World Health Organization

European Region

Rapid assessment of primary health care and palliative services in Kosovo[1]

[1] All references to Kosovo in this document should be understood to be in the context of the United Nations Security Council resolution 1244 (1999).

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Abstract

This report describes the main findings and recommendations of a rapid assessment of primary health care (PHC) and palliative services in Kosovo[1]. As part of its *2023 Development Strategy*, Kosovo[1] is seeking to strengthen family-based PHC, with a focus on preventing and managing chronic noncommunicable diseases. This assessment compares the progress with PHC reform with the findings of WHO's *Primary health care in Kosovo*[1]*: rapid assessment 2019* and provides recommendations on developing PHC integrated health services that can meet people's health needs throughout their lives.

Keywords

PRIMARY HEALTH CARE

KOSOVO[1]

PALLIATIVE CARE

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Abbreviations

AQH	Accessible Quality Healthcare
CHD	coronary heart disease
CVD	cardiovascular disease
EHR	Electronic Health Record
ICPC-3	International Classification of Primary Care
NCD	noncommunicable disease
OOP	out-of-pocket
PEN	WHO Package of Essential Noncommunicable Disease interventions
PHC	Primary Health Care

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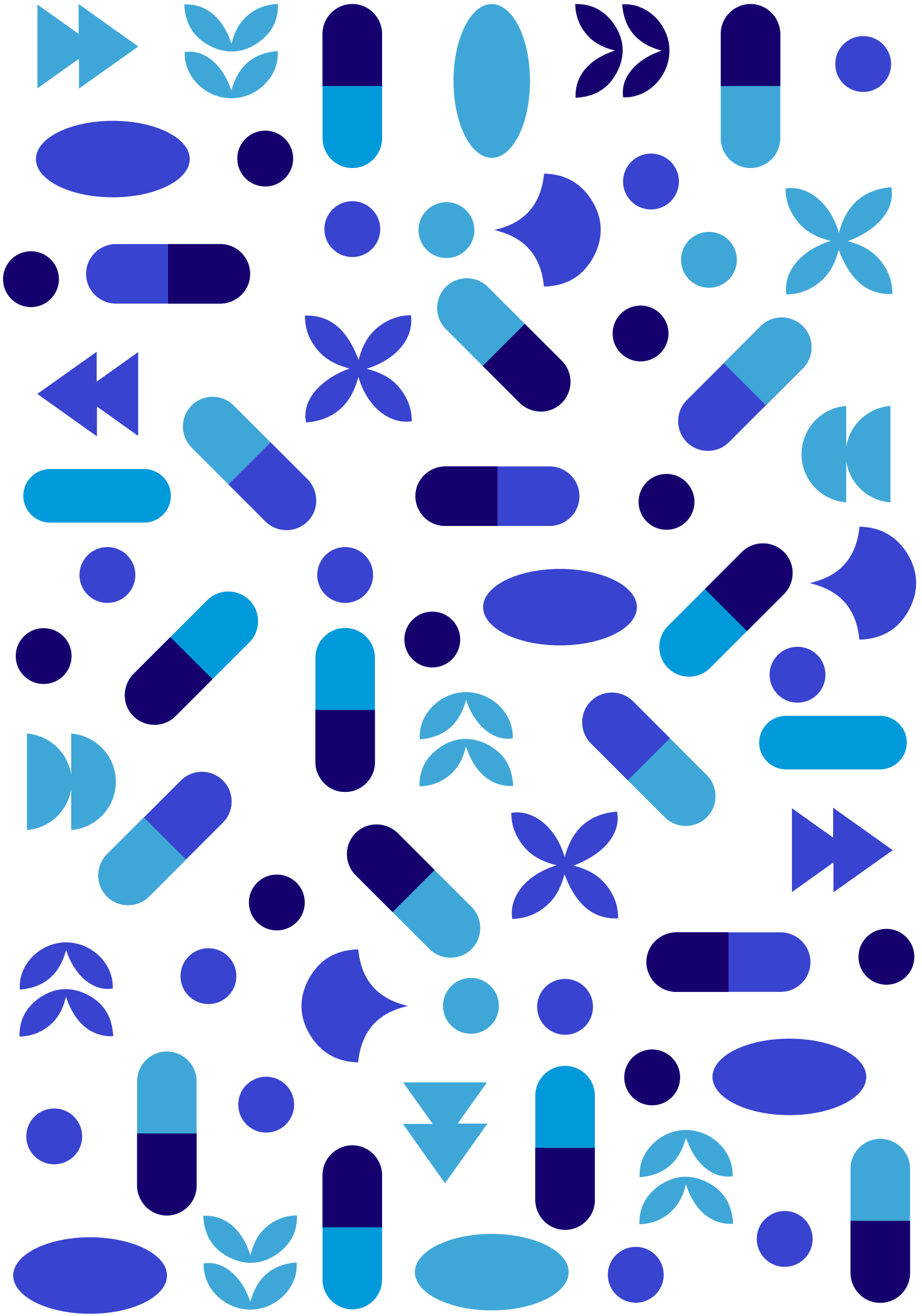

Introduction

Kosovo[1] authorities prioritize improvements in the delivery of primary health-care (PHC) services that aim at improving access to high-quality, innovative and efficient health services as well as improved resilience to health emergencies *(1)*. Kosovo[1] has been working on health-care reforms to improve the quality and accessibility of health-care services. These reforms aim to address some of the system's deficiencies and enhance overall health-care infrastructure. A particular focus is on strengthening family medicine-based PHC and enforcing a gatekeeper and coordinator role of family doctors.

Kosovo[1] is located in the Western Balkans in south-eastern Europe. According to estimates by the Kosovo[1] Agency of Statistics, the population of Kosovo[1] is approximately 1.58 million, with 24% of the population under 14 years of age and 7% over 65 *(2)*.

Kosovo[1] has a decentralized health-care system, where health authorities are responsible for health policy and regulation. Kosovo[1] is administratively divided into 38 municipalities with PHC services primarily delivered at the municipal level and provided through a network of family medicine centres, often referred to as *Qendra e Mjekësisë Familjare*. Each municipality has a network of PHC, including one main centre and several affiliated family medicine centres. The centres are distributed across Kosovo[1] to ensure accessibility. PHC is supported by public funds administered through municipalities.

In 2019, Kosovo[1] health authorities and WHO conducted a series of assessments on PHC *(3)*. The current regulatory framework of PHC services in Kosovo[1] is based on the Administrative Instruction N°04/2020[2] *(4)*, which defines the typology of PHC institutions, sets standards for the organization and functioning of PHC services and scopes the professional requirements of staff who provide PHC services.

In 2023, Kosovo[1] health authorities requested WHO support to comprehensively assess PHC service delivery, including palliative care. The WHO Office in Pristina and WHO European Centre for Primary Health Care organized a scoping mission to identify challenges and opportunities for strengthening the PHC service delivery model and making PHC service delivery more responsive to people's health needs.

Objectives of the mission

The objectives of the mission were to:

1. conduct a rapid assessment of PHC service delivery to identify the key challenges facing the current PHC model of care, including but not limited to organizational structure, performance and quality of services;
2. identify areas of PHC service delivery requiring a more in-depth assessment and analysis;
3. perform a scoping assessment and analysis of palliative care;
4. present preliminary findings to health authorities and counterparts; and
5. discuss and plan next steps and specify further WHO technical support.

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[2] Administrative instructions represent legal instruments in Kosovo that are equivalent to laws elsewhere.

Approach

A rapid assessment guide (Table 1) adapted from the *Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens (5)* (Fig. 1) was used to guide the assessment.

Table 1. Rapid assessment of all PHC dimensions

Structures	Tasks
1. Political commitment and leadership	• PHC placed at the heart of efforts to achieve universal health coverage and recognize the broad contribution of PHC to the SDGs • Priority outcomes (short-term, mid-term, longer-term)
2. Governance and policy frameworks	• Policy frameworks for PHC • Governance structures (e.g. PHC Task Force) • Mechanisms to promote multisectoral and community engagement • Institutional capacity to meet essential public health functions and operations • Evidence of effective stewardship of mixed (i.e. public/private) health systems
3. Adjustment to residents' needs	• Health priority-setting informed by data and evidence • Measurement and evaluation framework for health plan meeting criteria
4. Financing	• Financing for PHC (%) • Renumeration of PHC professionals • Co-payments from patients

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Inputs	
5. Physical infrastructure	• Health facility density/distribution • Availability of basic WASH[a] (i.e. safe drinking water, sanitation and hygiene) amenities • Availability of power • Availability of communications • Access to emergency transport for interfacility transfer
6. Health workforce	• PHC health worker density and distribution • Production and supply of health workers • Renumeration (i.e. salaries) at PHC level vs hospitals • Licensing of health professionals • Accreditation mechanisms for education and training institutions • National systems for continuing professional development
7. Medicines and other products	• Regulatory mechanisms for medicines to support safety, effectiveness and quality of health products • Availability of essential medicines • Availability of essential in vitro diagnostics • Availability of priority medical equipment
8. Health information systems	• Accountability mechanisms • Completeness of reporting by facilities: what data are collected/ reported by PHC facilities? • Percentage of facilities using comprehensive patient records • Functional national human resources information system and national health workforce accounts • Completeness of birth registration • Completeness of death registration • Existence of effective surveillance system (to alert emerging threats)
9. Digital technologies for health	• Existence of national e-health strategy • Telemedicine access • Percentage of facilities using EHRs

[a] WASH – Water, sanitation and hygiene.

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Processes	
10. Models of care	**Selection and planning of services** • PHC service package • PHC service package meeting criteria • Roles and functions of service delivery platforms/settings defined **Service design** • Existence of a registration system • System to promote first contact accessibility • Services delivered in an integrated way • Protocols for patient referral, counter-referral and emergency transfer • Existence of care pathways for tracer conditions • Collaboration between PHC and community mental health centres • Collaboration between PHC and palliative care services Collaboration between PHC and rehabilitation services **Organization and facility management** • Management capability and leadership • Multidisciplinary team-based service delivery • Existence of supportive supervision system • Facility budgets and expenditures meeting criteria **Community linkages and engagement** • Collaboration between facility- and community-based service providers • Community engagement in service planning and organization • Proactive residents' outreach
11. Systems for improving quality of care	**Percentage of facilities with systems to support quality improvement, including the following criteria:** • existence of focal person for quality improvement and patient safety • dedicated resources for action on quality and safety • regular application of quality improvement methods • processes for clinical audits and mortality reviews • availability of clinical guidelines, protocols and checklists • systems for adverse event reporting, including medication harm • existence of an up-to-date risk management protocol • system or mechanism to measure patient experience/patient voices • accreditation of health facilities

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12. Resilient health facilities and services	**Percentage of facilities meeting the following criteria for resilient health facilities and services:** • defined health facility emergency management plan • designated team or focal persons for emergency management and service continuity • identified priority primary care services to be maintained during emergencies • up-to-date protocols for case management for priority health emergencies and disasters • staff trained on emergency and disaster risk management and service continuity • recent (once in the past five years) assessment of risks and structural and non-structural functionality and preparedness of facilities • simulation exercises to routinely test the functionality of health facility structures, mechanisms and functions • post-emergency reviews conducted to evaluate performance and use lessons to recover and strengthen capacities for future risks
Outputs	
13. Access and availability	• Geographical access to services • Perceived barriers to access (geographical, financial, sociocultural) • Access to emergency surgery • Existence of a system of post-crash care • Percentage of facilities offering services according to national defined service package • Provider availability (absence rate) • Percentage of facilities meeting minimum standards to deliver tracer services • Percentage of facilities compliant with infection prevention and control measures
14. Utilization of services	• Outpatient visits • Emergency unit visits • Hospital discharges • Leading diagnoses (primary care/outpatient visits, inpatient diagnoses at discharge)
15. Core primary care functions	• First point of contact at primary care services • Patients have a regular health provider • Visits are managed effectively at the primary care level • Services are responsive to patient and community needs

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16. Effectiveness	• Diagnostic accuracy (provider knowledge) • Adherence to clinical standards for tracer conditions • 30-day hospital case fatality rate (for acute myocardial infarction or stroke) • Avoidable complications (e.g. lower limb amputation in diabetes) • Hospital readmission rate for tracer conditions • Admissions for ambulatory care sensitive conditions • The probability of dying between the ages of 30–70 from the four major NCDs (CVD, cancer, diabetes or chronic respiratory disease)
17. Safety	• Prescribing practices for antibiotics • Proportion of people 65 years and over prescribed antipsychotics
18. Efficiency	• Provider caseload
19. Timely access	• Cancer stage at diagnosis (by cancer) • Waiting time to elective surgery
Outcomes	
Examples	• Effectiveness of, for example, hypertension and diabetes mellitus type 2 management • Avoidable hospitalizations for NCDs (including mental health) • Visits of practitioners' distribution • Smoking (% of residents aged 15+) • Pure alcohol consumption (litres per capita) • Overweight (% of residents aged 15+ with body mass index >25) • Obesity (% of residents aged 15+ with body mass index >30) • Patient-reported experiences • People's perception of health system and services

The framework offers essential guidance on how PHC-enabling investments and processes in a health system can lead to improved access to, availability of and quality of care, which in turn contribute to achieving improved health outcomes and impact.

Additionally, findings described in this report result from bilateral meetings with health authorities, institutions responsible for PHC governance, health administrators, PHC managers and PHC professionals. Findings and recommendations on the delivery of palliative care complement direct observations made during visits to family medicine centres of different types by geographical areas and a desktop literature review of both primary care and palliative care. A rapid assessment of all PHC dimensions is provided in Table 1.

For each section of this report, key observations and recommendations have been outlined starting from six "Ws". The first section focuses on the "why" which presents the rationale for adopting the new approach and highlights the significance of responsive, holistic care for improved patient outcomes. The second section identifies "the services for whom," specifying the beneficiary populations. The third and fourth sections explore "what" services to be included and "who" will deliver them, emphasizing the need for fit-for-purpose PHC professionals with the right skills mix and competencies to provide high-quality care. The fifth section discusses "the how," detailing the strategies and processes for implementing the new model effectively. Finally, section six concludes with "the where" and "when," outlining the service locations and the implementation timeline to provide a roadmap for stakeholders.

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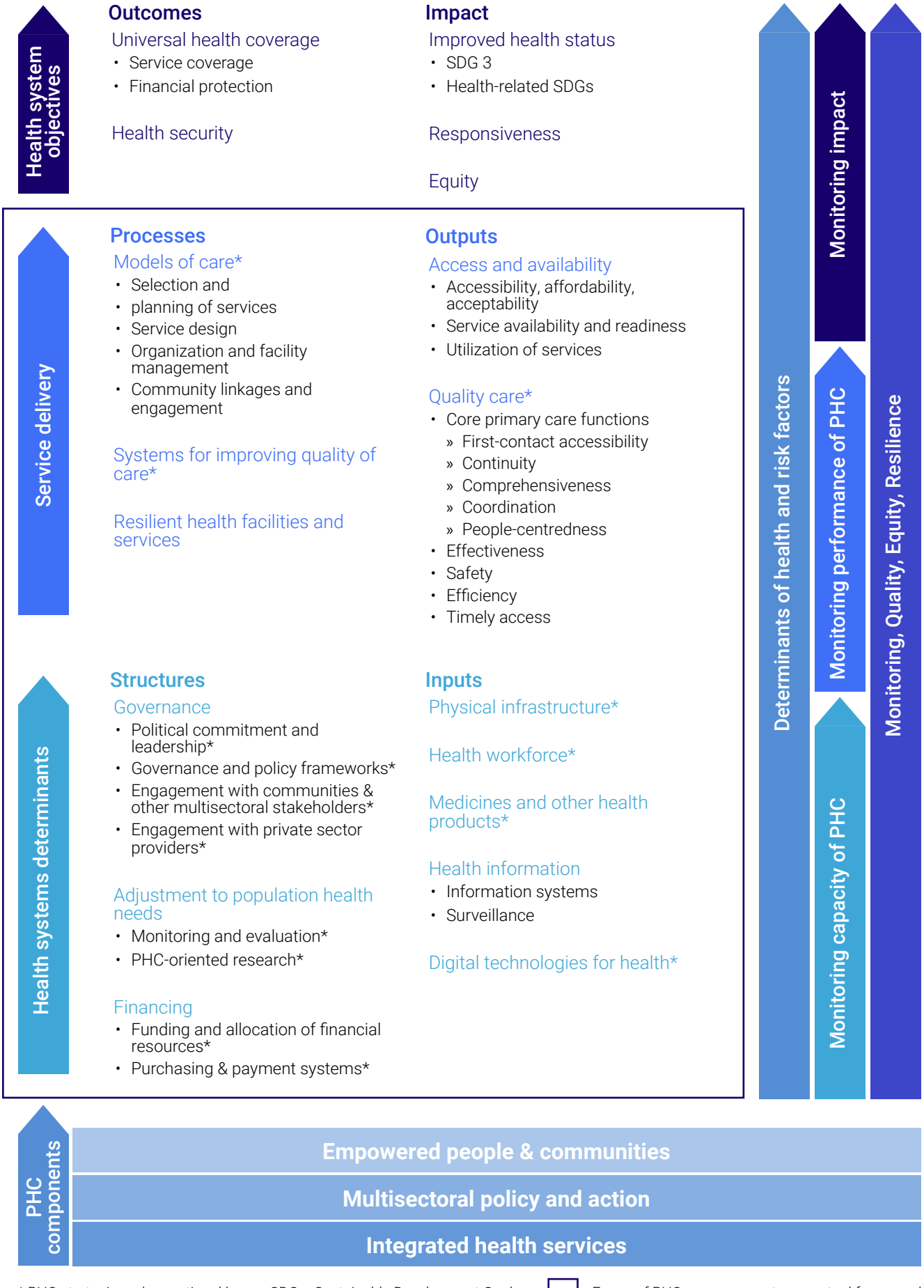
Fig. 1. Primary health care measurement framework and indicators



* PHC strategic and operational levers; SDG = Sustainable Development Goal. ☐ Focus of PHC measurement conceptual framework
Source: *(5)*.

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Observations and recommended actions

I. The case for change – the "why"

OBSERVATIONS

Life expectancy at birth in Kosovo[1] remains the lowest in the Western Balkans. Although life expectancy at birth increased from 70.44 in 2011 to 72.5 in 2019, Kosovars still have a lower life expectancy than elsewhere in the Western Balkans. The difference is more significant among members of the Ashkali, Egyptian and Roma communities. It is estimated that residents 50 years of age or older will constitute over 30% of the population by 2031, and over 50% by 2061.

Noncommunicable diseases (NCDs) are the leading cause of death. NCDs are the leading cause of death, representing over two thirds of all deaths. The rising burden of NCDs is accompanied by significant health-care and indirect costs – for premature deaths or disability. Kosovo's[1] burden of disease is similar to most other health systems in the WHO European Region and NCDs do not only affect the elderly, as more than a quarter of deaths among the 20–29 age group are due to NCDs. Cardiovascular diseases (CVDs) are the leading cause of morbidity and mortality (representing over 40% of all deaths in 2018), followed by malignant diseases and respiratory diseases *(1, 6)*. In 2019, mortality rates due to CVDs were higher in males (233 per 100 000) than in females (210.8 per 100 000). Similarly, death rates due to neoplasms were 105.8 per 100 000 in males and 63.7 per 100 000 in females. Despite palliative care being an integral part of PHC and an essential part of universal health coverage, palliative care provision in Kosovo[1] is limited.

NCDs often go undiagnosed and untreated. The WHO STEPwise approach to noncommunicable disease risk factor surveillance (STEPS) 2019 survey *(7)* revealed that 55% of hypertension cases in Kosovo[1] were previously undiagnosed, 9% were diagnosed but untreated and 25.4% were treated but uncontrolled. A similar picture was observed with diabetes, with only around half of patients with diabetes being treated. The low percentages of patients being diagnosed and treated reflect the lack of comprehensive screening programmes and suggest poor adherence to treatment and clinical guidelines. The reported number of insulin-dependent patients per 100 000 varies among municipalities. In 2020, the municipality with the highest number of patients under this treatment was Pristina with 1383 per 100 000; the lowest was Gjilan with only 111 per 100 000. The more than ten-fold difference between these two municipalities suggests differences in data quality and access to diagnosis and health care.

Mental health issues are prevalent. Mental health issues, including depression, anxiety and post-traumatic stress disorder, also represent a significant part of the burden of diseases, particularly given the historical context of conflict in the Western Balkans.

Policies and actions to reduce risk factors associated with the development of chronic conditions are fractional *(8)***.** Screening programmes are scarce, while policies to reduce exposure to harmful products, such as tobacco and alcohol, do not align with best international practices.

Despite the demand for palliative care, coordination between services is fragmented and the care provided is limited. This often includes chronic care rather than, specifically, palliative care. There are limited opportunities for palliative care education and training. Where palliative care is provided, it is based on experiential learning rather than formal education and training.

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RECOMMENDED ACTIONS

The burden and economic impact of NCDs call for urgent actions to protect the human capital of current and future generations. The current status of NCDs and their economic impact in Kosovo[1] emphasizes the need to build a PHC system that addresses the risk factors for chronic conditions while effectively managing NCDs to reduce their financial burden.

Develop condition-specific registries to improve the data quality and monitoring of NCDs. The existing cancer registry is adequately followed by health-care staff at regional hospitals and the Institute of Public Health in Pristina. Adopting a similar process for major NCDs, such as diabetes and hypertension, is necessary for PHC, too. The use of additional indicators in PHC is recommended, such as those that relate to NCD risk factor control (e.g. prevalence of smoking, alcohol, overweight and obesity) and the management of NCDs (e.g. avoidable hospitalizations for hypertension and diabetes).

Undertake a Kosovo[1]-wide palliative care needs assessment. Utilizing the WHO indicators, undertake a Kosovo[1]-wide palliative care needs assessment *(9)*. The assessment may identify policy development, level of need, requirements for education and training, funding of services, provision of palliative care for both adults and children, and challenges in access to essential medicines in Kosovo[1].

II. Services for whom

OBSERVATIONS

Low use of PHC services. There are on average 1.94 visits to family doctors per resident per year and 2040 residents per primary care physician *(10)*. It is not clear if the low utilization of PHC services can be attributed to low demand for PHC services or to inaccuracies in available data, or both.

A formal referral from a family physician is required for a resident to consult with specialists in secondary care facilities.

Limited access to palliative care. In 2018, a report *(11)* concluded that many Kosovans are without appropriate palliative care options. The report suggested that the development of community and inpatient palliative care, investment in equipment, increasing access to essential medicines and strengthening the existing referral system through pathways of care would result in strengthening palliative care. It also emphasized the importance of increasing staffing, workforce education and training and taking a broader approach to palliative care to include psychosocial and spiritual care.

High out-of-pocket (OOP) payments and informal payments are prevalent. Kosovo[1] health system is characterized by low health expenditure and a high reliability on OOP payments. Its residents are highly dependent on OOP payments to pay for pharmaceuticals, including essential medicines for palliative care, such as those for pain and symptom management. Informal payments are also prevalent and are used by patients under the perception that they will receive better care. The level of coverage for drugs from the Essential Drug List increased from 65% (2021–2022) to 75% (2022–2023). Moreover, patients from the Roma, Ashkali and Egyptian communities are more vulnerable in having challenges in accessing health care, creating additional barriers to living a healthy life. It is commonly reported that the already limited number of health professionals engage in dual practice (i.e. referring patients to their private practice or those of colleagues), decreasing the efficiency of public health services and putting the most vulnerable at risk of impoverishment due to higher health-care costs, including those in need of palliative care. At the clinical team level, users report dissatisfaction when accessing health care, leading them to rely on the private sector to meet

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their health needs. The allocation of public funds for palliative care is very welcome with funding of €20 per patient available for palliative care provision. However, despite this support, there are still significant OOP expenses for patients and their families, reported to be between 40–80%.

Lack of accurate population health data. There are no reliable data on the actual number of people being served in catchment areas or on the segmentation of the population by specific health needs and utilization of services. The affiliated family medicine centres report data on communicable diseases and vaccinations every week to the main family medicine centre. The latter submits to the municipality, which reports to the regional institute of public health. The regional institute of public health reports monthly back to the municipalities and family medicine centres. The regional institute of public health also reports on the incidence and prevalence of communicable diseases and NCDs, mortality and the utilization of services to the Institute of Public Health in Pristina every three months. Feedback from patients on health needs to municipalities and family medicine centres is limited. Available PHC data relate mostly to the size and age structure of the population in the catchment area. There is a dearth of data pertaining to palliative care need or the utilization of services.

RECOMMENDED ACTIONS

Invest in the development of an improved population e-registry that provides data on registered residents per family medicine centre. It is recommended to invest in the development of an improved and unified population registry for every family medicine centre, which reflects the actual numbers of residents and is stratified by the age, sex, area of living (i.e. urban vs rural) and health and social needs of the people being served. The implementation of such a registry would also allow for better prevention and control of NCDs.

III. What services are provided?

OBSERVATIONS

Kosovo[1] residents are entitled to health-care services defined under a basic benefit package. Basic health-care family medicine centres offer a range of health-care services, including general medical care, preventive services, maternal and child health services, the treatment of common problems and limited palliative care support. In practice, some services are less well-implemented, including evidence-based interventions for NCDs (i.e. "WHO best buys"), the integration of mental health in PHC, home care services, palliative care and rehabilitation services.

Health promotion and screening at the primary care level is not systematically or proactively performed. There is no comprehensive strategy to systematically implement health promotion at the primary level of care, leaving most risk reduction activities to initiatives funded by donors and nongovernmental organizations. The infrastructure for the early detection of breast cancer is limited (breast cancer represents the leading cause of death by type of cancer among women), but there is only a limited amount of mammography equipment to provide screening services for women. The number of mammographies performed at health-care institutions and through mobile mammography was below 25 000, accounting for less than 10% of eligible women. Current screening programmes have increased the number of women screened for breast and cervical cancer, but the majority of eligible women remain unscreened.

The lack of standardized clinical protocols for the majority of NCDs leaves health-care workers unable to adhere to evidence-based service provision. Although efforts have been made to expand the number of clinical guidelines, some have remained in the planning stages. One reason is that stakeholders lack awareness and/or knowledge of clinical guidelines *(12)*.

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There is no evidence that Kosovo[1] implements screening for conditions, such as diabetes and hypertension *(13)*. However, it has been reported that patients with diabetes receive routine blood glucose measurements. Over 80% of patients with diabetes reported regular visits to the doctor, yet examinations for complications (i.e. secondary prevention) are low, as only 17% reported having their feet examined . Moreover, the self-monitoring of blood glucose is limited to 78.2% of patients with diabetes, most of them (74.1%) reporting having to purchase their own blood glucose meter and only 4.2% receiving one from organizations or donors. Family medicine centres face constant shortages in the supply of drugs and medical equipment, reducing their capacity to deliver effective care.

RECOMMENDED ACTIONS

Advance health financing reforms to enable adequate resources and strategic purchasing for quality services. Health financing reforms could be accelerated to introduce the concept of strategic purchasing to deliver concrete benefits to residents. One such pilot could be an introduction of the outpatient drugs benefit package, which could significantly improve adherence to a treatment regimen for patients with chronic diseases.

Improve implementation of specific parts of the existing service package. Areas that need improved implementation are WHO "best buys" for NCDs, mental health, home care services, rehabilitation and palliative care. For example, palliative care is not limited to end-of-life care and, if introduced early in the disease trajectory as part of PHC, can prevent unnecessary tests and interventions – this, in turn, can improve quality of life for patients and their families and save health-care costs. Another example is the importance of ensuring close integration of primary care mental health with family doctor services. Professional guidance, policy and incentives should be deployed to promote this and ensure that the physical health of people with mental health conditions is systematically managed. Especially for the most vulnerable residents and those with a higher risk of mental illness, the health system should ensure that enough mental health professionals are available. In addition, expanding breast and cervical cancer screening programmes throughout Kosovo[1] will result in an increased share of eligible women benefiting from early detection of cervical cancer and a better prognosis.

Expansion of the service package. Priority areas for expansion of the service package include access to more advanced laboratory services that allow for analyses of samples at accredited, well-equipped laboratories. For example, the measurement of average blood sugar level (glycated haemoglobin – HbA1c) in diabetes care is a key parameter for quality of care. Access to laboratory services should not be possible only as part of preventive check-ups, but also as a part of the management of NCDs that require long-term follow-up of multiple parameters.

Develop standardized clinical protocols for the prevention and treatment of NCDs and build the infrastructure to provide evidence-based care. Standardizing NCD care through developing clinical guidelines will ensure everyone benefits from the same care. Equipping health facilities with resources to implement standardized protocols is important to ensure adherence to standardized care. Clinical audits for implementing the protocols should be embedded as a regular practice. Empowerment and accountability mechanisms for quality care coordinators across health facilities is also of high importance.

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IV. Who provides the services?

OBSERVATIONS

Kosovo[1] is facing important challenges in relation to its health workforce, including a pronounced territorial, gender and age imbalance of health workers and their ongoing outward migration to places with better working conditions. These problems are further underpinned by inadequate health services management and weak leadership within PHC facilities leading to poor health workforce planning and management. Kosovo[1] has among the lowest ratios of physicians and nurses in Europe *(14)* with 1.44 physicians per 1000 inhabitants compared to the European Union average of 3.4 doctors per 1000 residents *(15)*. In primary care, there are 1068 doctors. Overall, there are severe health workforce shortages, especially in family medicine, but also in several other specialties – due to ageing, low applicant pool and out-migration – including palliative care, paediatrics, psychiatry and gynaecology. The retention of family doctors and specialists poses a particular problem in rural and remote areas. Family medicine as a specialty generally holds much lower status than other specialties with few young people pursuing the specialization. There is also a need to strengthen the family medicine faculty and revamp the medical curriculum in Kosovo[1] universities. Palliative care is not included in the undergraduate curricula of all health-care professionals and there are no opportunities for specialization in palliative care.

Nurses have a limited scope of practice despite standards and descriptions on their roles being available. The capacity for the delivery of nursing home services is also limited. The mission met with some nurses with enhanced roles who were practicing autonomously, but it also encountered examples where a nurse was providing clerical/secretarial support to a family doctor during a consultation. If family doctors need this type of support, then training new staff to be administrative assistants would allow for a better use of staff and scarce nursing resources to be deployed elsewhere. Advanced training and development for the existing workforce and programmes to develop the primary care and palliative care nursing workforce will be required to make the concept of the multidisciplinary team work optimally.

Family medicine centres provide limited team-based approaches to care. A typical family medicine centre is staffed by up to three PHC doctors plus nursing staff. There is also a substantial turnover of managers in family medicine practices, which poses a threat to the continuity of and investments in PHC.

RECOMMENDED ACTIONS

Strategic planning is a powerful approach for achieving improved availability, accessibility and quality of the health workforce. This requires a comprehensive assessment of the health labour market and anticipating future needs – such as numbers, competences, skills-mix and distribution – and analysing the implications of different possible scenarios. Enhancing working conditions, building leadership capacity, providing career pathways, strengthening continuing professional development, and aligning health-care education with residents' needs are required *(16)*. Further investments will be needed to build a health workforce registry and strengthen the capacity for information collection and analysis for policy decision-making. Kosovo's[1] health workforce accounts will also help to keep track of progress in implementing the document *"National Employment Agency Action Plan 2024–2025"*.

Policies and interventions to increase the number of future health workers and optimize the utilization of the existing workforce in PHC and palliative care facilities are important. These include:

1. implementing strategies specifically designed to attract, recruit and retain qualified health profession candidates, especially in understaffed areas;
2. broadening the scope of practice of certain cadres, such as nurses, and considering the creation of new cadres, such as case managers and self-management counsellors;
3. retraining and reallocating, where necessary, existing staff, such as specialists in hospitals;

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4. reviewing and, where necessary, reorienting curricula to match people's demands and interprofessional teamwork; and
5. scaling up the capacity of production of educational institutions.

To achieve a more effective geographic distribution of staff in rural areas, designing packages of financial, professional and family-friendly incentives to attract and retain health workers in underserved geographical areas will be needed. Access in rural areas can also be improved by supportive technology and providing adequate diagnostic and treatment tools to deliver health services. Using communication technologies (e.g. eHealth/mHealth) more intensively and innovatively to connect staff in remote or isolated areas with specialists in facilities of higher complexity can improve access and effectiveness.

PHC teams with new profiles need to be expanded. There is an opportunity to expand existing PHC teams in family medicine centres with new profiles over time and to strengthen collaboration with public health, hospital care and social services. New profiles could include the development of multidisciplinary teams, with social workers, community nurses, psychologists, physiotherapists, physical activity counsellors, health promotors and clinical community pharmacists, all of whom operate under one roof. Support for self-management and patient education especially requires highly trained professionals, such as nurse practitioners. Existing teams should also allow for more flexibility in assigning tasks. New tasks for nurses could be transferred from family physicians, provided that adequate training of nurses is possible. Palliative care is a good example of an advanced practice role for nurses.

The integration of medical specialists (e.g. paediatricians, endocrinologists, gynaecologists, midwives, mental health specialists, cardiologists, palliative care services and dermatologists) into PHC teams allows for one-stop-shop service offerings providing convenience and efficiency to patients. In this context, different ways of working could be envisaged, such as consultant-run email and telephone helplines that provide advice for teams; consultant participation in multidisciplinary team meetings; consultants with sessional time to support primary care staff to work in extended roles (e.g. by running joint clinics where their main function is to give advice and support primary care clinicians); and consultant-led education sessions.

Areas where there may be particular value in using these collaborative practices include endocrinology, respiratory disease, dermatology, musculoskeletal disorders, paediatrics, neurology and cardiology. The integration of specialists in PHC teams will also allow for the development of locally adapted guidelines, which is considered a critical enabler to optimize care pathways and improve quality of care and quality of life for patients and their families. Such guidelines describe the respective roles and responsibilities of family physicians and specialists in terms of screening, diagnosis, treatment and palliative care provision for a particular condition of disease.

Accreditation mechanisms are important. It will be important to revise or establish functional accreditation mechanisms and, in this context, to review the role and responsibilities of professional councils and make them accountable for the quality of the actions of their members.

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The roles of nurses need to be strengthened to allow for the expansion of their roles and responsibilities. There is significant potential to expand the roles and responsibilities of nurses beyond the provision of secretarial support to doctors. If family doctors do need such support, then training new staff to be administrative assistants would allow for a better use of staff and scarce nursing resources to be deployed elsewhere. Advanced training and development for the existing workforce and programmes to develop the primary care and palliative care nursing workforce will be required to make the concept of the multidisciplinary team work optimally.

Develop capacity for family medicine in general practitioners. The percentage of doctors in PHC facilities who are trained in family medicine should be increased.

Describe the knowledge, skills and professional attitudes required for every member of the PHC team. The knowledge, skills and professional attitudes of every member of the PHC team should be described based on WHO recommendations for integrated health services delivery *(17)*.

Develop capacity for the management of family medicine centres. There are opportunities to ensure that municipalities and PHC facility managers have the right level of competence and capacity to take responsibility for the management of family medicine centres. Capacity-building is recommended in the following areas:

1. using data;
2. performance management and holding health service providers to account;
3. needs assessment, setting priorities and planning for multisectoral actions improving residents' health; and
4. developing integrated and multidisciplinary care that is more proactive in the community while targeting socioeconomic determinants of health.

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V. How are services provided?

OBSERVATIONS

PHC provides mainly reactive services. The mission observed that PHC services provide mainly reactive services, resolving the health problems presented, focusing on prescriptions and referrals to narrow specialists. Limited proactive and preventive people-centred interventions were reported, such as addressing the health needs of vulnerable groups. There is also no systematic screening for cervical, breast or colon cancer, and very limited access to palliative care services was observed. Kosovo[1] has undertaken various steps to improve quality of care, but the impact remains limited due to a lack of payment incentives for improved quality, institutional fragmentation and limited public resources.

The proactive health management of residents is needed. There are important opportunities to address health needs, especially of the most vulnerable groups, in a more timely and effective way through proactive health management and PHC services for residents. The mission found insufficient evidence on effective mechanisms for exploring the root causes (e.g. health service delivery system) of related gaps in health outcomes of the local community. The family medicine centres provide an important opportunity to develop such mechanisms. This analysis could form the basis for quality improvement mechanisms designed to identify:

1. gaps in PHC clinical performance, in particular for the prevention and management of patients with NCDs;
2. opportunities to improve health-care seeking behaviour in residents;
3. gaps in patient self-management;
4. vulnerable resident groups; and
5. social determinants of health.

There is an important opportunity for improved collaboration and coordination of services. The mission observed services to be fragmented with a lack of horizontal and vertical coordination. Coordination between inpatient and outpatient providers is particularly challenging. Many health-care practitioners noted difficulties in the continuity of care between PHC and social and mental health service providers and between inpatient and outpatient settings. Palliative care outpatient services were not well developed, and care was made more challenging by issues related to access to essential medicines for palliative care, such as strong opioids for the management of pain and other symptoms. Administrative Instruction 04/2020 *(4)* regulates the referral process from primary to secondary health care, but a counter-referral from secondary to primary health care is not generally performed. Furthermore, diagnostic support is frequently unavailable or difficult to obtain, resulting in patients seeking care in private facilities located in Pristina. Some interviewees also indicated that insufficient support is provided to patients on discharge from hospital. Several care providers and experts indicated that many patients are discharged from inpatient care without a care plan, recommendations, medication or information about the support available to them. This was notable in people with palliative care needs. These perceived quality gaps showed great variation: some facilities provided services while others showed greater variation in the quality of care because it is not a unified service, there are no standardized guidelines or the services are offered according to the capacities and internal organization of municipalities (e.g. number of professionals, infrastructure, equipment, training). Proper measurement of this variation in quality is warranted.

Lack of a functional health information system. The lack of a functional health information system was an additional contributor to the lack of coordination between different levels of health care for NCDs.

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RECOMMENDED ACTIONS

There are important opportunities to further upskill family doctors and nurses. It is important to acknowledge that the implementation of PHC competencies in practice depends on a comprehensive suite of policies that address the planning, education, regulation, continuous training, recruitment and retention of the PHC workforce. Upskilling of the PHC health workforce could initially focus on training for the implementation of WHO "best buys", which are evidence-based interventions for NCDs that are not only highly cost-effective but also feasible and appropriate to implement within the PHC setting. Such "best buys" include risk stratification and monitoring for hypertension, cholesterol, diabetes and CVD risk. As previously stated, palliative care is also a good example of an area of care where upskilling the workforce can have a positive impact. One way to demonstrate this is to pilot the development of community palliative care services in one rural and one urban location. Collecting data by monitoring and documenting the findings from this demonstration project would provide evidence of the value of developing community palliative care services.

Make use of a quality and outcome framework. The development and use of a PHC quality and outcome framework would be an important enabling factor to steer and leapfrog improvements in quality care in primary health care centres. There are ample opportunities to improve the quality and safety of PHC services provided. The Accessible Quality Healthcare (AQH) project promotes and improves the quality of PHC in the public sector in Kosovo[1] *(13)*. Specifically, this project implemented the *WHO Package of Essential Noncommunicable (PEN) Disease interventions*, which were adapted to the Kosovo[1] context by local experts.

While building on previous quality initiatives, family medicine centres could further focus on improvements to tracing and adequately explaining to whom care has been delivered and the clinical decisions taken, and if care was delivered to meet pre-defined standards, such as those for central-level service frameworks, evidence-based clinical guidelines and care pathways. They all contain detailed prescriptions of what activities should be undertaken by the teams that work in family medicine centres. For example, a coronary heart disease (CHD) framework can require, as a goal for teams, a systematically developed and maintained practice-based CHD register to be in place to provide structured care to people with CHD.

Other important examples are measures of access and availability (e.g. waiting times and telephone access to physicians); clinical markers relating to the quality of preventive, acute, chronic and social care; and measures of prescribing and referrals. Guidelines, indicators and care pathways for palliative care are needed at a primary care level. Compliance to standards may be measured qualitatively or quantitatively by, for example, episodic or routine surveys, assessments of medical records, audits, inspection, the production of annual reports and making audit results available to health authorities and patients.

Improve residents' health management. Managing the health and well-being of the registered residents of health care centres is a proactive approach. Patients who account for the majority of total disease burden and spending, especially, should be identified in a timely manner, and actions that a team can take to respond more effectively to their needs, thereby avoiding excessive costs, should be determined. Critical steps towards the development of residents' health management include the use of patient and health registries, using, for example, the International Classification of Primary Care (ICPC-3) coding system, developed by the World Organization of Family Doctors *(18)*. ICPC-3 classifies patient data and clinical activity in the domains of general or family practice and primary care, taking into account the frequency distribution of health problems seen in these domains. It

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allows for the classification of a patient's reason for a visit, the problems or diagnosis managed, interventions carried out, and the ordering of these data by episodes of care. The International Classification of Functioning, Disability and Health is another useful tool that allows for the multidimensional assessment of functional status in patients *(14)*. It is a WHO framework for measuring health and disability both at the individual and resident levels. A second critical step towards the development of residents' health management includes the use of advance risk stratification and monitoring the health of different residents' groups through the implementation of internationally used risk stratification tools. One example of a first-generation risk stratification tool is that used for CVD as recommended among the PEN disease interventions, where CVD and diabetes, with their risk factors, are considered in an integrated manner. This approach can be a good starting point given the high burden of disease from CVD and diabetes in Kosovo[1].

Improve chronic diseases management. Opportunities exist to support the objective of improved chronic disease management and reduced hospital admissions through developing new models of service delivery for PHC nurses and for family doctors to work with specialists. These might include:

1. a multidisciplinary review of the register to identify patients at high risk of having NCDs and the services most demanded by them;
2. follow-up and counselling of patients with NCDs by PHC nurses, aiming to improve their health literacy and self-management skills; nurses who currently provide check-up services are well positioned to provide such services;
3. replacing the referral of patients to specialists with advice and guidance via e-mail, phone or video;
4. running joint clinics with family doctors who have an interest in a particular disease area; and
5. joint consultations via video with a family doctor, other clinicians, a specialist and a patient.

Areas where these collaborative practices may be particular valuable include endocrinology, respiratory disease, dermatology, musculoskeletal disorders, paediatrics, neurology, cardiology and palliative care.

Involve patients and communities in the co-design and evaluation of services. An important opportunity exists in taking a public health approach and leveraging the role of patients and communities in the co-design and evaluation of services for both entities. This requires effective governance structures and processes that allow for empowerment and community participation, including enhanced legitimacy and improved accountability. This will result in sustainable, equitable and quality person-centred health care. Examples of such a governance structure include having community-elected representatives participate as full members of municipality management structures, having primary health-care centres provide oversight, or establishing a community advisory board that has a formal role in providing an oversight of health services. Empowering people and communities to be involved in their care choices is one of the foundations of the WHO public health model of palliative care *(19)*.

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VI. Where and when are services provided?

OBSERVATIONS

Accessibility to primary care services remains good despite the absence of an appointment system. Family medicine centres operate during regular working hours (8:00–16:00) and the network of facilities at the local level offers 24/7 services for primary care emergencies. However, there is no appointment system in place. Primary care services are free, but co-payments apply according to one's income (i.e. lower income patients have lower co-payments for some services). There are different exceptions to socially deprived groups that make services free at the point of care.

Physical infrastructure has improved through renovations. There are 430 family medicine centres with their respective ambulances forming a network of PHC facilities. Some have undergone renovations, mainly in urban areas, initiated by local administrations to improve the quality of infrastructure, given the increase of residents. Private primary care centres have also proliferated, especially for paediatric care.

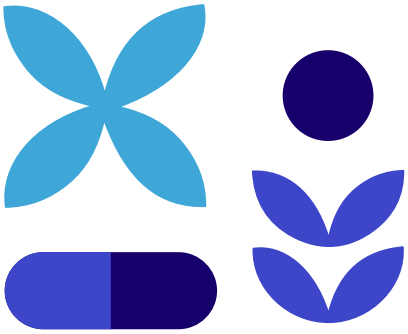
Patients with complex needs benefit from home visits. Chronic care teams conduct home visits. In Pristina, a centre for home services serves patients that cannot go to the centre. It conducts 40 home visits per shift and includes patients with palliative care needs and chronic conditions.

RECOMMENDED ACTIONS

Regulate demand through an appointment system. Although accessibility to primary care services is not identified as a critical issue, the introduction of an appointment system, including via digital means, would facilitate a better organization of clinical work. A well-functioning e-appointment system entails organizing the agendas of doctors and nurses and could be a trigger for introducing the registration of patients.

Introduce quality accreditation of PHC facilities. In addition to the effort to modernize health facilities, a programme for the quality assurance of PHC services would introduce new standards for medical equipment that could expand the quality and capacity of primary care services and reduce the variability between centres. Quality accreditation can go beyond infrastructure and equipment and cover care processes and compliance with clinical guidelines and protocols.

Plan primary care services and resources with updated census information. It is critical to update central- and local-level information about the population and their needs. The list of services offered in PHC at the local level should be based on the recommendations of Kosovo's[1] public health authorities. A health-care service mapping exercise should be carried out to identify areas where there are major gaps for professionals and resources as well as opportunities to provide services that exploit economies and scale.



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Progress on primary care developments

In relation to the assessment conducted by the WHO Centre for Primary Health Care in 2019, the following comparative table (Table 1) is provided to document progress for each of the domains of analysis.

Table 2. Progress on primary care developments

PHC domains	assessment 2019	assessment 2023	Status
Health needs	Need for data collection	Lack of accurate residents' health data	**No progress**
Utilization	Low rate of use	Low use of PHC persists	**No progress**
Access	Easy access, no appointment system	No appointment system	**No progress**
Referral system	Weak gatekeeping role Lack of clinical guidelines Pilot through the AQH project	Lack of clinical guidelines for NCDs Quality improvement in AQH pilots	**Improved**
Organization	Network of PHC facilities No accreditation process for public facilities	Renovation of family centres No accreditation of health facilities	**Improved**
Workforce	No incentive for family medicine specialty Ratio of patients per family doctor higher than the World Health Organization Regional Office for Europe average Potential of PHC nurses	Shortage of professionals aggravated Family medicine crisis No health workforce strategy Need to expand the role of nurses persists	**Worsened**
Scope of practice	Reactive services, prescription and referrals No patient lists No systematic screening for cancer	Health promotion and screening not systematically performed Slight improvement in screening for breast and cervical cancer	**Improved**
Performance	Focus on inputs, lack of information about hospitalizations at PHC facility level	Lack of information persists despite the introduction of a new PHC electronic health record (EHR) system	**No progress**
Governance	Commitment to strengthen people-centredness and disease prevention Involvement of local authorities	Commitment maintained, but no PHC development plan yet Health planning at local level based on the AQH project	**Improved**
Funding	Grants and budget lines High OOP payments	No changes in funding mechanisms	**No progress**
Information system	Need to prioritize data collection through eHealth projects	New EHR system working partially but not integrated with secondary care	**Improved**

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Priority actions for PHC and next steps

After the assessment of the situation of PHC services in Kosovo[1] and considering the evolution from the latest assessment in 2019, which shows little progress, the recommendation is to focus on a group of priority actions with relatively low investment requirements and high expected returns.

Following this effective action-oriented rationale, four priority actions are identified and presented. These actions rely on accompanying measures of health system enablers, such as policies for financing, medicines, human resources for health and information systems presented in the Fig.2. Their order here is not by priority.

Action 1. Setting up a PHC taskforce

Improving PHC services across Kosovo[1] requires a political mandate, a technical taskforce and the participation of key stakeholders. The first task is to identify the key stakeholders in PHC and organize meetings with the support of relevant authorities. The terms of reference for the taskforce will need to be defined, as well as a clear mandate that can lead to the creation of a technical unit for PHC within the structure of the agency that is responsible for health policies.

Action 2. Unpacking decentralization

The decentralization of primary care services delivery has benefits but also disadvantages if there is no policy to orchestrate and steer developments. Therefore, it is important to identify the main decentralization issues for PHC and their consequences. Initiatives, such as annual meetings with the directors of health of municipalities and PHC facility managers, can help to create a sense of unity and become a platform for collaboration and cross-learning. Institutional support and endorsements from health authorities would cement the importance of this initiative.

Fig. 2. Priority actions and system enablers

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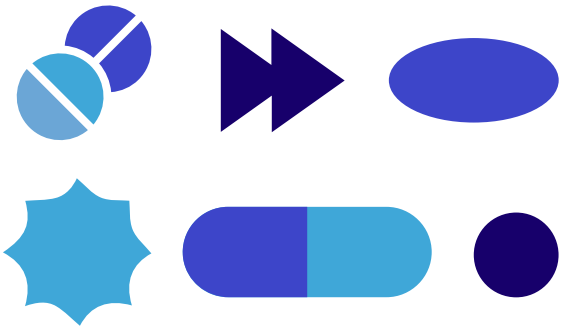
Action 3. Building the case for investing in PHC



Strengthening PHC involves further investment in the upcoming years. It is important to analyse the PHC component of Kosovo's[1] health accounts, including classification by major budget lines. Collaboration with local consultants is recommended in order to identify existing gaps and organize policy dialogues with health and finance authorities to develop the case for investing in PHC and improving the financing of basic medicines for the management of NCDs. A specific capacity-building programme should address PHC facility managers.

Action 4. Developing data-driven quality improvement

The link between data and quality improvement is critical. As a first step, it is necessary to analyse current health data collection efforts and reporting systems, considering the development of different patient registries. Further actions in digital health, such as an e-appointment system, can follow once the health information system is in place. Given the work developed in the AQH project, collaboration with the Swiss Agency for Cooperation and Development to conduct a thorough analysis of clinical processes of NCDs prevention and management would help to scale up the lessons learned in the pilots to the central level.

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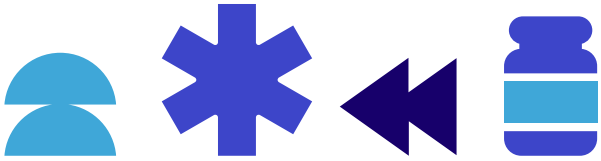
Priority actions for palliative care and next steps

Key issues include the following.

1. A lack of specialized services was identified as an issue with reports that many patients who need palliative care are not receiving it. Internationally, palliative care levels are organized around palliative care approach, generalist palliative care and specialist care), but it is reported that palliative care is not available at these three levels in Kosovo[1] and there is no process to refer patients for palliative care.
2. Guidelines, indicators and care pathways for palliative care are needed at the primary care level.
3. Data on the need for palliative care and place of death was not available.

Ensuring that residents in Kosovo[1] receive high-quality care requires the development and strengthening of palliative care. In line with the mission's objectives, the following first steps – short-term achievable objectives – are required.

- Undertake a Kosovo[1]-wide palliative care needs assessment. Identify the level of need; requirements for education and training, the funding of services and the provision of palliative care for children; and challenges in access to essential medicines.
- Identify key organizations and individuals involved in palliative care in Kosovo[1] and set up a key stakeholder group.
- Work with funders to include palliative care as part of projects, such as the current Swiss-funded project for NCDs, which includes palliative care.
- Pilot the development of community palliative care services in one rural and one urban location. Monitor and document the findings and data.
- Develop guidelines and care pathways for people with palliative care needs.



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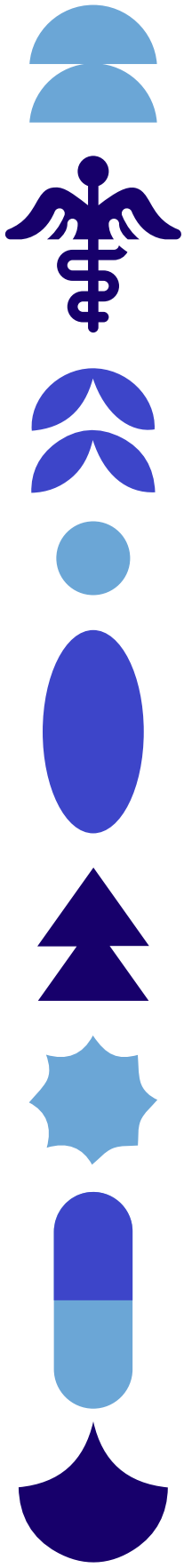

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