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This policy brief was prepared as an independent, non-partisan contribution to evidence-informed dialogue on health financing reform in Kosovo. The analysis is based on publicly available national and international data sources, including official documents, household survey data, legal frameworks, and internationally recognized databases such as those of the World Health Organization (WHO) and the World Bank.

The interpretations and conclusions presented in this document do not necessarily reflect the positions of any governmental institution, donor agency, or international organization, and should not be interpreted as official positions of any affiliated entities.

This brief examines the structural characteristics of Kosovo’s health financing system, with particular focus on financial protection, out-of-pocket spending, risk pooling arrangements, and ongoing legislative initiatives. Rather than limiting the analysis to a single budget year, it considers trends over recent years as well as current reform developments.

The objective of this brief is to assess how Kosovo’s health financing architecture affects equity, fiscal sustainability, and progress toward Universal Health Coverage (UHC), and to outline potential reform pathways that could strengthen financial protection and overall system performance.

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EXECUTIVE SUMMARY

Kosovo's health financing system remains predominantly government budget-funded and is characterized by substantial reliance on out-of-pocket (OOP) payments by households. In the absence of a fully operational public health insurance scheme, financial risk is borne directly by individuals at the point of service use.

Within international health financing frameworks, financial protection is a core dimension of Universal Health Coverage (UHC), requiring that individuals access needed health services without experiencing financial hardship^(1,2). Available data indicate that OOP payments in Kosovo account for approximately 38–40% of total health expenditure, significantly exceeding levels observed in most European Union Member States^(1,3).

Elevated reliance on direct household payments increases the likelihood of catastrophic health expenditure, commonly defined as health spending exceeding 10% or 25% of total household consumption⁽⁴⁾. High OOP shares are associated with weaker redistributive capacity, greater exposure among lower-income households, and reduced financial resilience at the population level^(5,6).

Kosovo established the legal foundation for compulsory health insurance through Law No. 04/L-249 (2014), amended in 2022^(7,8). In 2024, the Government approved a Draft Law on Compulsory Healthcare Insurance intended to operationalize a consolidated risk pool and formalize purchasing arrangements⁽⁹⁾. However, international evidence suggests that legislation alone does not guarantee improved financial protection without adequate administrative capacity and fiscal sustainability^(5,6).

Crucially, international experience indicates that health financing reform cannot be effectively implemented without parallel transformation of provider institutions. The coexistence of emerging purchasing mechanisms with a predominantly budget-based provider structure may limit the effectiveness of reform. Gradual evolution of major public providers toward more autonomous and contract-capable organizational models should therefore be understood as an integral component of reform, rather than a parallel or optional process.

The European Commission's Kosovo Report 2024 underscores the importance of strengthening fiscal governance and institutional capacity within Kosovo's broader European integration framework⁽¹⁰⁾. Health financing reform is therefore not only a sectoral issue but also part of a wider governance and social protection agenda.

This policy brief concludes that Kosovo's health financing architecture is at a structural turning point. Without strengthened pooling mechanisms and reduced reliance on direct household payments, financial risk will remain disproportionately concentrated at the household level.

A carefully sequenced reform approach is therefore essential. In the short term, priority should be given to strengthening financial protection and institutional capacity. In the medium term, structured pooling mechanisms should be developed. Full implementation of compulsory health insurance should be pursued only when sufficient administrative readiness, governance safeguards, and fiscal capacity are in place.

Section 1: Health financing context and reform landscape

Health financing is a core determinant of health system performance, influencing both resource availability and the distribution of financial risk. According to World Health Organization (WHO) frameworks, Universal Health Coverage (UHC) requires that individuals access needed services without experiencing financial hardship ^(1,2).

Financial protection is primarily achieved through prepayment and pooling mechanisms that distribute financial contributions across the population before illness occurs. Tax-based systems and compulsory health insurance models are designed to spread risk and reduce direct payments at the point of service use^(5,6). In contrast, systems with high reliance on out-of-pocket (OOP) payments shift financial risk to individuals and households, increasing the likelihood of catastrophic expenditure and inequitable access to care^(4,5).

Kosovo's health financing system is characterized by high reliance on out-of-pocket payments, limited risk pooling, and moderate public expenditure.

Kosovo's health financing system is characterized by three interrelated features:

- high reliance on out-of-pocket payments;
- limited risk pooling;
- moderate levels of public expenditure.

The system remains predominantly tax-funded, with public revenues as the main source of financing. However, in the absence of a fully operational insurance-based pooling mechanism, household payments continue to represent a substantial share of total health expenditure ^(1,3).

This financing structure must be understood within a broader institutional and fiscal context. The European Commission's Kosovo Report 2024 highlights the need to strengthen public administration, fiscal sustainability, and governance capacity across sectors⁽¹⁰⁾. Health financing reform is therefore closely linked to wider state capacity and public sector performance.

The legal basis for compulsory health insurance has existed since 2014⁽⁷⁾, with amendments adopted in 2022⁽⁸⁾. More recently, the Draft Law on Compulsory Healthcare Insurance (2024) represents a renewed effort to operationalize pooling mechanisms, define benefit entitlements, and establish structured purchasing arrangements⁽⁹⁾. However, international experience indicates that the effectiveness of such reforms depends not only on legislative frameworks but

also on administrative readiness, contribution collection capacity, and transparent governance systems^(5,6).

Beyond its role in financial protection and service delivery, the health sector may also be considered within a broader economic and development perspective. In many countries, health systems contribute to economic growth through employment, innovation, and cross-border service provision. In this context, the development of specialized services and potential health tourism targeting regional and diaspora populations may represent a complementary pathway for strengthening both financial sustainability and system capacity in Kosovo.

Overall, Kosovo's health financing system can be characterized as being in a transitional phase between a traditional budget-based model and a more structured, pooled financing system. This transitional position creates both opportunity and risk. Without carefully sequenced reform, structural inefficiencies and household financial exposure are likely to persist despite ongoing legislative efforts.

Section 2: Structure and key characteristics of the health financing system

2.1 Institutional architecture

Kosovo's health financing system is primarily organized as a tax-funded model, with public resources allocated through the state budget. Financing responsibilities are shared between central and municipal levels, resulting in a decentralized but also fragmented system structure.

The Ministry of Health is responsible for financing and overseeing secondary and tertiary health care services, while municipalities manage and finance primary health care. Although this division of responsibilities enables localized service delivery, it also introduces coordination challenges and potential inefficiencies in resource allocation across levels of care.

Budget allocation mechanisms remain largely input-based, with funding linked to historical expenditures rather than population needs, service outputs, or performance indicators. This limits incentives for efficiency, quality improvement, and outcome-oriented service delivery.

A central issue is the absence of a clear separation between purchaser and provider roles. While reforms aim to establish a Health Insurance Fund as a strategic purchaser, the main public provider—the University Clinical Service of Kosovo (UCSK), continues to operate as a traditional budgetary institution.

This creates a structural mismatch within the system: on the one hand, reforms are moving toward a model based on pooling and strategic purchasing; on the other hand, the primary provider remains embedded within a budget-based administrative framework. This misalignment constrains the development of contractual relationships, limits provider accountability, and reduces the effectiveness of performance-based financing mechanisms.

International experience suggests that effective health financing reform requires alignment between financing arrangements, provider organization, and governance structures^(5,6). In particular, strategic purchasing depends on the existence of autonomous providers that are capable of contracting, managing resources flexibly, and being held accountable for performance and outcomes.

Kosovo's health financing system reflects three core structural challenges:

- **Fragmented financing across levels of care**
- **Limited strategic purchasing capacity**
- **Misalignment between financing reforms and provider organization**

In this context, a potential strategic direction for Kosovo could involve the gradual transformation of the University Clinical Service of Kosovo (UCSK) into a more autonomous, clinically organized, and contract-capable institution. Experiences from European health systems suggest that increasing provider autonomy, combined with clear accountability mechanisms, can enhance efficiency and responsiveness.

Kosovo's mental health reform provides a relevant domestic example. Community-based services, organized through Mental Health Centers and supported housing structures, have been financed through dedicated budget lines and structured around functional service units. This model demonstrates how service-line organization can improve integration of care and resource efficiency, offering useful lessons for broader system reform.

2.2 Health expenditure and financing patterns

Assessment of financial sustainability requires examination of health expenditure relative to Gross Domestic Product (GDP) and total government spending.

Available evidence indicates that Kosovo's health expenditure remains relatively low compared with European Union standards^(1,3).

Public expenditure on health in Kosovo remains comparatively low, estimated at 3 – 3.5% of GDP, significantly below the levels observed in most EU Member States and also lower than the regional average.

Total health expenditure is estimated at approximately **4.0–4.5% of GDP**, while public health expenditure accounts for around **3.0–3.5% of GDP**.

These levels are significantly below EU averages, where total health expenditure typically exceeds **9–11% of GDP**⁽³⁾.

At the same time, out-of-pocket (OOP) payments account for approximately **38–40% of total health expenditure**⁽¹⁾. This is substantially higher than EU levels (**typically 15–20%**) and is associated with weaker financial protection and higher risk of catastrophic expenditure^(2,4).

Overall, Kosovo's financing structure reflects:

- relatively low public allocation;
- high reliance on household payments;
- limited redistribution through pooled mechanisms.

Table 1: Health Expenditure Trends in Kosovo (2019–2024)

Year	Government Expenditure (Euro mil)	Government Health Expenditure (% GDP)	Current Health Expenditure - CHE (% GDP)	OOP (% CHE)
2019	215.7	3.06%	~ 4.5	~ 37
2020	250.5	3.70%	~ 3.7	~ 38
2021	273.2	3.43%	~ 3.7	~ 38
2022	236.1	2.64%	~ 4.2	~ 39
2023	302.7	3.08%	~ 4.2–4.4 (est.)	~ 38–39 (est.)
2024	348.2	~3.3%	Not available	Not available

Note: CHE refers to total national health expenditure, while GDP refers to Gross Domestic Product.

Government expenditure data for 2019–2024 are based on Kosovo Budget reports, the National Audit Office, and the Kosovo Agency of Statistics. Estimates for Current Health Expenditure (CHE) and Out-of-Pocket (OOP) shares are derived from available international datasets and national analyses. Due to incomplete reporting of Kosovo in international health expenditure databases, values for 2023 are indicative and based on trend analysis. All values are rounded for policy interpretation purposes.

Preliminary budget projections for 2025 suggest a modest increase in public health expenditure; however, finalized and comparable data are not yet available.

Source: Kosovo Budget (2019–2024), National Audit Office, Kosovo Agency of Statistics, WHO Global Health Expenditure Database, World Bank.

Table 2: Health Expenditure Comparison – 2022 (Kosovo vs Region and European Union - EU)

Country	Current Health Expenditures – CHE (% GDP)
Kosovo	~ 4.0 – 4.5
Albania	~ 5.3
North Macedonia	~ 7.8
Serbia	~ 9.1
Montenegro	~ 9.3
EU average	~ 10.9

Source: WHO; World Bank; Eurostat.

Table 3: Key Health Financing Indicators

Indicator	Kosovo	EU Typical Range	Interpretation
Total Health Expenditure (% GDP)	~ 4.0–4.5%	~ 9–11%	Lower overall spending
Government Health Expenditure (% GDP)	~ 3.0–3.5%	~ 6–8%	Limited public financing
OOP (% CHE)	~ 38–40%	~ 15–20%	High household burden
Per capita spending	Low	High	Fiscal gap
Risk pooling	Limited	Universal	Weak redistribution

Source: Author's synthesis based on WHO Global Health Expenditure Database; World Bank.

2.3 Private health insurance and voluntary coverage

In addition to public financing arrangements, private health insurance (PHI) represents a supplementary financing mechanism within Kosovo's health system. While its overall scale remains limited compared with many European Union Member States, voluntary insurance products are present and merit analytical consideration as part of the broader financing architecture.

In European health systems, private health insurance typically performs one of three roles: complementary coverage (covering statutory co-payments), supplementary coverage (providing enhanced amenities or services), and duplicative coverage (offering parallel access to private providers outside the public system)^(5,6).

In Kosovo, the private insurance market appears to be concentrated primarily in corporate group policies and voluntary individual products targeted toward formally employed populations. Coverage remains limited relative to the total population, and PHI does not currently constitute a primary pillar of health system financing. However, it interacts with broader financing dynamics in several important ways.

From a health financing perspective, several structural considerations are relevant:

1. Risk pooling fragmentation

Voluntary private insurance pools are typically smaller and risk-selective. They may disproportionately cover healthier or higher-income groups, potentially increasing segmentation in the system⁽⁵⁾.

2. Equity implications

Where voluntary insurance primarily serves formally employed or higher-income groups, access to faster or higher-quality services may become income-dependent. In systems with elevated out-of-pocket spending, PHI may reduce financial burden for insured individuals while leaving others exposed^(2,6).

3. Impact on public sector incentives

Growth of duplicative private insurance may incentivize expansion of private provider markets and influence workforce allocation patterns. Without strong regulatory coordination, this may increase dual practice and reinforce parallel service pathways.

4. Interaction with compulsory insurance reform

The proposed compulsory insurance framework⁽⁹⁾ will need to clarify the role of voluntary private insurance to prevent overlap, adverse selection, and benefit duplication. International experience suggests that clear delineation between public benefit packages and voluntary supplementary coverage improves system coherence⁽⁵⁾.

Importantly, voluntary private insurance does not substitute for national pooling in achieving universal financial protection. While it may diversify financing sources and offer additional protection for specific groups, it does not inherently expand redistribution across the entire population.

From an analytical perspective, PHI in Kosovo should therefore be interpreted as:

- a complementary financing element;
- a potential equity modifier;
- a structural variable that interacts with public pooling reform.

Careful regulatory oversight, transparency in benefit definitions, and alignment with broader health financing objectives are therefore essential to ensure that voluntary insurance supports rather than fragments the health system.

Section 3: System preconditions for effective health financing reform

Health financing reform does not operate in isolation. Within established health system frameworks, financial protection and pooling mechanisms depend on the performance of broader system components, including service delivery, workforce capacity, access to medicines, governance, and health information systems^(13,14).

Strengthening these foundational elements is essential to ensure that financing reforms translate into improved equity, efficiency, and system performance. Without adequate system readiness, reforms aimed at expanding pooling or introducing insurance mechanisms risk remaining formal, with limited practical impact^(13,14).

Health financing reform in Kosovo should therefore be understood as part of a broader system transformation rather than a standalone policy intervention.

3.1 Service delivery and continuity of care

Health financing reform in Kosovo is constrained not only by funding levels, but by system readiness, particularly in service delivery, governance, and information systems.

Kosovo has established primary, secondary, and tertiary care structures. However, important gaps remain in the continuity, integration, and coordination of care. Services such as rehabilitation and palliative care are not consistently integrated into the publicly financed system. In addition, primary health care does not yet fully operate under a family medicine model

with defined patient lists and effective gatekeeping functions.

These limitations reduce system efficiency, weaken care coordination, and complicate the design of coherent benefit packages and purchasing arrangements. International experience demonstrates that strong primary health care systems, particularly those with gatekeeping roles, are critical for efficient resource use and cost control⁽¹⁶⁾.

Without a well-functioning service delivery model, expanded financing mechanisms may lead to increased utilization without corresponding improvements in health outcomes.

3.2 Revenue allocation and planning

Health financing allocation in Kosovo remains largely driven by budgetary processes rather than systematic needs assessment.

This may lead to variability in resource distribution and limit predictability in financing flows across institutions and levels of care. Budget allocations are not consistently aligned with population health needs, service demand, or performance indicators.

International evidence suggests that sustainable pooling and insurance-based systems require transparent, rule-based allocation mechanisms aligned with epidemiological and demographic profiles^(13,14).

Without such mechanisms, financing reforms may not achieve intended improvements in equity or efficiency.

3.3 Health workforce capacity

While workforce capacity is relatively stable at primary and secondary levels, gaps remain in specialized tertiary services.

Limited availability of subspecialized care contributes to continued reliance on treatment abroad and constrains the system's ability to respond to complex health needs.

Workforce distribution, specialization, and retention are therefore critical enabling factors for strengthening domestic service provision and reducing external dependence.

Without adequate human resource capacity, expanded financing alone is unlikely to improve access or system performance.

3.4 Medicines and medical products

The absence of a fully standardized, needs-based procurement and reimbursement system reduces predictability and may contribute to inefficiencies in pharmaceutical spending. Out-of-pocket payments for medicines remain a significant component of household health expenditure, reflecting gaps in public coverage.

Establishing a transparent and evidence-based medicines list, aligned with clinical protocols and reimbursement mechanisms, is essential for strengthening financial protection and ensuring efficient resource allocation⁽¹⁷⁾.

3.5 Governance and health information systems

A functional health information system (HIS) is a foundational requirement for modern health financing systems. It enables population registration, service tracking, claims management, and financial accountability.

Despite long-term investments, Kosovo's HIS remains only partially operational. Limitations in data availability, interoperability, and real-time reporting constrain system oversight and reduce the effectiveness of planning and purchasing functions.

International experience shows that effective pooling and strategic purchasing depend on reliable data systems, transparent reporting mechanisms, and strong governance frameworks^(14,15).

Without these elements, implementation of insurance-based financing mechanisms may face significant operational risks, including inefficiencies, delayed reimbursements, and reduced accountability.

The analysis highlights a central constraint: health financing reform in Kosovo is limited not only by funding levels, but by system readiness.

Key gaps in service delivery, governance, and information systems reduce the system's capacity to translate financial reforms into improved outcomes.

A sequenced reform approach is therefore essential. Strengthening core system functions, particularly primary care, data systems, and governance, should precede or accompany the expansion of pooling and insurance mechanisms.

Section 4: Financial protection and Out-of-Pocket spending

4.1 Financial Protection and out-of-pocket spending

Out-of-pocket (OOP) payments are a key indicator of financial protection in a health system. Under Universal Health Coverage (UHC), individuals should be able to access needed services without financial hardship^(1,2).

In Kosovo, OOP payments account for approximately **38–40% of total health expenditure**, significantly higher than in most European Union countries, where levels typically range between **15–20%**^(1–3).

High reliance on direct payments reflects limited prepayment and pooling mechanisms and indicates increased exposure of households to financial risk^(1,2).

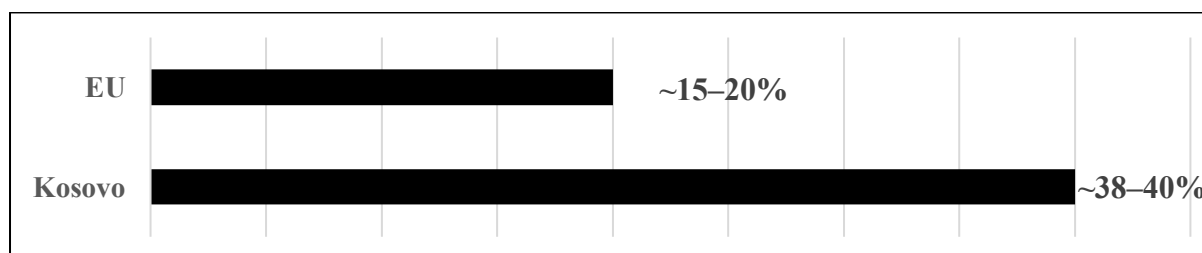
International benchmarks suggest that when OOP exceeds approximately 20% of total health expenditure, the risk of catastrophic and impoverishing expenditure rises substantially^(2,4).

In Kosovo, OOP payments arise from multiple sources, including medicines, diagnostic services, specialist consultations, and, in some cases, informal payments^(1,11). Structural factors, such as limited availability of services in the public sector, long waiting times, and perceived quality differences, may further drive patients toward private providers, where services are typically paid out-of-pocket^(11,12).

The combination of relatively low public health expenditure and high OOP reliance increases the likelihood of financial hardship, particularly among lower-income households, who are less able to absorb unexpected health costs and more likely to face barriers to accessing care.

Out-of-pocket spending in Kosovo (~38–40%) is nearly double the EU average (~15–20%). This indicates limited financial protection and a high risk of catastrophic health expenditure.

Figure 1. Out-of-Pocket Health Spending as a Share of Total Health Expenditure: Kosovo vs EU Average



Source: WHO Global Health Expenditure Database; OECD Health at a Glance.

From a system perspective, high reliance on OOP payments weakens the redistributive function of health financing. Instead of pooling risk across the population, financial burden is borne directly by individuals at the point of service use, reducing equity and undermining the core principles of UHC^(5,6).

International experience demonstrates that reducing OOP payments requires strengthening prepayment and pooling mechanisms, expanding coverage of essential services, and improving purchasing arrangements. Systems that rely on strategic purchasing and clearly defined benefit packages are better positioned to control costs and protect households from financial risk^(5,6).

4.2 Catastrophic health expenditure

Catastrophic health expenditure is commonly defined as household health spending that exceeds a defined threshold of total income or consumption, often measured at 10% or 25%⁽⁴⁾.

International evidence demonstrates a strong association between high out-of-pocket (OOP) shares and increased rates of catastrophic expenditure^(2,4). Systems characterized by

limited pooling and high point-of-service payments tend to generate higher financial vulnerability, particularly among low-income households.

While comprehensive national data for Kosovo remain limited, available evidence suggests that financial risk is unevenly distributed across the population. Households managing chronic conditions, long-term therapies, or repeated outpatient costs are particularly exposed.

Importantly, catastrophic expenditure does not arise only from major hospital interventions. It may result from the cumulative effect of routine expenses, including medicines, diagnostics, and repeated consultations.

In addition to direct medical costs, households may face indirect expenses such as transportation, accommodation, and income loss. These are often not captured in official statistics but can significantly increase the financial burden of illness.

From a structural perspective, high OOP reliance reflects incomplete risk pooling. In the absence of consolidated financing mechanisms, households effectively act as residual payers within the system, limiting redistribution and protection for vulnerable groups^(5,6).

High out-of-pocket spending in Kosovo is not only a financing issue.

It reflects deeper structural gaps, including incomplete risk pooling, limited purchasing mechanisms, and misalignment between financing reforms and provider organization.

4.3 Equity implications of health financing

Financial protection is closely linked to equity in access to health services. When a large share of health financing relies on direct payments, households with lower incomes face greater barriers to accessing necessary care.

In Kosovo, the relatively high share of out-of-pocket payments suggests that the financial burden of health care falls disproportionately on households with more limited financial resources. International evidence indicates that high reliance on direct payments contributes to inequalities in service utilization, as some households may delay or avoid seeking care due to financial constraints^(2,5).

Differences in financial capacity may also influence access to private health services or treatment abroad. Individuals with greater financial resources may bypass constraints within the public system, while others remain dependent on publicly financed services.

Particularly affected groups include patients with chronic conditions, individuals requiring long-term therapies such as oncology treatment, persons with disabilities, and populations in rural or underserved areas.

Without effective financial protection mechanisms, these dynamics may reinforce existing inequalities and widen disparities in health outcomes.

4.4 System level implications

High reliance on OOP payments has broader implications beyond individual financial hardship.

First, it limits strategic purchasing capacity. When a large share of expenditure occurs outside pooled mechanisms, public purchasers have reduced ability to influence provider behavior and control costs⁽⁵⁾.

Second, it constrains planning. High household spending may mask unmet need and distort demand signals within the system.

Third, it may erode public trust. When access to care depends on direct payment, confidence in public institutions may weaken. Financial protection is therefore also a matter of governance and social contract.

From a system perspective, elevated OOP shares signal incomplete pooling and limited redistribution. Strengthening financial protection requires both increased pooled resources and more effective purchasing arrangements^(5,6).

4.5 Structural interpretation

The analysis highlights a central structural issue: Kosovo's health financing system places a significant share of financial risk at the household level.

This reflects both relatively modest public financing and incomplete consolidation of pooling mechanisms. While the legal framework for compulsory health insurance provides a basis for reform⁽⁷⁻⁹⁾, effective implementation requires alignment with fiscal capacity, administrative readiness, and governance safeguards⁽¹⁰⁾.

The preceding analysis highlights several structural characteristics of Kosovo's health financing system with direct implications for financial protection and sustainability.

Overall health expenditure remains modest relative to European standards, limiting the capacity to expand coverage and strengthen financial protection. At the same time, a substantial share of health spending is financed directly by households, exposing them to financial risk and contributing to inequities in access.

The absence of a consolidated pooling mechanism further constrains redistribution. Despite an existing legal framework, implementation has not yet resulted in a fully operational system of pooling and purchasing.

In parallel, private sector development and household spending patterns continue to shape service utilization, with many households relying on private payments, including for care obtained abroad.

Taken together, these dynamics indicate that improving financial protection will require a combination of increased public investment, stronger pooling mechanisms, and better alignment between financing arrangements and service delivery.

Section 5: Cross-Border care and implications for health financing

5.1 Treatment outside Kosovo

Cross-border care represents a visible and politically sensitive component of Kosovo's health system. While not uncommon in smaller health systems, its implications must be assessed in relation to fiscal sustainability, equity, and long-term system development.

In Kosovo, treatment abroad largely reflects limited domestic capacity in highly specialized services, particularly advanced diagnostics and complex procedures.

In systems such as Kosovo, cross-border care often reflects limited domestic capacity in highly specialized services, particularly in advanced diagnostics and complex surgical procedures.

Rather than being interpreted as a system failure, cross-border care can be understood as a structural signal, reflecting the interaction between service capacity constraints, financing arrangements, and institutional design.

5.2 Publicly financed treatment abroad

Kosovo allocates public resources to finance treatment abroad when specific services are not available domestically. These cases are typically governed by administrative procedures and eligibility criteria.

From a financing perspective, publicly funded treatment abroad represents a form of external purchasing, whereby the state procures services from foreign providers.

This approach may be justified for rare or highly specialized interventions. However, international frameworks emphasize that purchasing decisions should align with long-term system development goals^(5,6).

When a significant share of public funds is directed externally, this raises important questions regarding opportunity costs and investment priorities.

Public financing of treatment abroad should therefore be assessed in relation to:

- the annual volume of cases financed;
- the share of the health budget allocated to cross-border care;

- the medical specialities most frequently referred;
- the transparency and consistency of eligibility criteria.

Without systematic monitoring and transparent reporting, cross-border financing risks becoming reactive rather than strategically planned.

5.3 Privately financed cross-border care

In addition to publicly financed cases, many households seek treatment abroad using private funds. These expenditures are not fully captured in official statistics but represent a significant financial burden.

High OOP spending within Kosovo^(1,11), combined with perceived quality differences and service limitations, contributes to cross-border care seeking.

Patients frequently access services in neighboring countries such as North Macedonia and Albania, as well as in Turkiye and other European countries for more complex interventions.

In most cases, these services are financed directly by households. This introduces clear equity concerns: access to specialized care becomes dependent on financial capacity.

Households with greater financial capacity are able to bypass domestic constraints, while lower-income families may face delayed or foregone care. The presence of privately financed treatment abroad therefore reinforces structural inequities within the health financing system.

In addition to financial costs, cross-border care may impose social and psychological burdens, including separation from support networks, language barriers, and uncertainty during treatment.

5.4 Fiscal sustainability and opportunity cost

Public financing of treatment abroad entails opportunity costs. Resources allocated externally are not available for domestic investment in infrastructure, workforce development, or equipment.

If sustained over time, external purchasing may contribute to structural dependency rather than system strengthening.

At the same time, complete elimination of cross-border care is neither feasible nor desirable. Small health systems often rely on regional cooperation for highly specialized services that cannot be efficiently developed domestically.

The policy challenge is therefore not elimination, but strategic management and alignment with long-term capacity development.

5.5 Equity and access considerations

Equity concerns arise when access to cross-border care depends on administrative discretion or household financial capacity.

Publicly financed treatment abroad requires clear and transparent eligibility criteria to prevent unequal or discretionary allocation. Strong governance safeguards are necessary to ensure that case selection is clinically justified and fiscally responsible.

Privately financed care reflects income-based differences in access. Without effective pooling mechanisms, disparities may widen, as some patients access advanced treatment abroad while others remain dependent on domestic services.

Private insurance may further influence these patterns, particularly if it facilitates access to international providers.

This dual-track dynamic, publicly financed selective referrals combined with privately financed external care, may widen socioeconomic disparities unless accompanied by strengthened pooling and purchasing reforms.

5.6 Treatment abroad as a structural signal

Cross-border care can be analytically understood as a structural signal of incomplete system consolidation, rather than as an isolated administrative issue.

Three interrelated structural elements are particularly relevant:

1. Limited pooling capacity and elevated out-of-pocket reliance^(1,5);
2. Moderate levels of public health financing relative to demand^(1,3);
3. Ongoing but incomplete reforms aimed at establishing insurance-based purchasing mechanisms⁽⁷⁻⁹⁾.

These factors interact with constraints in domestic service capacity, particularly in specialized and tertiary care requiring advanced infrastructure, workforce, and technology.

In health systems with consolidated pooling and strategic purchasing, cross-border care is typically embedded within formal reimbursement frameworks and integrated into national planning⁽⁵⁾. In this context, the evolution of Kosovo's insurance reform agenda will influence

not only domestic financial protection, but also the organization and governance of external purchasing.

Cross-border care should therefore be interpreted as an outcome of broader structural features of the health financing system, reflecting both financing constraints and service delivery capacity.

The analysis of cross-border care highlights several implications for the development of Kosovo's health financing system.

First, strengthening domestic service capacity, particularly in specialized and tertiary care, should be a strategic priority. Investment in infrastructure, workforce development, and clinical capabilities is essential to reduce reliance on external treatment pathways.

Second, financing mechanisms should provide clearer and more predictable coverage for services not available domestically. Transparent criteria for public funding of treatment abroad can improve equity and accountability.

Third, reducing reliance on cross-border care requires alignment between financing reforms and service delivery improvements. Expanding pooling mechanisms without strengthening domestic capacity may increase utilization without addressing underlying system constraints.

Fourth, policy approaches should explicitly consider the financial burden on households. Reducing out-of-pocket expenditure for necessary care, whether provided domestically or abroad, remains central to improving financial protection.

Overall, cross-border care should be understood not as an isolated issue, but as a reflection of broader structural characteristics of the health financing system.

Section 6: Health insurance reform: Pooling, purchasing, and system capacity

6.1 Role of health insurance in system performance

Health insurance reform should be understood not primarily as the introduction of contributions, but as a mechanism to strengthen pooling, purchasing, and financial protection.

International health financing frameworks identify three core functions of a financing system:

- revenue collection;
- pooling of funds;
- purchasing of services^(5,6).

Weakness in any of these functions may compromise equity, efficiency, and long-term sustainability.

In this context, the key policy question is whether reform improves risk pooling and enables more effective allocation of resources, rather than whether an “insurance” model is formally introduced.

International experience suggests that effective reform sequencing prioritizes improvements in service delivery and system functionality before large-scale introduction of mandatory contribution mechanisms. In this context, a “service-first, financing-second” approach may reduce implementation risks and strengthen public trust^(14,15).

6.2 Risk pooling and redistribution

Risk pooling refers to the accumulation and management of prepaid resources to distribute the financial risk associated with illness across a defined population⁽⁵⁾. Effective pooling mechanisms reduce reliance on direct payments and strengthen principles of solidarity.

In systems dominated by direct household payments, risk pooling remains limited and financial exposure becomes individualized. Elevated out-of-pocket reliance, as observed in Kosovo, indicates that pooling remains incomplete^(1,11).

Health insurance reform is not primarily about introducing contributions, it is about improving pooling, purchasing, and financial protection.

The legal foundation for compulsory health insurance in Kosovo was established through Law No. 04/L-249 (2014), subsequently amended in 2022^(7,8). The 2024 Draft Law on Compulsory Healthcare Insurance aims to operationalize a structured pooling mechanism and clarify institutional responsibilities⁽⁹⁾. Administrative frameworks for contribution collection have also been developed as part of earlier reform efforts.

If implemented effectively, consolidated pooling could:

- reduce direct household financial exposure;
- improve redistribution across income groups;
- enable clearly defined benefit packages;
- strengthen system planning capacity.

However, international evidence demonstrates that insurance legislation alone does not guarantee effective pooling. Outcomes depend on administrative capacity, contribution compliance, and governance safeguards^(5,6).

6.3 Strategic purchasing and provider incentives

Pooling alone is insufficient to transform system performance. The critical function of insurance-based systems lies in strategic purchasing, the ability to allocate resources through contracts, define benefit packages, set payment mechanisms, and influence provider behavior⁽⁵⁾.

In budget-based systems, financing is typically input-oriented and linked to historical expenditure. Strategic purchasing introduces tools such as capitation, case-based payments, and performance-based contracts to improve efficiency, quality, and accountability.

The Draft Law envisions the establishment of a purchasing entity responsible for contracting services⁽⁹⁾. However, the effectiveness of this approach depends fundamentally on the organizational structure and incentives of provider institutions.

In Kosovo, the primary public provider continues to operate as a budgetary entity. This limits responsiveness to contractual incentives, constrains managerial flexibility, and reduces the effectiveness of performance-based financing mechanisms.

A key strategic consideration is whether public providers, particularly the University Clinical Service of Kosovo (UCSK), should evolve toward more autonomous and contract-capable organizational models.

Such transformation could:

- improve resource management and cost control;
- strengthen accountability for performance and outcomes;
- enable implementation of advanced payment mechanisms;
- align financing arrangements more closely with service delivery.

International experience shows that purchasing reforms are most effective when accompanied by provider autonomy, clear accountability frameworks, and well-defined contractual relationships.

At the same time, poorly designed purchasing systems may generate risks, including cost inflation, supplier-induced demand, administrative complexity, and reimbursement delays. Strong governance, regulatory oversight, and technical capacity are therefore essential (5,6).

In this context, strategic purchasing and provider reform are structurally interdependent. Without provider institutions capable of contracting, managing resources flexibly, and being held accountable for performance, purchasing reforms are unlikely to achieve their intended effects.

6.4 Data systems and implementation capacity

The transition toward strategic purchasing requires robust data systems and institutional capacity.

Key enabling elements include:

- reliable data on service utilization, costs, and outcomes;
- digital claims and reimbursement systems;
- mechanisms for monitoring performance and financial flows.

Kosovo's health information system remains partially developed, limiting the capacity to support contracting and reimbursement functions.

International experience shows that financing reform and digital system development must progress in parallel to ensure transparency, accountability, and sustainability^(14,15).

A phased “digital-first” approach, prioritizing operational data systems before expanding pooling mechanisms, may reduce implementation risks and improve system performance.

6.5 Informal sector and coverage challenges

Kosovo's labor market includes a significant informal sector, creating challenges for payroll-based contribution models.

Without appropriate design, compulsory insurance may exclude informal workers or increase inequities. International evidence suggests that mixed financing models, combining general taxation with structured contributions, may be more feasible in such contexts⁽⁶⁾.

Key policy questions include:

- who contributes;
- who is exempt;
- how vulnerable populations are covered;
- how informal workers are integrated.

Ensuring inclusive coverage is essential to prevent widening disparities and to strengthen financial protection.

6.6 Governance and institutional capacity constraints

Health insurance reform represents a broader structural transformation rather than a purely technical adjustment.

Its success depends on alignment between:

- financing (pooling and resource mobilization);
- organization (provider structure and autonomy);
- governance (data systems, regulation, and accountability).

Currently, elements of modern financing coexist with traditional institutional arrangements, creating a structural mismatch—particularly between a contracting purchaser model and budget-based providers.

Implementation also requires substantial administrative capacity, including:

- population registration systems;
- contribution collection mechanisms;
- claims processing and reimbursement platforms;

- contracting and audit systems.

The European Commission Kosovo Report 2024 highlights broader governance challenges that directly affect reform implementation⁽¹⁰⁾. A key constraint is limited technical capacity in areas such as actuarial analysis, provider payment design, and financial management. Without strengthening these capabilities, reforms risk remaining formal rather than functional^(5,6).

Health insurance reform in Kosovo represents a potential shift from a predominantly allocation-based system toward a pooled and strategically purchasing model.

The central policy question is whether reform will effectively:

- consolidate pooling;
- strengthen purchasing;
- improve financial protection;
- enhance equity.

The current system reflects a partial transition, where financing reforms are advancing more rapidly than institutional capacity.

Addressing this imbalance, particularly the gap between financing design and implementation capacity, will be critical to achieving meaningful system transformation.

Section 7: Reform scenarios and policy options

7.1 Overview of reform options

Health financing reform in Kosovo should be approached as a phased and sequenced process, rather than a single institutional change. Reform sequencing should prioritize system readiness, particularly digital infrastructure, primary care gatekeeping, and clearly defined benefit packages, before full-scale implementation of compulsory health insurance^(14,15).

Health financing reform in Kosovo requires a sequenced approach, balancing financial protection goals with institutional readiness, fiscal capacity, and governance constraints.

International experience shows that rapid reforms without adequate administrative and institutional capacity may undermine financial protection and weaken public trust^(5,6). At the same time, continued reliance on high out-of-pocket (OOP) payments risks perpetuating financial vulnerability and inequities^(1,2,4).

Recent analyses, including World Bank (2023), highlight that reducing OOP and establishing a coherent financing model are central to improving equity and system performance⁽¹²⁾.

Based on the system diagnosis, three reform scenarios are proposed. These represent increasing levels of structural change and provide a framework for sequencing and decision-making.

7.2 Scenario A: Strengthening financial protection (Short-Term)

This scenario focuses on improving financial protection within the existing predominantly budget-funded system, without immediate operationalization of a compulsory insurance scheme.

The development of advanced purchasing mechanisms depends on reliable data on service utilization, costs, and outcomes. Strengthening health information systems and reporting capacity is therefore a critical enabling factor.

Core objective

Reduce direct household financial exposure and improve equity without major institutional restructuring.

Key policy measures

1. Strengthen financial protection mechanisms

- Expand exemption categories for vulnerable populations and ensure consistent enforcement
- Introduce or strengthen caps on co-payments, particularly for chronic conditions and essential medicines
- Ensure transparent eligibility criteria and monitoring

2. Improve access to medicines and outpatient services

- Prioritize essential medicines policies and targeted reimbursement approaches
- Strengthen supply chains to reduce reliance on private purchases

3. Improve transparency and purchasing within existing systems

- Strengthen reporting on publicly financed services, including treatment abroad
- Introduce basic purchasing elements (e.g., service agreements and accountability rules) within current budget frameworks

Advantages

- Lower implementation complexity
- High short-term political feasibility
- Reduced risk of institutional failure

Limitations

- Does not fundamentally change pooling structures; reductions in OOP are likely to be gradual
- Limited leverage for strategic purchasing^(5,6)
- Financial protection gains depend on enforcement capacity

7.3 Scenario B: Partial pooling reform (Medium-Term)

This scenario introduces structured pooling mechanisms progressively, combining tax-based financing with targeted mandatory contributions while building administrative capacity.

Core objective

Establish a credible pooled financing structure that improves redistribution while enabling gradual institutional strengthening.

Key policy measures

1. Establish a unified pooling mechanism

- Create a consolidated pooling function responsible for benefit entitlements and purchasing
- Ensure governance arrangements are transparent and insulated from short-term political influence^(5,6)

2. Introduce contributions in the formal sector

- Implement feasible and enforceable contribution mechanisms
- Minimize evasion and administrative burden

3. Ensure coverage for vulnerable and informal populations

- Use general taxation to finance vulnerable groups
- Develop mechanisms to include informal workers
- Link eligibility verification with social protection systems

4. Develop purchasing capacity progressively

- Introduce provider contracts and payment mechanisms as administrative readiness improves⁽⁵⁾

Advantages

- Strengthens redistribution and financial protection
- Builds administrative capacity gradually
- Creates a foundation for strategic purchasing

Risks and limitations

- Increased administrative complexity
- Challenges in integrating the informal sector^(5,6)
- Transitional uncertainty for providers and patients

7.4 Scenario C: Full insurance implementation (Long-Term)

This scenario reflects the full operationalization of compulsory health insurance in line with Kosovo's legal framework, including the 2024 Draft Law⁽⁹⁾.

Core objective

Establish a fully operational insurance system with consolidated pooling, defined entitlements, and strategic purchasing capacity.

Core system components

1. Universal population coverage

- Inclusive enrollment pathways, including informal workers
- State-subsidized coverage for vulnerable groups^(2,6)

2. Defined benefit package

- Explicit entitlements to improve transparency
- Alignment with fiscal capacity and service availability

3. Purchasing and contracting systems

- Structured provider contracts
- Digital claims, reimbursement, and fraud control mechanisms

4. Cost control mechanisms

- Payment systems designed to prevent cost inflation and inefficiencies^(5,6)

Advantages

- Strongest potential for pooling and redistribution
- Most effective pathway to reduce OOP payments if implemented successfully^(1,2)
- Enables full strategic purchasing

Risks and limitations

- High implementation complexity
- Requires strong governance and IT systems
- Fiscal sustainability risks if poorly calibrated
- Potential resistance to contributions

7.4 Comparative assessment and decision logic

A structured comparison highlights trade-offs across reform pathways:

Dimension	Scenario A	Scenario B	Scenario C
Fiscal Impact	Moderate	Moderate–High	High
Administrative complexity	Low	Medium	High
Financial protection impact	Gradual	Moderate	Potentially Strong
Fiscal and political feasibility	High	Medium	Variable

Given Kosovo’s current structural context, characterized by high out-of-pocket reliance, moderate public financing, and incomplete pooling mechanisms, Scenario A alone is unlikely to achieve substantial financial protection gains.

At the same time, immediate transition to Scenario C without intermediate steps carries a high risk of implementation failure.

A sequenced reform pathway combining:

- **Short term:** Scenario A (strengthen protection and capacity)
- **Medium term:** gradual transition to Scenario B
- **Long term:** progression toward Scenario C

Policy choices should be guided by:

- fiscal space;
- institutional readiness;
- labor market structure;
- governance capacity;
- reform sequencing strategy.

The analysis indicates that sustained reliance on high out-of-pocket (OOP) payments is unlikely to decline without strengthened pooling mechanisms. At the same time, the pace and design of reform must be carefully calibrated. Overly rapid institutional change may create implementation risks, while delayed reform may prolong financial vulnerability.

A sequenced approach, balancing financial protection objectives with institutional readiness and fiscal capacity, is therefore essential for sustainable reform.

Section 8: Implementation risk and system constraints

8.1 Overview of implementation risk

Health financing reform is inherently complex. While strengthening pooling mechanisms and reducing reliance on out-of-pocket (OOP) payments are central objectives of Universal Health Coverage (UHC)^(1,2), outcomes depend heavily on reform design and sequencing.

International experience shows that reforms involving compulsory insurance, contribution systems, or major purchasing transformations require strong fiscal planning, administrative capacity, and governance safeguards^(5,6).

In this context, implementation risk is not peripheral, it is a central determinant of whether reform leads to improved financial protection or unintended system pressures.

8.2 Fiscal sustainability risks

Reforms that expand pooling and benefit entitlements require stable and predictable financing.

In a context where public health expenditure remains moderate relative to GDP^(1,3), rapid expansion of coverage without corresponding revenue growth may generate structural deficits.

Key risks include:

- underestimation of service demand following expansion of coverage;
- incomplete contribution collection, particularly in payroll-based systems;
- growth in pharmaceutical and hospital expenditure without cost controls;
- mismatch between defined benefit packages and available fiscal space.

International evidence shows that poorly calibrated insurance rollouts can lead to expenditure inflation if cost-containment mechanisms are not introduced early^(5,6).

Mitigating these risks requires:

- clearly defined initial benefit packages;
- realistic revenue projections;
- phased expansion of coverage;
- strong financial monitoring systems.

8.3 Coverage gaps and informal sector challenges

Kosovo's labor market includes a significant informal sector, creating structural challenges for contribution-based models.

Payroll-based systems may fail to capture informal workers, self-employed individuals, and seasonal labor, potentially leading to coverage gaps.

Without state-financed coverage for vulnerable and informal populations, reform may inadvertently increase inequities^(2,6).

International evidence indicates that mixed financing models, combining general taxation with structured contributions, may improve inclusiveness in similar contexts⁽⁶⁾.

Potential risks include:

- exclusion of informal workers from coverage;
- administrative difficulties in income verification;
- unequal contribution burdens across population groups;
- perceptions of unfairness in system design. .

Mitigation strategies may include:

- tax-financed subsidies for vulnerable groups;
- simplified contribution categories for self-employed individuals;
- integration of insurance registries with social protection databases.

8.4 Governance and institutional capacity risks

Insurance-based reform requires robust administrative and institutional infrastructure. Core capacities include:

- accurate population registration systems;
- contribution collection mechanisms;
- claims processing and reimbursement platforms;
- audit and anti-fraud systems;
- transparent provider contracting frameworks.

The European Commission's Kosovo Report 2024 highlights broader governance and institutional capacity challenges across public administration⁽¹⁰⁾. Health financing reform therefore intersects directly with wider institutional strengthening efforts.

Weak governance structures may result in:

- delayed reimbursements to providers;
- financial mismanagement;
- provider capture or preferential contracting;
- erosion of public trust in the health system.

Institutional sequencing is therefore critical. Administrative and information systems should be operational before large-scale financial commitments are introduced.

8.5 Cost inflation and provider behavior

Expansion of coverage may increase demand for services. Without appropriate payment mechanisms, this may lead to cost escalation.

Key risk factors include:

- fee-for-service models without expenditure controls;
- limited monitoring of service volumes;
- weak pharmaceutical price regulation;
- insufficient data for utilization review.

Strategic purchasing mechanisms, such as capitation, diagnosis-related groups (DRGs), or global budgets, are essential to manage these risks when properly implemented^(5,6).

8.6 Political economy and reform sequencing

Health financing reform intersects with taxation, labor policy, and social protection, making it inherently political.

Contribution-based systems may face resistance from employers, employees, and informal workers, particularly where trust in institutions is limited.

Key risks include:

- public resistance to new contributions;
- employer opposition to payroll costs;
- reform fatigue due to complexity;
- perceptions of inequitable burden-sharing.

Maintaining public legitimacy requires:

- transparent communication of benefits;
- clear entitlement definitions;
- gradual implementation.

International experience shows that successful reform typically occurs through incremental strengthening rather than rapid structural change⁽⁶⁾.

The analysis highlights that implementation risk in Kosovo is closely linked to institutional capacity and reform sequencing.

While expanding pooling mechanisms is essential to reduce reliance on out-of-pocket (OOP) payments, premature or poorly sequenced reform may create fiscal pressures, administrative bottlenecks, and reduced public trust.

A phased approach, aligning financial reform with system readiness, governance capacity, and fiscal constraints, offers the most credible pathway to sustainable implementation.

Section 9: Conclusions and strategic implications

Kosovo's health financing system is characterized by a predominantly budget-based structure, moderate public allocation relative to GDP, and substantial reliance on out-of-pocket payments by households.

Current evidence indicates that direct household payments account for a significant share of total health expenditure, exceeding levels typically observed in European Union countries^(1,3). This financing pattern is associated with an increased risk of financial hardship and reflects limited redistribution through pooled mechanisms^(2,4).

Kosovo's health financing reform is fundamentally a question of how financial risk is distributed across society, requiring a balance between financial protection, fiscal sustainability, and institutional capacity.

The analysis presented in this brief demonstrates that Kosovo's health financing model places a considerable share of financial risk at the household level, reflecting both moderate public allocation and incomplete consolidation of pooling and purchasing functions^(5,6).

While the legal framework for compulsory health insurance has been established^(7,8), implementation remains incomplete. The 2024 Draft Law represents a renewed effort to formalize pooling and purchasing arrangements⁽⁹⁾, but its effectiveness will depend on institutional capacity, governance, and fiscal sustainability.

Health financing reform should therefore be understood not as a purely technical adjustment, but as a structural transformation requiring alignment between financing mechanisms and provider organization. In particular, the effectiveness of pooling and strategic purchasing depends on the ability of provider institutions to operate as autonomous, contract-capable entities accountable for performance and outcomes^(5,6).

The central strategic implication is that maintaining the current model is unlikely to significantly reduce financial vulnerability. At the same time, rapid implementation of insurance without adequate system readiness carries substantial risks.

A carefully sequenced reform approach, combining strengthened financial protection in the short term, gradual development of pooling mechanisms in the medium term, and full implementation of insurance when institutional capacity, governance safeguards, and fiscal capacity are in place, represents the most credible pathway forward.

Section 10: Policy actions and implementation priorities

10.1 Overview of policy priorities

Health financing reform requires not only a legislative framework but also institutional and technical capacity to operationalize pooling, purchasing, and financial management functions.

The analysis in this brief indicates that the primary constraint in Kosovo is not policy direction, but implementation capacity. Reform should therefore follow a sequenced and capacity-driven approach, combining immediate financial protection measures with gradual system development.

Effective reform in Kosovo depends on sequencing: strengthening system capacity first, followed by gradual expansion of pooling and purchasing mechanisms.

Key priority directions include:

- operationalizing a national Health Information System prior to large-scale insurance rollout⁽¹⁵⁾;
- strengthening primary health care as a gatekeeping mechanism⁽¹⁶⁾;
- developing standardized clinical protocols and service packages⁽¹³⁾;
- establishing a transparent and reimbursable medicines list⁽¹⁷⁾;
- introducing phased purchasing mechanisms before expanding contribution systems⁽¹⁴⁾.

10.2 Foundational priority: Institutional and technical capacity

Before large-scale implementation of compulsory insurance, Kosovo should prioritize development of core technical capacities required for pooling and purchasing.

Key actions:

- establish specialized units for actuarial analysis, provider payment systems, and financial management;
- develop targeted training programs and international partnerships;
- introduce standardized financial reporting and auditing systems;
- shift institutional focus toward strategic purchasing functions.

10.3 Short-Term actions (0–2 Years)

1. Strengthen financial protection

- expand coverage of essential medicines;
- introduce or reinforce co-payment caps;
- improve enforcement of exemption policies.

2. Improve transparency and governance

- establish reporting mechanisms for publicly financed services;
- introduce standardized criteria for treatment abroad;
- strengthen financial monitoring systems.

3. Pilot purchasing reforms

- test capitation or case-based payment models;
- develop basic provider contracting frameworks.

10.4 Medium-Term actions (2–5 Years)

4. Build institutional capacity

- develop expertise in actuarial analysis, DRGs, and financial management;
- establish dedicated technical units.

5. Strengthen data systems

- improve data on service utilization, costs, and outcomes;
- introduce digital claims and reimbursement systems;
- integrate health and social protection data systems.

6. Establish pooling mechanisms

- consolidate financing streams;
- introduce contributions in the formal sector;
- ensure tax-financed coverage for vulnerable groups.

10.5 Cross-Cutting system reforms

7. Align financing with provider reform

- gradually transform public providers toward autonomous and contract-capable organizational models;
- establish contractual accountability frameworks and enable performance-based financing mechanisms;
- develop legal and institutional frameworks to support provider contracting, financial autonomy, and accountability for results;
- organize service delivery around clinical pathways and integrated care models.

8. Strengthen governance

- enhance audit and oversight systems;
- ensure transparent provider contracting;
- monitor risks such as supplier-induced demand.

10.6 Strategic reform pathway

A sequenced reform approach, combining immediate financial protection measures with gradual development of pooling and purchasing capacity, represents the most feasible pathway for Kosovo.

Rapid implementation without institutional readiness carries significant risks, while maintaining the current system is unlikely to reduce household financial burden.

Balancing reform ambition with implementation capacity is therefore essential.

Engaging stakeholders, including patient organizations and civil society, can further strengthen accountability, responsiveness, and public trust throughout the reform process.

References

1. World Health Organization (WHO). *Global Health Expenditure Database*. Geneva: WHO. Available at: <https://apps.who.int/nha/database>
2. World Health Organization (WHO), World Bank. *Tracking Universal Health Coverage: 2023 Global Monitoring Report*. Geneva: WHO; 2023.
3. Organisation for Economic Co-operation and Development (OECD). *Health at a Glance: Europe 2022*. Paris: OECD Publishing; 2022.
4. Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL. *Household catastrophic health expenditure: A multicountry analysis*. *The Lancet*. 2003;362(9378):111–117.
5. Kutzin J. *Health financing for universal coverage and health system performance: Concepts and policy implications*. *Bulletin of the World Health Organization*. 2013;91(8):602–611.
6. World Health Organization (WHO). *The World Health Report 2010: Health Systems Financing – The Path to Universal Coverage*. Geneva: WHO; 2010.
7. Official Gazette of the Republic of Kosovo. *Law No. 04/L-249 on Health Insurance*. Prishtina; 2014.
8. Official Gazette of the Republic of Kosovo. *Law No. 08/L-042 Amending and Supplementing Law No. 04/L-249 on Health Insurance*. Prishtina; 2022.
9. Government of the Republic of Kosovo. *Draft Law on Compulsory Healthcare Insurance*. Prishtina; 2024.
10. European Commission. *Kosovo 2024 Report*. Brussels: European Commission; 2024.
11. Mustafa M, Hashani A, Maloku B, Shkodra T. *An Absent Therapy for Healthcare Financing in Kosovo*. Prishtina: Riinvest Institute; 2024.
12. Nguyen HT, Strizrep T, Prinz D, Aliu M. *Advancing Health Financing Reforms Toward Universal Health Coverage in Kosovo*. Washington, DC: World Bank; 2023.
13. World Health Organization (WHO). *Monitoring the Building Blocks of Health Systems*. Geneva: WHO; 2010.
14. World Bank. *Strategic Purchasing in Health Care*. Washington, DC: World Bank; 2016.
15. World Health Organization (WHO). *Global Strategy on Digital Health 2020–2025*. Geneva: WHO; 2021.
16. World Health Organization (WHO). *Primary Health Care: Transforming Vision into Action*. Geneva: WHO; 2018.
17. Organisation for Economic Co-operation and Development (OECD). *Tackling Wasteful Spending on Health*. Paris: OECD Publishing; 2017.

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