5. POLICY IMPLICATIONS: FROM DIAGNOSTICS TO ACTIVE TREATMENT

The deepening problems in the health sector in Bulgaria suggest that the health reform has strayed from the optimal solutions. The anticorruption measures in the health sector, particularly through ethical codes of conduct and hotlines, can hardly achieve any tangible results if the structural causes of corruption remain unaddressed. These causes are well-known and have been repeatedly reiterated in consultancy reports, electoral programs, and governance strategies over the past 17 years. It is time to move on from diagnosing the problems in healthcare to active treatment through bolder structural measures. There exist several pressing challenges on which efforts should focus in the short and medium term.

First, the restructuring of the outpatient sector has still not been completed. The problems there are mainly those of access and coverage, as well as the need for optimal balance between financing on per-patient and per-activity basis. It is necessary to allocate more funds for prevention and prophylactics in order to reduce health risks and the load on the hospital sector. The solution is to expand the coverage and access to primary and particularly to specialized medical assistance, which should take in the at-risk social groups. The financial incentives intended to improve the care for these groups and attract medical staff to the remote and under-populated regions should be more substantial and better targeted. The efficiency and scope of the various national health programs should also be subject to a cost-benefit analysis.

Second – a great many of the problems of health service provision stem from the insufficient health insurance coverage. The very groups that are most exposed to health risks remain outside the reach of the insurance system. The state also needs to find a solution concerning those whose insurance rights have been suspended and to optimize the insurance collection system instead of penalizing those who are hardly responsible for their employers' irregular payment of health-insurance contributions.

Third – government policy and regulations in the field of medical products and medicine procurement needs to be thoroughly reassessed and restructured. There is a call for guarantees that the hospitals will actually spend the amounts budgeted for medicine expenditures under each clinical pathway as specified in the contract with NHIF so that the burden is not passed onto the insured. Currently the government sets a minimum payroll threshold but no such minimum threshold for medicine expenditures. The list of medicines reimbursable by NHIF in outpatient care should be negotiated in the most transparent manner possible,

specifying the quantity and price of each medicine. It might be worthwhile to consider more active price monitoring and control over this oligopoly market.

Fourth – the most pressing problems in healthcare stem from the current impasse in the hospital sector. Hospital financing is still far from optimal and the funding advanced by NHIF tends to reflect more the choice and capacity of the providers than the real demand for hospital services by the insured, and still less, their actual cost. This calls for reassessment of the financial relations between the hospitals and NHIF, i.e. these relations should shift from a supply-driven, to a demand-driven model.

Last but not least, the role and responsibilities in health service provision of the private sector, as well as the nature of public-private partnership in this area need to be strategically reconsidered. The private sector is still held off from the market for health services.

The last two issues are at the very heart of the problem with the blocked health reform in Bulgaria and are the key to restarting it in the short term. They are considered in more detail in the next two paragraphs.

5.1. CLINICAL PATHWAYS VS. DIAGNOSTICALLY RELATED GROUPS

Initially the adoption of clinical pathways was seen as a stepping stone to the internationally established system of diagnostically related groups (DRG). These are at the core of the so-called case-mix approach to hospital service financing. In fact, these are diagnoses and procedures that can be grouped together based on similar hospital resource requirements for the purposes of financing contracts between hospitals and health-insurance companies. The adoption of standardized DRGs is an important precondition for liberalization and competition in the market for health services. Otherwise each insurance company would have to implement its own clinical pathways or classification, which would impede competition and would increase hospital expenditures for concluding contracts with more than one company.

DRGs are further considered a superior means of hospital reimbursement for several reasons. This methodology sets hospital services within a standard framework for measuring the value of the output with a cost breakdown of the various inputs. For the system to work it is necessary to categorize all procedures and activities based on cost similarity. All expenditures are recorded and codified in accordance with this classification. The use of the same codes in cost breakdown and output value measurement ensures fairer comparative evaluation of the contribution of each unit to the patient treatment process and hence, improved planning and allocation of health-insurance funds. This makes DRGs a more flexible instrument for assessment and funding of the actual costs of medical services provided. As mentioned above, the actual treatment may deviate from the one laid down in the clinical pathway leading to possible discrepancy between actual costs and funding by NHIF. This motivates hospitals to admit patients under the most expensive CP so as to make sure they would not incur any losses. On the one hand, DRGs allow more accurate reporting and data bases on expenditures for

medical services and activities, and on the other hand, greater flexibility in the course of the treatment, which is not influenced by financial considerations. This reduces the variances between the actual costs and the costs reimbursed by NHIF.

In addition, CP-based contracts reflect the government-assessed capacity of the hospitals to provide medical services rather than the real demand for such services on the part of the consumers. Clinical pathways are an instrument more befitting a supply-side health economy, whereas DRGs bring the allocation of collected insurance funds closer to the real demand for medical services. It is regarded as a financing system based more on output than input values.

The evaluation and development phase of DRG introduction in Bulgaria began in 1993, i.e. 7 years before the outset of the transition to a health-insurance system. Many projects financed by USAID, the World Bank, and PHARE Program, provided the technical and expert resources needed for their adoption. Among the more notable results achieved over the next 12 years of intensive consultations, are the translation of the International Classification of Diseases, testing of the code system and the accounting software by an ever increasing number of pilot hospitals, developing comprehensive strategies, road maps and action plans for DRG introduction and training of trainers, accountants, and hospital managers, etc. Most of the work was done with the consultancy assistance of 3M of Switzerland. Ten years after their first contract in Bulgaria, 3M reported having compiled an observation database covering more than 640,000 patients in 40 pilot hospitals; training of 1,585 trainers; a road map for DRG implementation in 2005-2006. According to this program, by 2005 all of the hospitals should have been included in a DRG reporting and accounting system and the financing itself was to be introduced on a pilot basis; in 2006, the hospitals should have moved to DRG-based financing. After significant spending on technical assistance and training for the introduction of DRG, their implementation has been left outside the new health strategy for 2007-2012. There has been no explanation as to whether they have been rejected and why.

5.2. EQUITY, CONSUMER CHOICE, AND COMPETITION

So far the reforms in the health system have been centered largely on state-run compulsory health insurance. Little has been done to supplement the system with private insurance so as to allow consumers to at least partly take healthcare into their own hands. The state should primarily bear the responsibility for those in need, i.e. should ensure minimum health standards. Improved services are usually achieved through private insurance that allows greater consumer choice depending on individual ability to pay. This stimulates hospitals to compete for patients and to invest as well in capital-intensive clinical pathways. It is the obligation of the state to support private health insurance through appropriate incentives and a more favorable business environment. Currently, little efforts are made to promote additional private health insurance and taking out such a policy does not substantially reduce tax obligations or the rates of compulsory insurance contributions. Instead of increasing the latter, the government should consider whether it would not be more effective to encourage employers, the employed,

and the self-employed, to take out additional health insurance. Naturally, such encouragement is hardly likely to have a great impact if the choice of additional insurance policies is again reduced to the state insurer – NHIF. It is necessary to promote private health-insurance services and improve public-private partnership in the health sector. Within such a health system it would be the responsibility of the state to control the insurance market and the market for medical services, as well as to provide adequate protection of consumer rights.

The broader choice of consumers with regard to service quality should be left up to the market rather than regulatory measures as is presently the case. Hospital revenues should hinge on the ability to attract patients with state-of-the-art technologies and good specialists instead of depending on the contract with the state monopoly holder in health insurance. This calls for various managerial skills on the part of the service providers, including investment project management and a changed attitude to the clients, as well as a clear-cut and well-defined price policy. The hospitals where costs are higher on account of better equipment and more highly paid specialists should make it perfectly clear to patients what part of the expenses would be covered by NHIF and what they would have to pay for themselves. This would stimulate the purchase of additional health-insurance policies.

It equally implies new management that would assign higher priority to the patients rather than NHIF. Naturally, if the hospitals were rational business entities, to them the client would be the one who pays or on whose choice the size of their revenues depends. In the case of the Bulgarian system, the revenues depend more on the National Framework Agreement, i.e. on negotiations with NHIF, than on the choice of individual consumers. The way the system is designed to work still makes the state, as represented by NHIF, a far more important client to the hospitals than the patients who pay health-insurance contributions.

It is nevertheless worth noting that the potential of the market for health services, where competition is generally more limited, should not be overestimated. The years of budget financing of healthcare has brought about a deficit in project management skills and lack of consideration for the patients' satisfaction. Moreover, it is not a market where one can rely too much on competition between service providers, particularly outside the big cities and university towns. The concept of consumer choice is hardly applicable to the larger part of the country, where patients have limited access to a single hospital or a single diagnostic center. Most hospitals, owing to their specialty or location, have a monopoly or oligopoly position in the market and can abuse of the possibilities to supplement NHIF financing with overpriced "extra services". This is a market for services, meaning that labor costs account for a substantial portion of the end consumer price. It may exceed 50-60%. Under limited competition, price variations may reflect differences in pay, which may not result directly from differences in qualification, skills, and new technologies, but rather, from the possibility for hospitals to overprice their services owing to low elasticities of demand for hospital care (i.e. their opportunity to exploit the lack of consumer choice for securing higher incomes). It is precisely the flawed competition in this market that justifies the regulatory role and intervention of the state. But it by no means justifies the absence of political will for the government to create some

competition, to the extent possible. All the more that, compared to the current practices of under-the-table payments, the price list including all services is the better and more efficient instrument for optimizing the expenditures even in the absence of competition among the providers.

The advanced health systems are trying to find the optimal balance between consumer choice and market incentives, on the one hand, and the responsibilities of the state, on the other. As a rule the state takes on the obligation to ensure coverage and access for the groups most exposed to health risks. Secondly, it manages the implementation of the national health priorities, such as active prevention, immunization and prophylactic activities, the outcomes of which are monitored through the public health indicators. The responsibility for ensuring greater consumer choice should be assigned to the private sector. In the case of Bulgaria, this means more active involvement of the private sector in hospital care and individual and collective insurance plans. The state has control and regulator functions, both in the insurance market and in the market for healthcare services, but the present balance between incentives and sanctions should be changed in favor of better targeted and more effective incentives.

5.3. RISK MONITORING AND MANAGEMENT SYSTEM

An important instrument of anticorruption policy would be a system of indicators making it possible to pinpoint and assess corruption risks, to identify measures to reduce them, as well as to subsequently evaluate the results achieved. The indicator matrix presented here is a general and open framework for risk monitoring and management that facilitates early warning of problem areas with high corruption risk, as well as the formulation of measures of prevention and counteraction. The indicators can also be used in follow-up evaluation of the effectiveness of the steps taken.

The system is based on information from two groups of sources. The first group comprises instruments for qualitative analysis and monitoring of the types of corrupt practices and corruption risk by sector. It draws information from:

- In-depth interviews with the specialists and supervisors in the respective structural units;
- Reports submitted by citizens through hotlines, anticorruption websites, ombudsman, and other channels for civic control and counteraction of corruption.

The information collected in this manner is processed and analyzed in order to provide the main parameters and objectives of the second part of the system: the quantitative indicators. These are structured in a way as to allow monitoring the dynamics of corrupt practices by type and area of occurrence. Some of them are the so-called soft data (sociological surveys) and unlike most corruption surveys, what is of central importance here is citizens' shared personal experience concerning corruption in the health sector. A considerable part of corrupt and abusive practices, however, remain concealed from the patients. That is why it is equally important to conduct qualitative and quantitative surveys of health service

providers, as well as of the units exercising control in the sector of health services and in hygiene-and-epidemiological inspection.

The system also contains diagnostic indicators of the risk of ″grand″ (political) corruption in healthcare that involves high-level abuse of powers in the interest of particular investors or suppliers of equipment and medications, or of particular hospitals, for personal gain. They are not easy to measure but form an integral part of the overall assessment of corruption risk. Most are found in the sphere of public procurement and their detection therefore relies on such transparency and civic control instruments as the public procurement registry, the observation of the legal framework of party financing, lobbying, property declarations, and conflicts of interests involving health sector executives. Much of this framework has still not been finalized or is not being implemented effectively within the national legal system.