicator/Analysis	A	B	C	Comments
<u>Progress</u> Analysis: Significant. Most stakeholders believe rural populations better served.	10	5		
	CS:	CS:		
	2;	4;		
	RS:	RS:		
	8	1		
Question 31b:	a. Provided more access for poorer populations?			

b. Provided less access for poorer populations? Why?				
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Progress</u> Analysis: Significant. Most stakeholders believe that the poor are not as well served.	8 CS: 3; RS: 5	12 CS: 5; RS: 7		
<u>Question 31c:</u>				
a. Provided more access for women? b. Provided less access for women? Why?				
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Progress</u> Analysis: Significant. Most stakeholders believe women are better served.	19 CS: 6; RS: 13	2 CS: 2 RS: 0		<ul style="list-style-type: none"> • No funds for poor population—other questions unknown. (Luma) • No doctors in villages, corruption and co-payment and poverty reduce access for poor people; improved access for women because a number of programs were implemented in public health. (Ahmeti) • There is a shortage of doctors in villages, medicine is going for profits, and there are lots of programs to benefit women. (Begolli) • Programs have been implemented to help rural populations, poor people's access remains the same, lots of programs have increased women's access. (Ukmata) • Unknown for rural; more access for poorer populations, and more access for women. (Hasani) • Should have access to health facilities within ten minutes—but in Kosovo it is forty-five minutes away. (Sejdiu) • There are more PHCs in villages, health services are institutionalized, patients that are social cases are exempt from co-payments, and there are more maternities. (Huruglica) • No doctors for rural areas, no health insurance for poor people, more maternities and better services for women's health. (Ymerhalili) • Rural populations have doctor visiting a minimum of one to three times per week, poor people have access to free medication in the villages, and there have been programs on training in women's health. (Kabashi) • Rural populations have more access than during the 1990s; poor people have no

				insurance, and there is more emphasis on mother/child services. (Rexhepi)
Question 32: <i>Central-Level Stakeholders Only</i>	In the past year, the delivery of primary healthcare services in Kosovo's health centres has: a. Increased in quality. b. Quality is unchanged. c. Quality has decreased. Why?			
Indicator/Analysis	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Progress</u> Insufficient response.	2	1	1	<ul style="list-style-type: none"> The reforms did not work—cannot state how they impact on quality. (Luma) For the moment, the quality of primary care has decreased, but I am sure the quality will increase as the programs are institutionalized. (Ukmata) Better training and organisation has increased the quality of care. (Hasani) Training and better equipment. (Sejdiu)
Question 33: <i>Central-Level Stakeholders Only</i>	What is your opinion of the importance of healthcare in the overall public reforms in Kosovo? a. High importance. b. Moderate importance. c. Low importance. Why?			
Indicator/Analysis	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
Insufficient Response—unclear question.	4	2	2	<ul style="list-style-type: none"> Other political problems overshadow reform. (Luma) There are other important problems to concentrate on. (Ukmata) The prime minister gives special importance to health. (Hasani)
Question 34: <i>Central-Level Stakeholders Only</i>	If the government in Kosovo is not supportive of the reform process: a. The reforms will be reversed. b. The reform process will slow down. c. The reform process will stop. Why?			
Indicator/Analysis	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Sustainability</u> Analysis: Problematic question, because the option of the reforms process continuing is not available.	1	4	2	<ul style="list-style-type: none"> The implementation of reforms depends on Kosovo's institutions—if the government does not promote the reforms, then the interests of different groups will prevail. (Ukmata) Without government support, there would be no financial and no legislative support. (Hasani)
Question 35:	In your opinion, the decentralisation of primary healthcare responsibility to the municipalities has:			

	<p>a. Improved the delivery of healthcare. b. Made no change to the delivery of healthcare. c. Worsened the delivery of healthcare.</p> <p>Why?</p>			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Progress</u> Analysis: Significant. Most stakeholders believe that decentralisation has made no change or worsened the delivery of care.	6 CS: 2; RS: 4	10 CS: 3; RS: 7	3 CS: 3; RS: 0	<ul style="list-style-type: none"> • There is no decentralisation. (Luma) • Decentralisation has only been done for financing, and the human-resource implications were not considered. (Ahmeti) • Responsibilities were given to people who do not have the capacity to deal with the problems. (Begolli) • The municipality was not ready to take on these responsibilities. The centre does not have the capacity to monitor municipalities and they are left to themselves. (Hasani) • No clear coordination, weak capacities, bad organisation of finance, central budget decisions, municipal workers weak. (Sejdiu) • We now have direct contacts between the municipality and the health house. (Kabashi) • The municipal level was not ready, and did not have capacities to absorb these responsibilities—this was only a political change. (Rexhepi) • It has improved the supply of medical goods—although now very bureaucratic. (Sopi) • Decentralisation has not started yet. (Tahirukaj) • We are solving our problems ourselves. (Selaj)
<u>Question 36:</u>	<p>In your opinion, the decentralisation of responsibility for public health services has:</p> <p>a. Improved public health services. b. Made no change to public health services. c. Worsened public health services.</p> <p>Why?</p>			
<i>Indicator/Analysis</i>	<i>A</i>	<i>B</i>	<i>C</i>	<i>Comments</i>
<u>Progress</u> Analysis: Significant. Most stakeholders believe that the decision to decentralize public health services either made no change or worsened	2 CS: 1; RS: 1	12 CS: 5; RS: 7	2 CS: 2; RS: 0	<ul style="list-style-type: none"> • There is no decentralisation. (Luma) • Same as for Question 35. (Begolli) • We now have regular vaccination, municipalities office have supported this and other programs, such as regular checks of water. (Kabashi) • IPH resisted these changes. (Rexhepi)

services.				
Question 37:	<p>In your opinion, in fifteen years the health system in Kosovo will:</p> <ol style="list-style-type: none"> Reflect closely the vision of a decentralized, primary care-based system that is outlined in the health-policy document. Reflect closely the highly specialized system that existed before the conflict. Be somewhere between the two systems. <p>Why?</p>			
Indicator/Analysis	A	B	C	Comments
<p><u>Sustainability</u> Analysis: While stakeholders are optimistic in their numerical responses, their verbal responses reflected more concern. Significance unclear.</p>	<p>19 CS: 8; RS: 11</p>		<p>1 CS: 0; RS: 1</p>	<ul style="list-style-type: none"> • Hope that this is what will happen, but the reforms have to be implemented soon. (Luma) • The healthcare will be worse than before the war and expensive for the population—the healthcare providers are interested in profits, and there are no mechanisms in place to control profit mentality. (Begolli) • Kosovo has to fulfil standards, and one of these is health-sector reform. (Ukmata) • Young people who are living and working abroad will come back and try to implement what they learned. (Hasani) • We are in a critical situation—it is the last moment to understand reality and to start public discussions, but this will depend very much on the government. (Sejdiu) • Somewhere in between all of these, because of multiple problems. (Kabashi) • The older generation will retire and the younger generation will work more seriously. (Qosaj) • We are a poor country and we do not have any other option. I hope that regulated functioning of the private sector will raise the quality of care. (Hoti)

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