CORRUPTION IN THE HEALTHCARE SECTOR IN BULGARIA

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THE STUDY OF
DEMOCRACY

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    ISBN-987-954-477-149-2
19. **Corruption in the Healthcare Sector in Bulgaria, Sofia, 2006.**
    ISBN: 987-954-477-154-6

ISBN: 987-954-477-154-6

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INTRODUCTION

Healthcare is one of the sectors in Bulgaria in which structural reforms have stalled. One incontestable achievement of the past nine years has been the transition from central budget financing of healthcare to a health insurance system. The gain, however, has largely been for the budget. Health-service users have still not fully felt the advantages of the change. On the contrary, a considerable portion of the population has lost access to health services and the rest are dissatisfied with the quality of medical assistance. The equipment is outdated, the staff not motivated enough, and corruption is prevalent. In the first 17 years of the transition, the system lost the advantages of state healthcare, namely, universal coverage and access, without tangibly benefiting from the advantages of market-based healthcare: more competition and customer choice, technological innovation, and higher quality of services.

The ultimately negative balance of results achieved by the healthcare reform is evident from the deteriorating general public health indicators. The combination of a falling birth rate and a mounting mortality rate, together with the rising number of young people migrating from Bulgaria, further aggravate the problem with population ageing.

The high mortality rate is largely accounted for by cardiovascular disorders. Two-thirds of deaths are due to heart attacks and strokes. These are followed by cancer diseases, which are increasing in number at a fast pace. Respiratory conditions are the most common reason for hospitalization, with nearly half of the cases with lethal outcome in this category being caused by pneumonia. Another alarming tendency is the increasing incidence of mental disorders. Since they are relatively less likely to cause premature death, they tend to remain outside the focus of attention of health statistics in Bulgaria. It is also the reason why their high social and economic price is often overlooked.

The number of people with disabilities has increased three times in the years of the transition, with the incidence of newly registered cases being twice higher than the average rate in the European Union and among the highest worldwide. As with mortality, cardiovascular diseases are a major cause of disability.

One important indicator of healthcare effectiveness is the infant mortality rate. At the outset of transition, Bulgaria used to rank close to the countries of Central and Eastern Europe, ahead of Poland and Hungary. Fifteen years later Bulgaria is at the bottom of the rating. In the Balkans, Albania and Romania are the only countries with higher infant mortality rates. In this country, the probability of a child dying before the age of five is three times higher than in EU-15

and about twice higher than in the new EU member states from Central and Eastern Europe. The most common causes of infant mortality are premature births, prenatal complications, respiratory diseases and various infections. The years of the transition have also been marked by deterioration of certain health indicators reflecting problems typical of low-income countries, such as the spread of tuberculosis and hepatitis.

Yet it should be noted that these health indicators represent mean values, i.e. they tend to obscure the critical situation in some regions of the country. The mortality rate, including infant mortality, is far higher in the countryside and the regions with geographically compact ethnic minority population.

The deteriorating health status indicators in Bulgaria are in part due to the adverse demographic tendencies, as well – falling birth rate, increasing number of young people migrating abroad, etc. The chief reason for the poor indicators, however, remains the limited access to health services. In this respect, the main obstacle to providing generally accessible medical care is posed by the drop in incomes and the increasing economic vulnerability of the population combined with the transition to a health-insurance system. Poverty and deteriorating health are creating a vicious circle where, due to lack of financial means, people are left outside the reach of the health service system and in turn, poor health undermines their prospects in the labor market and ultimately leads to deepening poverty and social exclusion.

The healthcare reform has so far failed to come up with adequate solutions to the challenges facing healthcare in Bulgaria. The government has withdrawn from health service delivery to concentrate on the management of the health insurance system. The existing disease prevention programs largely rely on external financing, which makes them projections of international programs rather than of the public healthcare agenda in Bulgaria. The high infant mortality rate and the increasing incidence of infectious diseases may be attributed to the limited scope of immunization programs. The transition from a state-financed healthcare system to health insurance has reduced the scope and reach of prophylactics and medical assistance, particularly as regards the increasing number of Bulgarians not covered by health insurance.

The unemployed and the low-income groups are not the only ones exposed to higher health risks. In varying degrees, this applies to society as a whole. The liberalization of prices and private enterprise were not accompanied by adequate legal and institutional measures to safeguard the rights of employees and consumers. This led to increased health risks in the workplace and the home. The state is not yet fully effective in implementing work and food safety standards, or environmental protection standards, and does not have a clear-cut policy for the protection of medicine consumers against monopoly or oligopoly prices. The high social and economic stress combined with weaker employee and consumer protection have brought about a sharp deterioration of the health status and quality of life of a large portion of the population in Bulgaria.

In addition to the social and economic difficulties of the transition, the problems with Bulgarian healthcare to a great extent stem from deficiencies in the

management of the health system. The present report examines the institutional problems and corrupt practices conducive to the poor quality of medical care in Bulgaria. The results of the transition from state-financed health system to health insurance have been analyzed with a view to identifying the sources of corruption risk and their relative weight.

Chapter one deals with the healthcare problems related to poor management. They essentially fall into three groups: lack of political will to bring the health reform to successful completion; insufficient state funding; and insufficient managerial and administrative capacity. These problems provided a fertile breeding ground for corrupt practices and non-compliance by health service consumers and providers. Chapter two outlines the dimensions and dynamics of corruption in the health sector and the most common corrupt practices. Chapter three is concerned with the specific driving forces of corruption in the outpatient sector and chapter four, in the hospital sector. Chapter five formulates the main conclusions and policy recommendations. It also presents a system of indicators for the monitoring and assessment of corruption risk in the healthcare sector in Bulgaria.

The Center for the Study of Democracy would like to thank **Gergana Kirova**, head of the Inspectorate Division of the Ministry of Health and **Denitsa Sacheva** from the International Healthcare and Health Insurance Institute for their comments on earlier drafts of the report. Responsibility for any errors or omissions rests solely with the author.

1. HEALTHCARE REFORM IN BULGARIA: THE ACQUIRED INSTITUTIONAL DEFICIENCY SYNDROME

1.1. BELATED AND INCOMPLETE REFORMS

Reforms in the health sector in Bulgaria did not actually begin until ten years after the start of the transition to market economy. Moreover, upon their launch in 1999, Bulgaria chose a partial restructuring approach, with only outpatient care conceded to the private sector. The hospitals remained in the public sector. In fact, even health insurance is public since it is mandatory and is managed by the National Health Insurance Fund (NHIF).

Under the former system, medical care was provided by polyclinics and hospitals. All medical services and necessary medications were free-of-charge and financed by the national budget. The flaws of this system are well-known. They are related to the fact that central distribution of financial resources and the lack of competition undermine the effectiveness of health care and do not offer any incentives for improved quality of service. Conversely, competition in the market stimulates providers to deliver higher-quality services at lower prices and encourages insurers to offer more advantageous insurance plans. Voluntary (private) health insurance is an intrinsic part of modern market economies. Here, the consumers and their employers purchase health policies from private health insurance companies, which in turn cover partially or fully their medical care expenses.

The chief shortcomings of this system are related to certain market drawbacks. Private health insurance is unable to automatically achieve the results attainable by an active government health policy – high coverage rate of planned immunizations, guaranteed access to health services, and protection of at-risk groups (typically remaining out of the reach of private insurance). With prophylactics and disease prevention, the public benefits outweigh the respective private expenditures, which is sufficient reason for financial support by the state. Reducing health risks in society largely depends on the access to health services of the more exposed low-income groups. In addition, health insurance and the market for health services as a rule require a certain amount of government regulation and control in order to safeguard consumer rights and guarantee adherence to minimum standards of treatment and service.

For these reasons, many countries opt for a combined system bringing together the responsibilities of the state regarding the health policy and the health and social protection of the most at-risk groups on the one hand, and the opportunity for market-based choice of health-service provider depending on the patient's ability to pay. It remains up to the state to regulate and supervise the market in order to ensure definite standards of health service quality and consumer rights protection.

This includes licensing and control of insurers and accreditation and supervision of health establishments.

The Bulgarian health reform combines public and private responsibilities, too. The country has a health-insurance system managed by the National Health Insurance Fund (NHIF), with private outpatient care and public hospital care. The reform, which started in 1999, introduced three health service levels. The first one comprises services provided by the general practitioners (GPs), who find themselves at the "entry point" of the system. They provide initial medical checkups and treatment or refer the patients to specialists or hospital. If necessary, the GP can also issue a sick-leave certificate for temporary incapacity for work.

The second level comprises medical (and dental) services provided by specialists. These fall within the outpatient sector even though the offices of the specialists and the specialized laboratories may sometimes be located on the premises of the public hospitals. When necessary, they too, can issue referrals to hospital or other specialists.

Hospital care constitutes the third level of health services, i.e. the services provided by hospitals and dispensaries. The costs of these are covered by the health insurance when the patients have been referred by the GP or a specialist. However, the number of referrals that a single doctor may issue each month is limited. This leads to numerous complaints by patients that their GPs declined to issue such a referral or postponed it for the next month because they had exhausted their quota.

1.2. SHORTAGE OF FUNDS

The healthcare reform in Bulgaria was largely motivated by the shortage of public funds for health care, which are in the range of 4-5% of GDP (*Table 1*).

Table 1. Public Healthcare Expenditures in Bulgaria

	1999	2000	2001	2002	2003	2004	2005	2006
Percentage of GDP	3.9	3.7	4.0	4.4	4.9	4.6	4.7	4.1
Percentage of total public expenditures	9.7	10.1	10.0	11.3	12.1	11.6	12.1	11.1
Share of health insurance in healthcare expenditures (%)	9.9	13.0	35.8	40.6	51.6	63.2	76.1	–

Source: NSI, Ministry of Finance

By international comparisons, presented in *Table 2*, public healthcare expenditures in Bulgaria – both per capita and in percentage of GDP – are among the lowest in the EU. By expenditures per capita, this country only surpass Romania and by

share of public healthcare expenditures in GDP, Romania and Latvia. Even in the Balkans, under these indicators, we lag behind Croatia, Serbia, and Macedonia.

Voluntary private health insurance has still not established itself as an alternative to public one. According to the World Health Organization, private health insurance funds in this country represent less than 1% of health-care expenditures. In fact, the 2-3% of GDP that supplement public health-care expenditures are made up by direct extra payments by patients (*Table 3*). These data do not take in the informal (bribe) payments. That is why the actual health-care financing burden borne by the patients in Bulgaria is far greater than in the other countries. Since patients in Bulgaria pay almost as much as the state in official and unofficial payments, one might logically wonder why they are not opting for voluntary private health insurance.

Table 2. Public Healthcare Expenditures in Bulgaria – International Comparison

Public sector expenditures	Percentage of GDP*						USD per capita at the average annual exchange rate **				
	1999	2000	2001	2002	2003	2004	1999	2000	2001	2002	2003
Czech Republic	6.0	6.0	6.3	6.6	6.8	6.5	347	327	373	471	600
Hungary	5.4	5.0	5.1	5.5	6.1	6.0	250	231	258	348	495
Poland	4.2	4.0	4.3	4.7	4.5	4.5	177	172	210	234	248
Slovakia	5.2	4.9	5.0	5.1	5.2	5.1	196	186	193	228	318
Slovenia	5.8	6.7	6.9	6.8	6.7	6.7	628	640	683	751	930
Estonia	4.9	4.3	4.0	3.9	4.1	4.2	197	170	176	203	282
Latvia	3.8	3.3	3.2	3.3	3.3	3.3	114	107	110	129	155
Lithuania	4.7	4.5	4.6	4.9	5.0	4.9	145	148	160	197	267
Bulgaria	**3.9**	**3.7**	**4.0**	**4.5**	**4.1**	**4.3**	**63**	**58**	**69**	**88**	**104**
Romania	3.4	3.5	3.6	3.8	3.8	3.4	54	59	65	79	100
Albania	3.1	2.8	2.8	2.8	2.7	2.7	35	33	37	41	49
Croatia	7.5	8.1	7.2	6.5	6.5	6.6	333	330	317	325	413
Bosnia and Herzegovina	6.1	5.0	4.4	4.4	4.8	4.6	76	58	54	62	85
Serbia and Montenegro	4.1	3.6	–	–	–	–	45	34	54	86	136
Macedonia	5.4	5.1	5.1	5.8	6.0	5.9	98	91	86	107	136

*Source: * TransMONEE 2007; **WHR 2006*

The explanation is usually attributed to the fact that private insurance is as yet hardly able to compete with public health insurance and cannot offer greater coverage and choice of plans. The advantages for the patient taking out a private insurance policy in addition to the mandatory health insurance are the broader choice of health service providers and reimbursement of prescribed medications that may not be covered by public health insurance. So far, in this country, these

advantages tend to remain more theoretical than practical. They even decline as the NHIF provides increasing opportunities for choice of service provider and covers a widening range of medications. Private insurers are not in position to offer many different plans. Both private insurers and the NHIF rely on the same providers, with the latter depending almost entirely on their contracts with the Fund.

Table 3. Public and Private Healthcare Expenditures in Bulgaria

Indicator	1999	2000	2001	2002	2003	2004
Percentage of GDP	6.0	6.2	7.2	7.9	7.5	7.7
Of which: public (%)	65.4	59.2	56.1	56.6	54.5	55.8
private (%)	34.6	40.8	43.9	43.4	45.5	44.2
Of which: out-of-pocket (%)	99.0	99.0	99.2	98.4	98.4	–

Source: WHR 2006 (up to 2003), Health Systems in Transition: Bulgaria 2007 on 2004

Whereas the benefits of the purchase of private health insurance policy are not very substantial, the costs are considerable. First of all, it does not cancel or reduce the mandatory health insurance contributions to the NHIF. Secondly, the tax incentives for individual health insurance policies are reduced to a deduction of up to 10% of the taxable personal income. And thirdly, it may not be so easy to get an advantageous individual insurance plan. The private health insurance market in Bulgaria is still not developed enough and caters mainly to corporate clients. Additional health insurances, if any, are typically part of the benefit packages offered by employers as incentives for their workers and employees.

The advantages for employers taking out private health insurance policies for their employees are not too big either. For tax purposes, insurance expenditures are treated as social expenditures that are tax-free up to a certain amount per person per month.[1] As an extra incentive, some insurance companies try to attract new corporate clients by offering to take on the mandatory medical checkups of employees as well as to monitor workplace safety in addition to the health insurance.

In sum, the state has placed considerable limitations on the development of the private health insurance market. These restraints lead to the withdrawal of insurers from the market and reduce competition. Instead of taking measures to stimulate this sector, the policy concerning Bulgarian healthcare treats the market as underdeveloped and ineffective and is instead aimed at stricter regulations and quality control of the services provided by NHIF. There is a call for a radical change in the existing public-private partnership schemes.

[1] In 2007, this amount is 60 Leva.

1.3. UNSTABLE REGULATORY FRAMEWORK HINGED ON ADMINISTRATIVE CONTROL

LEGAL FRAMEWORK

The legal framework of health sector management in this country has been drastically changed in the past 9 years (see Box 1). Health sector financing is regulated by the Law on the National Budget of the Republic of Bulgaria and the Law on the NHIF Budget. The secondary and tertiary legislation comprises numerous decrees and ordinances by the Council of Ministers, the Ministry of Health, and the other agencies dealing with various health hazards and the protection of public health. The wide-ranging and complex legal framework is undergoing constant changes in the process of reform and harmonization of the Bulgarian legislation with that of the EU. The Law on Health Insurance alone has gone through 44 amendments in the past 9 years. These continuous changes have rarely been accompanied by assessment of the implementation of the regulations. Neither have they been taking into account the capacity of the administration and the judicial system to ensure effective enforcement. Thus a great many loopholes have emerged due to vertical and horizontal inconsistencies between various components of the legal framework.[2] This has placed serious challenges before the synchronization of reform efforts and the relations between the different stakeholders. What is more, it has created conditions conducive to abuse and corruption on the part of the administration. The bureaucratic chaos in healthcare can in part be attributed precisely to the excessive and inconsistent law-making in the years of the health reform.

Box 1. Legal Framework

- Law on Health (2004), amended 16 times, succeeding the Law on Public Health (1973), amended 23 times between 1991 and 2003.
- Law on Health Insurance (1998), amended 44 times
- Law on Healthcare Establishments (1999), amended 22 times
- Law on Medications and Pharmacies in Human Medicine (1995), amended 25 times
- Law on Control on Narcotic Substances and Precursors (1999), amended 11 times
- Law on Foods (1999), amended 12 times
- Law on Healthy and Safe Work Conditions (1997), amended 13 times
- Law on Professional Organizations of Physicians and Dentists (1998), amended 7 times
- Law on Professional Organizations of Medical Nurses (2005), amended 4 times
- Law on Organ, Tissue and Cell Transplantation (2003), amended 2 times
- Law on Blood, Blood Donation and Transfusion (2003), amended 3 times

Source: Ministry of Health

[2] Vertical inconsistencies are found between primary and secondary legislation, while horizontal ones are those between the rules within the different health and public sectors subject to regulation.

POLICY PRIORITIES

The priorities in the health sector are laid down in about 25 national health strategies and programs (Box 2). They are concerned with the problems perceived as the gravest health risks: AIDS, tuberculosis, measles and rubella, cardiovascular diseases, early diagnostics of cancer, osteoporosis, mental health, suicide prevention, drugs and cigarettes, food safety, and transplantations. Most of these programs and strategies are part of international projects and campaigns. According to the draft National Health Strategy of 2006, the budget funds allocated to disease prevention programs amounted to BGN 18 million, which constituted less than 1% of the annual health-care budget in 2006.[3]

These priorities fall within the powers of the Ministry of Health but other institutions have important responsibilities, as well. The Ministry of Labor and Social Policy is chiefly responsible for the implementation of work safety standards, while the Ministry of the Environment and Ecology is responsible for the implementation of environmental protection standards.

In addition, there exist more than ten specialized agencies with educational, informational, and control functions. Many of them were created in the past 16 years within various donor programs. From the present point of view and because of the lack of real restructuring, most of them seem a necessary but costly contribution to the health reform the benefits of which have not yet taken full effect.

Box 2. Policy Strategies and Programs

- National Health Strategy 2007 – 2012
- National Strategy on Supply of Medicines 2004
- National Program for Development of Invasive Cardiology, 2002 – 2008
- Narcotic Dependency Prevention, Treatment, and Rehabilitation, 2001 – 2005
- National Strategy and Working Program for Prophylactic Oncological Screening, 2001 – 2006
- National Program for Psychic Health Reform 2001 – 2010; Mental Health Policy of the Republic of Bulgaria, 2004 – 2012
- National Program on Nephrology and Dialysis Treatment
- National Program for Control of Tuberculosis, 2004 – 2006
- National Program to Reduce Tobacco Smoking, 2002 – 2006
- National Program for Suicide Prevention
- National Environmental Action Plan – Health
- HIV/AIDS Prevention and Control Program, 2001 – 2007
- National Program to Reduce Osteoporosis, 2006 – 2010
- National Program for the Elimination of Measles and Rubella, 2005 – 2010
- Food Safety Strategy of the Republic of Bulgaria, 2000

Source: Ministry of Health

[3] National Health Strategy 2007-2012, p.17

QUALITY MANAGEMENT

Health service quality management relies almost entirely on all-embracive administrative control rather than on adequate financial incentives. Moreover, the control is concentrated largely at entry. Its main instruments are the accreditation of the healthcare providers and the medical standards.

The accreditation of healthcare establishments aims at ensuring minimum equipment and qualification standards necessary for the delivery of the respective services covered by NHIF. These requirements are stipulated in the Ordinance on the Criteria, Indicators, and Method of Accreditation of Healthcare Establishments with the Law on Healthcare Establishments. The process of accreditation, however, is not in position to act as a filter at the entry point to the system – in practice, nearly all of the old and ineffective hospitals and medical centers obtained accreditation. One of the reasons is that, in a large part of the country, coverage and access to medical care matter more than quality. Another reason is that local political and social priorities usually outweigh quality concerns.

In addition to accreditation, quality in the health sector is regulated by **24 medical standards** of service by group of disease, which lay down in detail the requirements concerning medical equipment, the necessary medical staff and qualification; contain comprehensive definitions of the various syndromes covered by the respective standard, as well as the respective medical interventions.

In sum, quality management is heavily dependent on strict and exhaustive regulatory requirements and control, which involves significant administrative costs. Moreover, the money reimbursed by NHIF is not conditional on the quality of the services delivered. Thus, once they obtain accreditation, the medical practices and hospitals have no motivation whatsoever to invest in human resource development, new technologies, or other improvements that would enhance the quality of medical care. The system has been designed with a view to ensuring a uniform minimum standard level.

At the same time, its implementation is still not effective enough because neither the Ministry of Health nor NHIF have the necessary administrative capacity to impose sanctions or refuse accreditation to health establishments in regions with limited coverage and access, where the problems with the quality of medical care are most critical. This system, hinging on control and sanctions, yet lacking the capacity to apply administrative coercion, places decision-makers in a vicious circle where the ever-increasing requirements and control lower the level of compliance with the regulations on the part of the physicians and managers in the health sector, and the mutual trust and consideration between the state, medical specialists, and patients grow ever more fragile.

HUMAN AND PHYSICAL CAPITAL

As a result of the above-outlined weaknesses in the management of the health sector, it is weighed down by worn-out and obsolete equipment and facilities, poor maintenance, ineffective use of resources, and outdated technologies for diagnosis and treatment. The number of **hospital beds** has been reduced (see

Tables 8 and 9 below), while the average annual bed occupancy per patient (in days) has increased. This, however, has not led to significant cost optimization since the reduction of the number of hospital beds did not entail reduction of the rooms and facilities for the treatment of one patient.

In terms of the **physicians per capita** indicator, Bulgaria has always maintained a high record. Yet, there are a great many vacancies, particularly for doctors with a specialty. The oversupply and the concentration of physicians in the cities are causing a twofold problem – low remuneration and poor motivation of medical workers, on the one hand, and poor regional coverage, on the other. An additional problem is posed by the shortage of nurses. It is due to the migration of nurses to Europe and the small number of specialized colleges. The nurse: doctor ratio in Bulgaria is about twice lower than in the rest of Europe and the prospects for its optimization in the near future are not too bright.

Overall, although much has been done and significant funds have been spent, the results of the reforms fall very much short of the prevalent expectations of patients and physicians alike. If, from the consumers' viewpoint, the reform was supposed to replace the old state healthcare system with a health-insurance system guaranteeing access and coverage together with increased competition among service providers and greater choice for patients, then this goal has not been attained. Alternatively, from the perspective of the providers (physicians and managers in the health sector) the reform was to establish the "money follows the patient" principle, i.e. the distribution of public funds was to take place on the basis of the number of patients, activities carried out, and results achieved, and this goal has not been attained either.

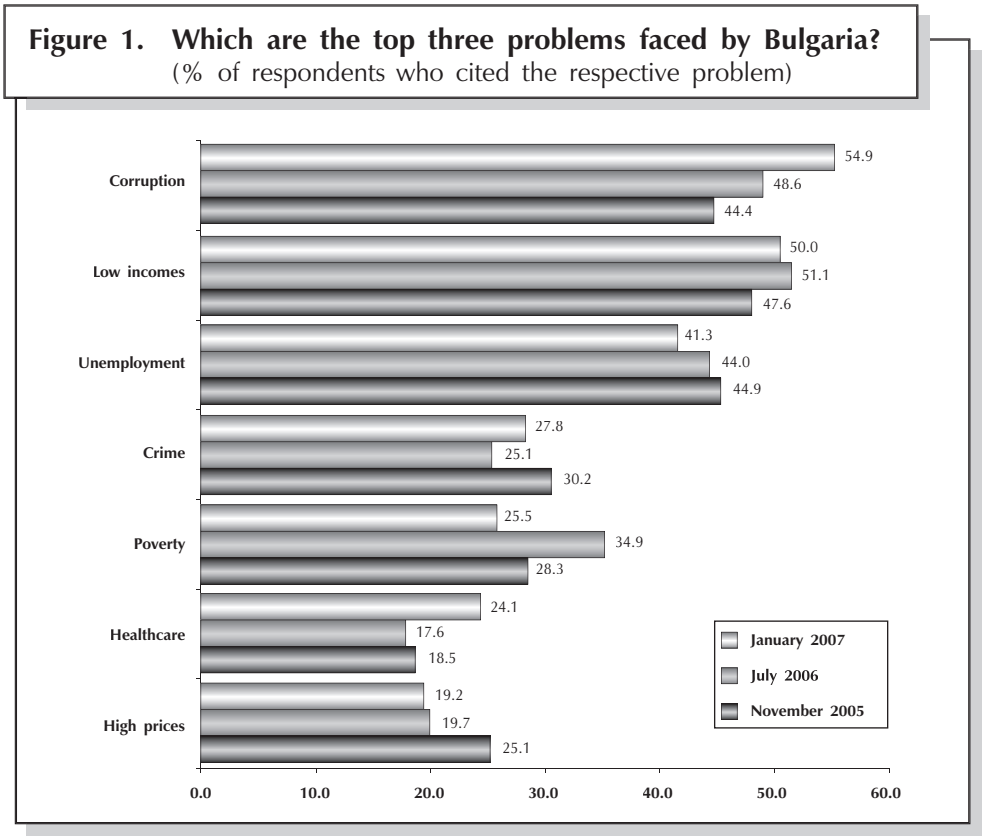
In sum, in terms of the results, and still less in terms of the spending to date, the reform in public healthcare management can hardly be evaluated as satisfactory. The total amount of funds allocated to health is not so small by international standards, but a relatively large proportion is made up by direct individual payments for health services, for the most part under the table. Bulgarians pay more (health-insurance contributions, formal and informal payments) than the citizens of other countries in transition, moreover, for poorer quality services. The present system ignores investment in new technologies and the continuing education of medical specialists. Preventive medicine remains outside the reach of the restructuring effort and is still under-funded and poorly managed. Last but not least, access to medical services for the most at-risk social groups is limited and inequitable.

2. CORRUPTION IN HEALTHCARE

2.1. LEVEL AND SPREAD

Bulgarian society demonstrates high sensitivity to the problems of healthcare and corruption in general. Citizens traditionally rank them among the foremost challenges of Bulgarian transition. In 2007, corruption came out as the top problem faced by Bulgaria while healthcare was ranked sixth, nearly on a par with problems such as crime and poverty (*Figure 1*).

Figure 1. Which are the top three problems faced by Bulgaria?
(% of respondents who cited the respective problem)



Source: Vitosha Research

The international and national corruption assessment indexes reveal a tendency towards decline in petty and administrative corruption in Bulgaria in the past five years. Healthcare deviates from the general trend and even marks a rise in some respects. The Vitosha Research Corruption Monitoring System (CMS) shows a twofold increase in the proportion of citizens citing the health service sector among those where corruption is most prevalent: from 20% in 2002 to 40% in 2007. This places healthcare in the third position, after customs and the

judicial system. In the latest ranking they surpassed the bodies of the Ministry of Internal Affairs as the institutions most affected by corruption. The public has a similar assessment of the spread of corruption among physicians. Two-thirds of the citizens believe all or nearly all doctors are involved in corrupt practices (*Table 5*). Under this indicator, doctors follow immediately behind customs officers and law-enforcement and justice representatives, and are ranked ahead of tax officials, the political elite, ministers, and mayors.

Table 4. Where in Bulgaria is corruption most widespread?
(% of those citing the respective institution)

	2002/10	2003/10	2004/11	2005/11	2007/01
In customs	30.4	49.5	50.9	52.6	63.1
In justice administration	28.5	42.0	40.8	43.0	49.8
In healthcare	**20.6**	**27.8**	**35.2**	**35.1**	**39.6**
In the Ministry of Interior (MoI) system (incl. Traffic Police)	19.9	33.9	33.8	32.3	39.4
Among the political elite	30.3	26.1	16.9	16.4	33.0

Source: Vitosha Research

Naturally, the conclusions about the actual level of corruption drawn on the basis of the assessments of the public should be taken with certain reservations. In many cases they may reflect real achievements in the fight against corruption in a particular area, the exposure of more cases, better anticorruption control within a given institution, as well as rising public intolerance of these corrupt practices. All of this can increase the values of public assessments of the rate of corruption in the short term, whereas the actual incidence of corrupt practices may have different dynamics. For this reason, the indicators should not be used to draw definitive conclusions about the scope of corruption. They rather reveal the public's attitude to the problem and its perceived importance, and it is in this sense that they are useful tools in anticorruption policy-making. They show that prevention and counteraction of corruption in healthcare are among the top priorities on the Bulgarian anticorruption agenda.

Table 5. Assessments of the Spread of Corruption in Various Occupational Groups
(Percentage of those who answered "all" or "nearly all" are involved in corruption)

	2002/10	2003/10	2004/11	2005/11	2007/01
Customs officers	79.2	74.5	70.3	71.8	78.0
Judges	63.0	57.3	56.1	59.3	67.5
Prosecutors	63.0	55.7	55.3	57.1	66.9
Lawyers	62.3	55.8	54.9	54.7	64.5
Police officers	59.6	59.2	58.8	56.1	65.4
Physicians	**54.9**	**52.9**	**55.4**	**54.5**	**64.1**
Tax officials	58.0	49.3	49.9	53.5	63.8
MPs	56.2	54.5	50.7	53.4	63.8
Political and party leaders	54.0	47.6	50.5	51.6	62.7
Ministers	50.8	52.6	45.4	51.1	61.7
Investigators	57.5	49.2	51.7	50.5	60.3
Mayors and municipal councilors	48.3	43.4	47.0	47.5	58.0
Ministry officials	48.3	40.1	42.6	44.4	50.8
Municipal officials	49.1	36.5	44.3	43.4	43.8
University teachers	33.4	36.5	33.1	29.9	32.3
NGO representatives	21.4	22.3	23.7	26.6	31.7
Teachers	13.9	11.0	14.0	14.4	15.7

Source: Vitosha Research

A more reliable indicator about the actual dynamics and spread of corrupt practices is the patients' shared personal experience. This indicator reflects what portion of the population has actually experienced requests for undue compensation in their contacts with doctors. Revealingly, by respondents' self-reported experience, doctors head the CMS ranking, having moved up from the fourth to the first place over the past 5 years (*Table 6*). Of course, this does not necessarily mean that physicians are more corrupt than the remaining groups in the ranking. The reported higher incidence of corruption pressure may result from more frequent interaction with doctors than with customs or police officers.[4] However, what the results definitely imply is that corruption in healthcare affects more people than corruption in any other occupational group, i.e. it has the strongest adverse impact felt throughout society.

[4] In this sense, a more accurate indicator would be the percentage of those who have been asked for money or favors out of the respondents who have interacted with the respective group, but such a breakdown would require a very large sample.

Table 6. Personally Experienced Corruption Pressure by Occupational Group
(% of those citing the respective group in answer to the question "If, in the course of the past year, you have been asked for something (money, gift or favor) in order to have a problem of yours solved, the request came from:...")

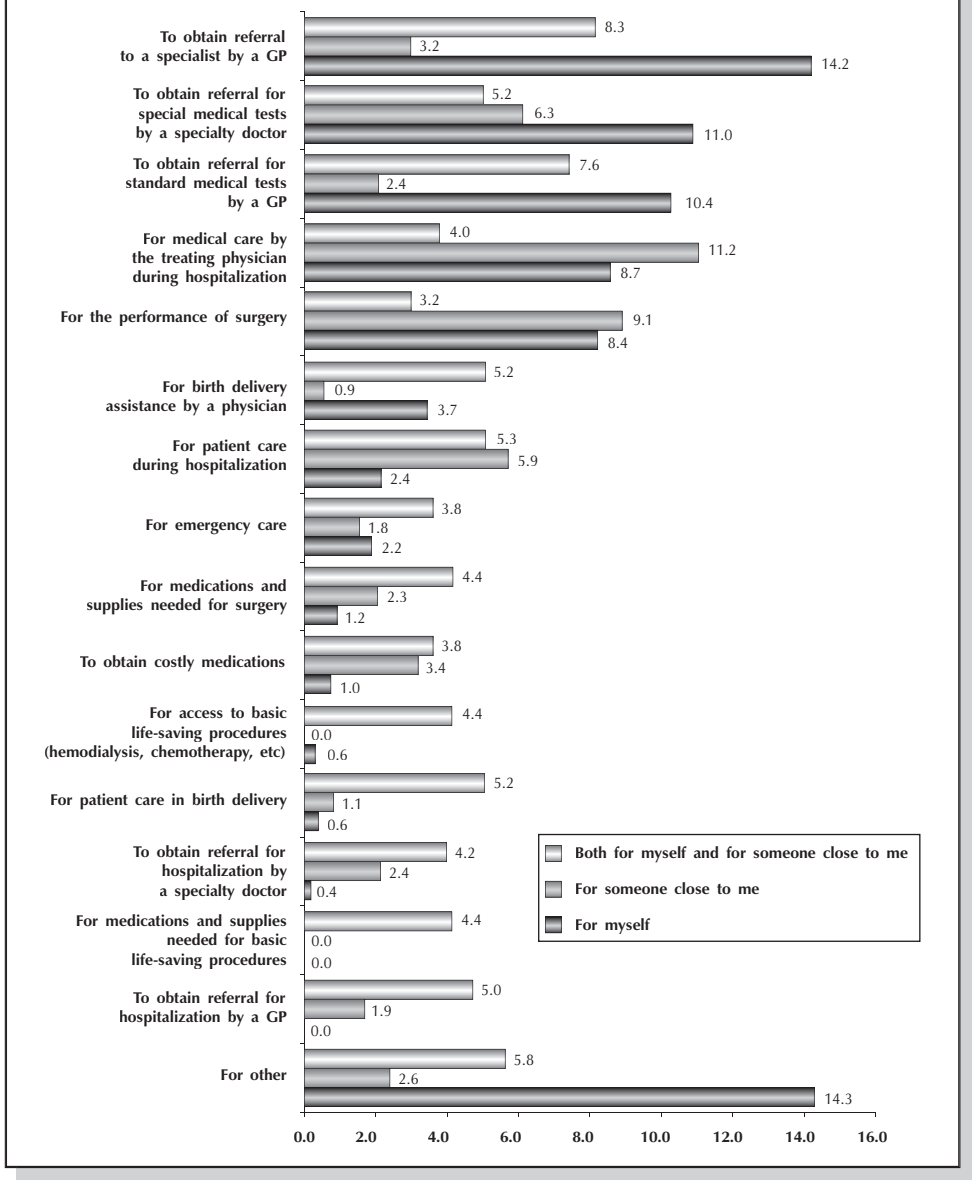
	2002/10	2003/10	2004/11	2005/11	2007/01
Doctors	**20.3**	**16.6**	**22.5**	**26.2**	**30.1**
Police officers	22.3	13.9	22.2	27.7	26.7
Customs officers	19.4	15.3	13.8	22.1	23.8
Lawyers	26.5	13.8	16.5	22.0	18.9
Prosecutors	12.3	4.2	5.1	1.2	14.3
Investigators	8.3	9.6	5.0	1.3	13.3
Judges	16.6	8.5	5.8	3.4	11.7
Ministry officials	5.6	8.2	6.3	8.2	11.5
Tax officials	4.2	5.9	5.1	8.1	11.3
University teachers	11.9	16.6	12.6	15.3	10.7
University employees	5.6	9.0	9.0	10.1	9.8
Mayors and municipal councilors	5.3	3.3	6.6	6.5	9.8
Municipal officials	10.9	6.4	10.3	9.5	9.5
Politicians and political party leaders	7.1	4.1	5.0	2.5	7.7
Teachers	7.4	5.6	6.2	6.0	4.0
NGO representatives	5.0	1.4	1.3	1.5	2.5

Source: Vitosha Research

2.2. TYPES OF CORRUPT PRACTICES

The most common corrupt practices in healthcare involve offering gifts or payments beyond the officially established fee rates. Unlike other types of "petty corruption", here the end users of health services are subjected to corruption pressure leaving them little freedom of choice as to their corruption behavior. This is a typical instance when the bribe giver is a victim rather than an accomplice or beneficiary. The patients pay bribes in order to ensure the proper quality of service to which they are in fact entitled under their health insurance. This is what makes healthcare one of the areas where victimization surveys are an effective diagnostic tool. *Figure 2* presents the most common corrupt practices in healthcare.

Figure 2. What was the specific purpose or occasion for the provision of gifts/favors/payments beyond the official fees?
(% of those who gave the respective answer)



Source: Vitosha Research, 2005

The idea is currently being advanced that informal payments in the health sector do not constitute a corrupt practice as long as they follow, rather than precede, the service delivery. In other words, if a patient pays the surgeon 300-400 Leva after the operation, it is an expression of gratitude rather than a bribe since it is entirely up to the patient whether to pay or not and the doctor does not have any levers of corruption pressure. We shall not go into the legal arguments that the time when it is obtained is irrelevant to determining an undue gain. Moreover, experience shows that some doctors can be quite firm in defining the

anticipated ″proportions″ of gratitude and may even refuse to accept less than they expected.

In practice, however, the physicians who expect extra compensation for their efforts (and all or nearly all of them do, according to two-thirds of the representative sample) rarely leave it up to the patients' sense of gratitude. They either use as a pretext costly medical procedures and supplies or refer the patients to their private practices for diagnosis and treatment. Under the conditions of artificially maintained market deficit in high-quality specialized services, those in need have to resort to connections and string-pulling in order to get access to good doctors in which case direct cash payment, at tacitly agreed rates, is the norm rather than the exception.

Not all corrupt practices in the health sector, however, can be assigned to this type. There exist other forms related not so much to the use of health services as the exercise of certain social security and health insurance rights such as temporary incapacity for work (sick-leave certificates), permanent disability, and vocational rehabilitation. With these types of corruption, the patients may be victims of extortion but likewise accomplices to the doctors for the purpose of unduly profiting (the gain by far exceeding the value of the bribe or gift) from social security and pension funds.

In another type of corrupt practices in healthcare, the interests of the patients are indirectly affected while they are not directly involved in a corruption transaction. It includes corrupt practices in the medicine market and in the financing of hospitals by NHIF, administrative corruption related to the supervision of health service providers, as well as to the implementation of hygiene and work safety standards in regulating commercial activity. These types of corruption may involve various other participants and stakeholders in the economy of healthcare and may reach the higher ranks of government. Thus for instance, irregular practices in the trade in medicines fall within ″petty corruption″ when distributors are giving commissions or bribes to physicians in order to have them prescribe their medications; or within the area of public procurement corruption, when supplies to hospitals are involved; or even, corruption in the high ranks of power, when it comes to approving the lists of medications reimbursed by NHIF and the centralized public procurement of medicines and medical products.

Sociological surveys among patients indicate that the big problems with corruption in the health system are related to hospital treatment. In a survey conducted by ASSA-M sociological agency in 2006, the largest proportion of respondents perceived corruption as most prevalent in the hospital sector (*Table 7*).

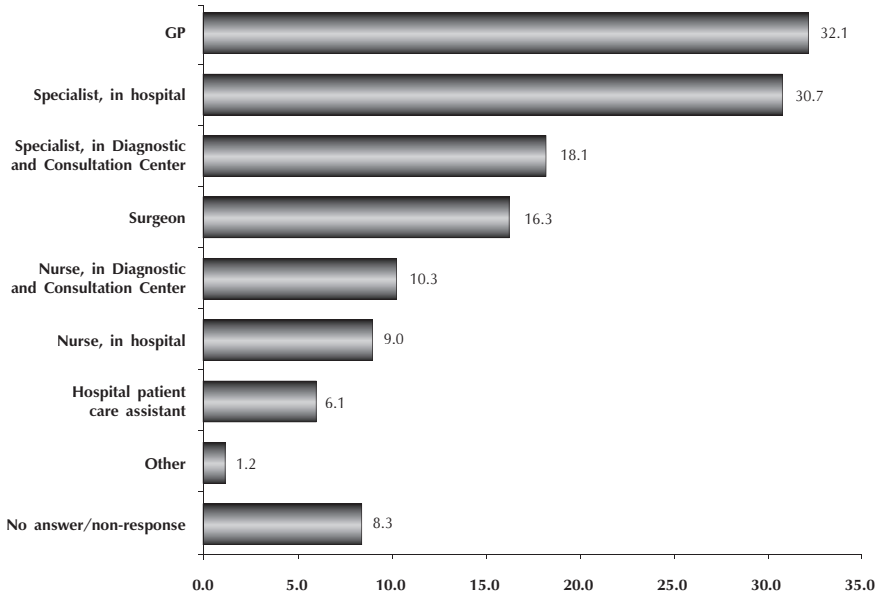
Table 7. Assessment of the Spread of Corruption in Healthcare
(% of respondents who perceived corruption as widespread in the respective sector)

In hospitals – performance of surgical operations	47.9%
In hospitals – birth delivery assistance	39.5%
In hospitals – daily care	28.9%
In hospitals – hospital admission	24.8%
Among specialty doctors in outpatient care	19.5%
Among GPs	9.9%

Source: ASSA-M, 2006 N = 1028

While of a more limited scope and variety, the informal provision of money and gifts is common in the outpatient sector, as well, despite the prevalence of private practices. According to the 2005 survey by Vitosha Research on corruption in healthcare, 32% of the respondents had given money or gifts to their GPs, and 18% had resorted to this kind of "stimulation" of specialists in the outpatient sector (*Figure 3*). The next two paragraphs consider the preconditions for corrupt practices in the two sub-sectors of healthcare.

Figure 3. To whom have you made unregulated gifts and payments?
(% of those who gave the respective answer)



Source: Vitosha Research, 2005

3. CORRUPTION IN THE OUTPATIENT CARE

The lower rate of corruption in outpatient care compared to the hospital sector is due to the more advanced process of restructuring of the former. This does not mean that the restructuring has progressed as far as to minimize corruption risks. The outpatient sub-sector still suffers from excessive regulation, ineffective promotion of quality improvement, and inadequate coverage. Accordingly, the corruption risks and practices are largely related to the shortage of GPs and the existing limits on specialist and hospital referrals. Money or gifts to GPs are typically provided in connection with home visits and the issuing of referrals. The purpose of the bribes may also concern the issuing of sick-leave certificates. Insofar as paid sick leave is covered by the General Illness and Maternity Fund, the physicians do not lose anything out of this; on the contrary, they only gain in patients and appointments. Another relatively frequent corrupt practice in the outpatient sector is to prescribe particular medications or refer patients to specific pharmacies for a commission or other "incentives" from the respective medical retailer.

The question why the outpatient sector needs extra "under-the-table" payments in order to provide better-quality services calls for closer investigation of the organization of outpatient service delivery, of the ways in which it is controlled by the state, and whether doctors are getting adequate remuneration for their work.

3.1. CORRUPTION RISKS AND PRACTICES AMONG GENERAL PRACTITIONERS

Primary medical care is provided entirely by general practitioners (GPs) who conclude individual or collective contracts with NHIF.[5] The number of GPs exceeds 6,000, with most of them working in individual private practices (*Table 8*). GPs may provide services either as natural persons (freelance GPs) or in the capacity of sole proprietors.

[5] The system of contracts between GPs and NHIF entered into effect on July 1, 2000.

Table 8. Outpatient Health Establishments in Bulgaria

Outpatient health establishments	2004		2005		2006	
	Number	Beds	Number	Beds	Number	Beds
Primary medical aid dispensaries						
Individual practices	5,897		5,186		4,296	
Group practices	224		216		202	
Primary dental care dispensaries						
Individual practices	7,758		7,483		5,504	
Group practices	142		146		131	
Specialized medical care dispensaries						
Individual practices	6,422		5,623		2,342	
Group practices	124		116		91	
Specialized dental care dispensaries						
Individual practices	152		132			
Group practices	1		1			
Medical center	454	440	495	518	492	568
Dental center	56	4	53	4	51	4
Medical-and-dental center	44	21	47	29	46	20
Diagnostic and consultation service	107	204	105	268	102	246
Independent diagnostic and technical laboratories	828		854		881	

Source: National Health Information Center

GPs are paid for their services by the NHIF and by the patients. The consumer fee paid by patients for each visit amounts to 1% of the minimum monthly salary.[6] There have lately been increasing calls to abolish this fee as a social measure. What is actually being overlooked is that it is not just a supplement to the income of doctors in the outpatient sector, but also a filter of sorts for limiting unwarranted visits and reducing waiting lines in GPs' and specialists' practices.

The payment received by GPs from the NHIF is based on the number of patients and activities performed. In the past 7 years it has been the goal of the reform to modify the initial financing scheme where the bulk (85%) of GP remuneration was a function of the number of registered patients to one where most of the amount would be earned on the basis of activities actually performed. Currently, the latter account for about 40% of NHIF payment to GPs.

The amount received on the basis of the number of patients still makes up about 60% of the total monthly sum doctors receive from NHIF. All health-insured citizens are obliged to choose a personal GP and to register with him/her. Initially, in order to conclude a contract with the NHIF, physicians had to have a minimum of 800 registered patients and there was likewise an upper limit on

[6] In 2007, with the minimum salary set at 180 Leva, the fee is 1.80 Leva.

the number of patients. These limitations were subsequently dropped. The Fund differentiates between patients with chronic diseases (dispensarized patients) and the rest, who are divided into age groups: aged 65 and over; under 18; at an active age of 18 to 65. For each patient NHIF pays an amount set annually in the National Framework Agreement. For 2007, the amounts for the different patient groups were BGN 1.25, 1.09, 1.00, and 0.72, respectively. These sums are determined in view of the varying amount of work and frequency of visits to the personal GP. Yet, the need for such a differentiation is debatable since the consumer fee is supposed to compensate the doctors for the greater workload associated with the elderly and dispensarized patients.

Activity-based payment covers prophylactic tests of children or immunizations (these fall within the National Child Health Program), maternity consultations, one prophylactic checkup a year for the patients over 18 years of age, or incidental visits by health-insured patients who are not registered with the respective GP (temporary residents, visitors, etc). The amounts paid for examinations are 2 to 5 times higher than those paid by NHIF on a monthly basis for the various groups of patients. The doctors receive additional remuneration if they open a practice in areas with a shortage of medical personnel or in remote and hard-of-access regions.

Despite the financial incentives, the problems with the unequal coverage and low service quality have still not been addressed. The chief managerial tool employed by the government to achieve more balanced coverage is the National Health Map (NHM). It features the desired distribution of medical staff by district. Since 2005, the Map has rather been a nominal instrument since it has not been updated and neither has its implementation progress been monitored.[7] The latest published reports on NHM implementation indicate that the deviations from the indicators range from 67% for Razgrad District to 128% for Sofia. The average number of patients registered with a single personal GP was 1,472. In some north-east districts such as Turgovishte and Razgrad, the average number exceeded 2,000, whereas in Sofia and Pleven, for example, it was under 1,300. In practice, most medical resources are concentrated in the cities and university centers. In the under-populated regions that are also characterized by the lowest rates of employment and health-insurance coverage there is a shortage not only of specialists, but also of GPs. The special financial incentives provided by NHIF are clearly insufficient to make up for the fewer patients and activities that form the basis of doctors' remuneration. The number of vacant practices was indeed significantly reduced from 1,200 at the outset of the reform to about 300 five years later. The differences in earnings and the shortage of doctors in some areas, however, remains the main challenge facing the health system in Bulgaria. These differences are, naturally, far more pronounced in the field of specialized medical services.

The unresolved problems with the coverage and access to medical services make the declared guidelines for the reform in healthcare towards greater

[7] The current National Health Map was adopted by Decision No 429 of the Council of Ministers of June 16, 2003 (Promulgated in State Gazette No 57/ 24.06.2003; amend. No 102/21.11.2003; amend. No45/31.05.2005. The last amendment dates back to May 2005 and the latest implementation report, to 2004).

consumer choice and competition relevant only in the big cities. Since service quality cannot improve under the pressure of competition, incentives assume primary importance. At present, GPs receive extra financial compensation in order to register more retired patients, to pay special attention to children and prophylactics during pregnancy, and generally to increase the number of visits by patients, because of the consumer fee. They cannot afford to be too scrupulous about issuing sick-leave certificates because they risk losing some of their patients, particularly the ones insured on the basis of their full salary, such as public administration employees, for example. The personal GPs are also motivated to prescribe more expensive medications if they are covered by NHIF. In some cases, the doctors may have additional reasons to do so – special promotional schemes offered by medical manufacturers and suppliers including commissions for the physicians for each prescription. However, they do not have particular financial encouragement to improve medical service quality or the health status of their patients. These would probably be difficult to measure and thus, the NHIF has not adopted any financial motivation instruments in this respect. Similarly, NHIF does not allocate any funds for stimulating investments in new technologies and professional training. As a result, such expenditures are highly limited, particularly in regions with little elasticity of demand, i.e. where patients are unable to change their medical service provider and switch to another.

In the absence of competition, the regulatory standards constitute important instruments for safeguarding patients' rights. Their purpose is to only admit in the market health service providers who have attained a minimum threshold in terms of the level of equipment and qualification. The standards also define the interventions performed by physicians. But modern primary medical care calls for a more adequate system of financial incentives, with increased share of the indicators of individual productivity and results achieved in determining the size of GP remuneration. Furthermore, if it is a health policy priority to actually improve the health status of the population rather than increase the number of visits to personal GPs, it is necessary to stimulate prophylactic activities, including immunizations. GPs ought to be encouraged by NHIF or the central budget on the basis of their contribution and results in implementing the national health priorities. They otherwise stand to gain more from the deterioration than from the improvement of the nation's health.

3.2. CORRUPTION IN SPECIALIZED OUTPATIENT CARE

The sector of specialized medical care was significantly restructured and has been taken over entirely by private individual and group practices. Most polyclinics in the towns were transformed into Diagnostic-and-Consultation Centers (DCC) and medical (dental) centers rented out by the municipalities to specialists and GPs at relatively low rental rates. The individual practices exceed 2,300, and group practices number 91. In addition, there are 492 medical centers, 102 DCC and 881 laboratories (*see Table 8 above*).

Despite the progress made, coverage in the sector of specialized care is more unequal and access to specialists, more difficult than to personal GPs. The shortage of specialists is greatest in the districts of Silistra, Razgrad, and Russe,

where one specialist serves 2,000 insured persons. By comparison, in Sofia, this indicator is more than three times lower, with 600 insured persons per specialist. These enormous regional discrepancies include the complete lack of certain specialties in the countryside. In fact, about 80% of the contracts concluded with NHIF cover about one-third of medical specialties. Access to specialty services such as surgery, cardiology, pediatrics, endocrinology, psychiatry, and dermato-venereology is far below the indicators laid down in the National Health Map for the regions of Razgrad, Silistra, Smolyan, and Shumen.[8]

Similar to GPs, specialists may work on a freelance basis or be employed by the respective medical centers. The chief source of financing is NHIF. Payment by the Fund is based on the number of visits. According to the current National Framework Agreement between the Fund and the physicians, most of the specialized services are reimbursed at a rate of 12 Leva per first-time examination, half of that amount for the second examination, and no reimbursement of subsequent visits. The highly specialized and laboratory services are subject to a comprehensive tariff included in the National Framework Agreement. The number of reimbursable repeat examinations by a single specialist may not exceed half of the number of first-time examinations conducted by him/her. Thus, NHIF assumes that on average half of the insured patients actually need a second visit to a specialist.[9] In addition to this restriction, the access to specialized services is also limited by the upper bound on the number of referrals that may be issued by a GP or a specialist each month.

Such regulatory constraints on reimbursement of specialized medical services by NHIF have the effect of a ration system. As any other deficit-based system, it is inevitably conducive to corruption and unregulated payments in order to overcome the limitations. Patients' and press reports, indicate that GPs and specialists typically exhaust their quotas of referrals by the middle of the month and then postpone patient referrals to specialists to the beginning of the next month. The problem is that this "deficit" may not always be genuine but result from deliberate corruption pressure by doctors who wish to profit from the NHIF-generated shortage of specialized services.

Even if they manage to obtain a referral by using connections or offering some favors, should the insured patients need a second appointment with the specialist, they have to pay again. Thus, after the first examination, the cost of the visits is borne by the patients, who ultimately stop seeing the specialists and interrupt the treatment. If a good specialist is able to reach the upper limit with first-time examinations alone, he/she would have no motivation whatsoever to follow up on the prescribed treatment unless the patient covers the subsequent expenses. This practice increases the total sum paid for medical services and is more likely to lead to higher hospitalization rates than to address the problem in the outpatient sector, where treatment costs are lower.

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[8] Ministry of Health, Report on the Public Health Status at the Onset of the 21st Century. Health Reform Analysis, Sofia, August 2004.

[9] The pediatricians are an exception and are entitled to reimbursement by NHIF of second examinations up to the number of first-time ones.

Such efficiency loss is evident in connection with some specialized interventions assigned to the hospitals although they can and used to be performed in the outpatient sector. One such example is the transfer of certain types of biopsy from specialized to hospital care. This is rather an instrument for the financing of hospitals (directing insurance reimbursements to the public sector) than a means of optimization of health expenditures.

Finally, the application of universal rates by NHIF fails to take into account the varying costs of the wide range of specialized services and examinations. It encourages the provision of cheap, labor-intensive services instead of high-technology ones. Furthermore, it exposes reimbursement schemes to constant pressure from physicians, thus increasing transaction costs of the tripartite agreements.

However, detailed differentiation is not a cheap or stable solution either. It would be better to adopt instead clear-cut and transparent rules for additional payments by patients. It would hardly place a greater burden on them than the current practice of covert payments. The effect may even be reversed with the development of the additional health insurance policy market.

In conclusion, the sector of outpatient care relies largely on excessive regulation and administrative control, which pushes physicians to sidestep the rules and undermines the mutual trust between the state and health-service providers. The National Framework Agreement is usually finalized late in the year and thus doctors for a long time provide services without knowing how these will be remunerated. All of this constitutes a fertile breeding ground for corrupt practices and interactions, with the inflated medical bills covered out of the pockets of the insured.

4. CORRUPTION IN THE HOSPITAL SECTOR

Compared to outpatient care, the restructuring efforts in the hospital sector practically derailed. It is hardly surprising that it is marked by the highest concentration of corruption risks and practices. The sector comprises in excess of 300 hospitals and dispensaries (*Table 9*). At the outset of the reform in 2000, all of them were transformed into state and municipality-owned public companies. About 20 university hospitals and national health establishments became entirely state-owned. In addition, the state retained the majority share (51%) in all 28 district hospitals. The remaining 49% were divided among the municipalities in the respective districts. Another 102 hospitals are completely municipality-owned. The number of private hospitals is 45, with 1,565 beds, which constitutes a mere 3% of the total number of hospital beds in the sector. According to the draft National Health Strategy of 2006, up to at least 2013, hospital privatization is not among the priorities of the health reform.

Table 9. Health Establishments and Number of Beds

	2004		2005	
	Number	Beds	Number	Beds
Total	306	47,709	262	45,537
General hospitals, incl.:	127	29,665	125	29,270
For active treatment	126	29,545	125	29,270
For extended treatment, follow-up care, and physical therapy	1	120	–	–
Specialty hospitals, incl.:	70	8,723	70	8,327
For active treatment	28	3,743	29	3,742
For follow-up care and extended treatment	9	585	9	570
Extended treatment, follow-up care, and physical therapy	9	591	10	711
For physical therapy	24	3,804	22	3,304
Psychiatric hospitals	11	2,750	12	2,790
Other hospital establishments	2	110	1	60
Hospitals with other institutions	7	1,530	9	3,525
Private hospitals	40	819	45	1 565
Dispensaries	49	4,112	48	4,089
For lung diseases	13	787	13	787
For dermato-venereological diseases	12	208	11	203
For oncological diseases	12	1,593	12	1,575
For psychic diseases	12	1,524	12	1,528

Source: National Health Information Center

When NHIF first started reimbursing hospital services on July 1, 2001, the total sum amounted to 20% of the hospital budget. In 2007, the amount covers more than 90% of public hospital care expenditures. Payment takes place on the basis of activities performed under **clinical pathways** (CP). These contain explicit requirements and instructions for hospital diagnosis, treatment procedures and interventions – according to disease symptoms and according to the referral by the GP or specialist. The clinical pathway regulates the minimal period of hospitalization for each medical intervention or service included in the clinical pathway; the codes of the diseases and procedures according to the international classification of diseases;[10] the minimum requirements for concluding a contract, including hospital wards, equipment and specialists; symptoms requiring hospitalization, including - treatment process, instructions concerning medical procedures, post-hospital rehabilitation. Since the beginning of the reform, the clinical pathway coverage has expanded more than 10 times: from 30 CP comprising 158 diagnoses in 200, to 299 CP covering about 7,500 diagnoses in 2007.

The expanding health insurance coverage made it possible to discontinue state and municipal budget subsidies to most hospitals and dispensaries in 2006 and NHIF became the sole source of financing for the hospital sector. In 2006, the Ministry of Health took on the financing of psychiatric dispensaries and the activities under national health programs such as the transplantation program. In this manner, out of the total budget of the public hospital sector, which amounts to BGN 835 million, 740 million are covered by NHIF and 95 million, by the Ministry of Health budget.

In sum, the increased coverage and completed transition to a health-insurance system are the two chief positive outcomes of the reform in the health sector. Nevertheless, the main problems making the hospital sector susceptible to corrupt practices and extortion, for the most part related to the system of financing by the NHIF, have still not been overcome.

One of the most symptomatic indicators of the poor financial health of hospitals is the chronic problem with their indebtedness. The reasons are found in the inadequate financing of some costly clinical pathways by the NHIF, as well as the soft budget constraints until the end of 2005, which spurred a trend of overspending in the hospitals. The later were not motivated to reduce their debts to suppliers since they were confident that by the end of the year the Ministry of Health would cover their arrears. In most hospitals the transition to financing entirely by the Fund is expected to reduce such financial irresponsibility on their part. However, since under many clinical pathways the funding is less than the actual costs, such an effect is not certain. On the contrary, tension between hospitals and the NHIF may actually deepen. The hospital sector started the year of 2006 with BGN 200 million in unpaid debts, which amounted to 25% of its budget for the year. Toward the end of the year, about 160 million of this debt of university and district hospitals were quietly paid by the state, again with public vows by the Minister that this was happening for the very last time. In fact, there is still no agreement between the physicians and the state on a

[10] International classification of diseases, 10th version (ICD 10); and International Classification of Diseases, 9th clinical modification (ICD 9CM)

lasting solution to this problem. In 2007, the parties could not even agree on the National Framework Agreement itself. Thus the negotiation mechanism was completely blocked and this opened the way for strikes and trade-union demands by doctors and nurses.

Of course, far more important than who will pay this debt is its origin and how to prevent its accrual in the future. The present system, based on clinical pathways, has significant shortcomings that impede the efficient use of the available resources. The assessment of some CP shows that there still exist certain elements aimed more at redistribution of funds and keeping the small hospitals alive, than covering real costs under the pathways. In this manner, certain basic pathways, essential to the majority of the hospitals, are overrated while other costly ones are underestimated and remain at the expense of the hospitals and the patients. This narrows down access to the more expensive hospital services and is conducive to corrupt practices.

There also exist a number of restrictions in the financing of clinical pathways that actually stimulate overspending. Thus, for instance, hospital expenditures can only be reimbursed if all of the procedures and interventions defined in the clinical pathway have been performed. Even if some of these become unnecessary in the course of the treatment, the hospital has to perform them or just report them so as not to lose payment for the activities actually carried out. This "all-or-nothing' principle leads to overspending or insufficient financing of clinical pathways to the detriment of the patients' treatment. What is more, such risks force the hospitals to register the newly admitted patients under the more expensive clinical pathway, when possible, as a safety measure in case more costly interventions than initially expected have to be performed.

Last but not least, the clinical pathway based financing takes place within a framework agreed with NHIF and the respective hospital budget rather than on the basis of the real cost of medical service provision. This budget framework takes into account the capacity of individual hospital to admit patients under each CP agreed with NHIF. It is determined on the basis of reports on previous years, available facilities and experience. The hospitals are only allowed to exceed this budget by 5%.

These strict budget constraints have their justification. They are a preventive measure against overestimating expenditures and/or accumulating debts. They are aimed at ensuring equity, transparency and accountability in the allocation of funds to the hospitals. In the past, owing to differences in facilities and equipment, and in the level and quality of services, university hospitals used to get more money than district ones under the same CP. Besides, allegations were often heard that some select hospitals more easily have their debts paid in full by the Ministry of Health owing to connections with the political elite. Within this health economy of deficits and debts, it is the Ministry of Health, as the principal, that decides which hospital to save first and how much of its debts to pay, which in turn constitutes a lever for keeping their management in a state of dependence and subordination.

Since 2006, all hospitals have been receiving the same amounts for equivalent CP and, as mentioned above, are allowed to exceed this budget within up to 5%. The underlying idea is that NHIF finances the minimum level for a given CP. Should the quality and actual costs be higher, the difference has to be covered by the patient. In other words, patients have the choice between the minimal, NHIF-financed services or higher quality ones, at additional charge. This however, implies that each hospital should have a price list from which patients can find out what part of the clinical pathway is covered by NHIF and how much they have to pay themselves.

The problem with the underestimation of a number of clinical pathways by NHI is in turn causing problems with the inadequate remuneration of doctors and specialists, which became the chief reason for the strikes against health sector management in 2007. The poor motivation of medical workers and specialists in the hospitals and frustration with pay are equally the main source of corruption risks and practices. Unlike their colleagues in outpatient care, specialists in the hospital sector are hired by the hospitals. Their incomes and conditions of work depend on how well the hospital is managed. In the past years, the differences in pay between the outpatient and hospital sectors have increased considerably. In order to retain them in the hospitals, their managers tend to close their eyes to many overt and covert compromises with professional ethics and loyalty to the employer. Thus, for instance, many of the specialists working in the hospitals also have their own private practices. This mixing of public and private commitments is not always in the interest of patients and still less, of the employer.

So far, the attempts to address the problem with the inadequate pay in the hospital sector have been reduced to deconcentration of the management of public healthcare and the delegation of more rights and responsibilities to the executive bodies of the hospitals. The principal is always the state (Ministry of Health) or the municipality, which appoints the board of directors and endorses the framework for the collective bargaining agreement and pay levels. The board of directors has considerable freedom of action concerning the distribution of the payroll fund. The national framework agreement guarantees that no less than 40% of the funds granted by NHIF under the clinical pathways are allocated for payroll. There is no upper limit on the funds that may be distributed as salaries. In view of the inadequate payments under the clinical pathways, this system practically ties the hands of hospital management with regard to investments and the purchase of medications and services. The tax framework has a similar effect. Exempting hospital services from VAT in fact promotes labor-intensive activities and avoidance of the purchase of goods, services and equipment since the hospital is not entitled to VAT rebates for them. As a result, hospitals do not invest in fixed assets and with respect to current expenditures they tend to accumulate debts to the suppliers in the hope that in the end of the year the principal will bail them out. Or else they simply pass current expenditures on to the patients, charging them extra for medications and services.

In its present form, although nominally based on universal mandatory health insurance, the financing of the hospital sector is marked by pronounced elements of centralized distribution of healthcare funds. Progress has been made only in the sense that instead of the state distributing budget funds collected from taxes

among the hospitals, it is now the NHIF that allocates the money collected from the mandatory health insurance contributions. The hospitals are not motivated to provide more services than those agreed with NHIF since they may not get reimbursed for them. The system does not offer any incentives for seeking the optimal balance in allocating funds for payroll, medications and other inputs under each CP. In the absence of regulations on minimum expenditures for medications under CP reimbursable by NHIF, the system leaves room for abuse, since the hospital management may, under pressure from the doctors and nurses, allocate funds paid by NHIF for payroll and charge patients for medications that have actually been calculated into the cost of the CP.

Furthermore, the system provides no incentives for innovations and new technologies. There is no mechanism in place to take into account and encourage such expenditures in NHIF funding allocation. A similar situation is found with respect to improving the qualification of medical staff. With the bulk of the financing coming from NHIF and the lack of competition among hospital care providers, there is no means of compensation of such expenditures. On the contrary, when funds are granted under clinical pathways without making any distinctions between old and new equipment and technologies, any spending on investments and training in fact reduces the payroll fund. In other words, at this stage, investments in quality can only be paid back through unregulated payments by solvent patients directly to the treating physicians.

Finding themselves between the NHIF and the patients in their struggle for survival, the hospitals are trying to shift the financing burden onto either the Fund or the patients. Therefore, for the purposes of the present analysis, the corrupt and abusive practices in hospital care can be divided into two groups: those affecting the patients directly, by taking unregulated extra payments from them; and those affecting the patients indirectly, through the over-reporting of costs reimbursable by the Fund.

Typical instances of corruption in the hospital sector are bribes to secure hospital admission, purchase of medical supplies and medicines included in the cost of the clinical pathway, soliciting official donations to the hospital, extra charges for treatments and operations (*Table 10*).

It is a commonplace practice to force the insured patients to pay for medical supplies and medicines. The excuse typically cited is the lack of funds, insufficient financing from NHIF, etc. The patients are not in position to refuse and the doctors are ever less inclined to perceive such unregulated forcible payment as a corrupt practice. All too often, the reason is found in the fact that it is not an individual but a collective, semi-institutionalized, indirect instrument for increasing earnings, where personal inhibitions do not play any role. As already noted, in the present situation of shortage of funding for hospitals, the physicians' salaries are safeguarded by the minimum threshold of expenditures, whereas patients' rights are not protected by corresponding regulation of the expenditures for medications. Thus, with the increasing autonomy of hospitals and the shift of responsibility and pressure by physicians from the state to the hospital management, the latter are encouraged by the system to use the funds extended by NIHF for payroll on a priority basis, allocating whatever is left to expenditures for medications.

Table 10. Incidence of Corrupt Practices According to Those who have Undergone Hospital Treatment
(% of those who reported experiencing some of the situations listed during their hospitalization)

Have you bought supplies for your own use during your hospitalization?	28.2%
Have you bought medicines for your own use during your hospitalization?	27.8%
Have you made cash payments to the treating physician for an operation?	9.9%
Have you made cash payments in order to secure your hospital admission?	5.6%
Have you been asked to make an official financial donation to the hospital?	4.1%
Have you made cash payments to the treating physician for birth delivery?	1.3%

Source: ASSA-M 2006 N = 1028

An even more institutionalized, if less prevalent, type of corruption pressure is to request a donation to the hospital from the patient. Such instances were reported by 4% of the respondents who had undergone hospital treatment in the survey conducted by ASSA-M in 2006.

A similar situation is found with respect to the widespread semi-institutionalized incidence of conflicts of interests. Each physician working in a hospital may also have a private practice as a specialist in the outpatient care sector. Most of the diagnostic equipment is found in the hospital sector. This is conducive to conflicts of interests: using hospital equipment for private examinations, referring patients to private offices. The sociological surveys show prevalence of these practices that run against neither any legal regulations nor any formal rules of ethics. On the contrary, the public increasingly tends to view them as a means for the good doctors to supplement their low salaries from the public sector. Thus the private practices of the specialists hired in the public sector make it possible for what would otherwise be unregulated payments to take place in accordance with the law.

Naturally, the main corrupt practices primarily affect the active hospital treatment, surgical interventions, etc., where the additional direct payment to physicians and surgeons is the norm rather than the exception. In the public mind the justification for these practices is again the disparity between the official pay of physicians and the huge stake for the patient. Most of those who can afford it probably pay the money with hope and gratitude. Far more wronged are those who cannot afford to pay since it reduces their chances of getting timely and quality treatment even though they have health insurance coverage.

Even more revealing regarding the existence of corruption risks and practices is the "insider view", i.e. the polls among doctors. By data of the Ministry of Health, about two-thirds of those interviewed confirm the existence of such practices of varying intensity (occasionally, often, all the time). The rates are highest in connection with birth delivery assistance (71%) and operations (68%). A considerable proportion reported having made unregulated payments for patient care (feeding, dressing, etc), as well as being solicited for donations upon admission to hospital (54.5%).

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.

INDICATORS FOR CORRUPTION RISK ASSESSMENT AND MANAGEMENT IN HEALTHCARE

Corrupt practices: typology		Quantitative indicators				
		Sociological (soft data)				Statistical (hard data)
Area	Types (by purpose of the bribe)	Health service users		Providers		
Outpatient care						
GP	Home visit	Assessment Perceptions	Personal experience	Assessment Perceptions	Personal experience	
	Issuing a referral to a specialist or for hospitalization	Assessment Perceptions	Personal experience	For which three specialties do you run out of referrals first?		Referral quotas (upper limits)
	Undue sick leave	Assessment	Personal experience	Assessment Perceptions	Personal experience	Sick-leave certificates issued per month
	Prescribing medications from the NHIF list against a bribe					Are there unlisted substitutes for the medications in the NHIF list
	Getting a commission for prescribing certain medications (medical supplies); referring patients to particular pharmacies			Assessment Perceptions	Personal experience	

Corrupt practices: typology		Quantitative indicators				
		Sociological (soft data)				Statistical (hard data)
Area	Types (by purpose of the bribe)	Health service users		Providers		
Outpatient care						
Specialist	Issuing a hospitalization referral	Assessment Perceptions	Personal experience	What are the monthly referral needs in your specialty		Deficit: assessment of average monthly needs/ current quotas
	Undue sick leave	Assessment	Personal experience	Assessment Perceptions	Personal experience	
	Prescribing medications from the NHIF list against a bribe	Assessment	Personal experience	Assessment Perceptions	Personal experience	
	Getting a commission for prescribing certain medications (medical supplies); referring patients to particular pharmacies	Assessment	Personal experience	Assessment Perceptions	Personal experience	
	Unduly passing onto the patient expenditures for medical supplies and medications	Assessment	Personal experience	Assessment Perceptions	Personal experience	
	Undue additional payments by the patient	Assessment	Personal experience	Assessment Perceptions	Personal experience	
Emergency care	Bribe for service	Assessment	Personal experience			
	Referrals to related funeral agencies					

Corrupt practices: typology		Quantitative indicators				
		Sociological (soft data)				Statistical (hard data)
Area	Types (by purpose of the bribe)	Health service users		Providers		
Hospital care						
Unregulated payment for hospital admission		Assessment	Personal experience	Assessment Perceptions	Personal experience	Average waiting days for hospital admission
Unregulated payment to the treating physician or surgeon		Assessment	Personal experience	Assessment Perceptions	Personal experience	
Unregulated payment to patient care staff		Assessment	Personal experience	Assessment Perceptions	Personal experience	
Unregulated payment for medical supplies and medications		Assessment	Personal experience	Assessment Perceptions	Personal experience	
Referring patients to own private practices		Assessment	Personal experience	Assessment Perceptions	Personal experience	Proportion of hospital doctors with private practices
Nepotism				Assessment Perceptions	Personal experience	
Administrative regulation and control in healthcare						
Hospital accreditation				Assessment Perceptions	Personal experience	
Licensing of medical practices				Assessment Perceptions	Personal experience	
Control and implementation of medical standards				Assessment Perceptions	Personal experience	Number of formal sanctions imposed; number of successful appeals
Approval and control of medicines						
Hygiene-and-sanitation inspections of commercial premises		Business surveys		Assessment Perceptions	Personal experience	Number of formal sanctions imposed; number of successful appeals

Corrupt practices: typology		Quantitative indicators				
		Sociological (soft data)				Statistical (hard data)
Area	Types (by purpose of the bribe)	Health service users		Providers		
Financing by NHIF						
GPs	Over-reporting the number of registered patients					Number of violations registered
	Deviating from the minimum standards			Assessment Perceptions	Personal experience	Number of violations registered
Specialists	Over-reporting the number of examinations			Assessment Perceptions	Personal experience	Number of violations registered
	Deviating from the minimum standards			Assessment Perceptions	Personal experience	Number of violations registered
In-patient care	Reporting more expensive clinical pathways than actually implemented			Assessment Perceptions	Personal experience	Number of violations registered
	Over-reporting the number of patients treated			Assessment Perceptions	Personal experience	Number of violations registered
"Grand corruption"						
Economically unwarranted decisions for investments in the hospital sector for personal gain		Findings of investigative reports and of specialized investigation authorities				
Inclusion of particular clinical pathways or medications in NHIF coverage in the interest of definite manufacturers, equipment suppliers, or hospitals		Findings of investigative reports and of specialized investigation authorities				
Centralized public procurement of medical products and medications		Public Procurement Registry				
Public procurement in hospitals		Public Procurement Registry				

CONCLUSION

The indices of the level and spread of corruption in Bulgaria show that it is growing in the healthcare sector. This stands out against the downward trend in corrupt practices in all other areas of public services (the so-called "petty corruption") over the past few years. This report identifies the reasons for this negative tendency and puts forward policy recommendations for counteraction.

The review of health reform achievements in Bulgaria indicates they are chiefly of the transition from budget financing to health insurance. This process is by and large completed. The problems, however, especially in the hospital sector, persist. And judging by public health indicators, they are even aggravating. Thus, the question of how and at what point the health reform deviated from the optimal solutions arises with particular urgency.

In the Bulgarian public debate, healthcare sector problems, including the high rate of corruption, are associated with the shortage of funds. The debate increasingly boils down to the inadequate pay of physicians.

The close analysis of the reform process, however, suggests that low pay is the outcome of poor management and incomplete reforms not the cause of all problems of the sector. Outpatient care suffers from insufficient coverage, reduced scope of preventive programs, and deep regional disparities. But the situation is worst in hospital care, which in addition to coverage and access problems, is saddled with outdated equipment and inadequate financing by the National Health Insurance Fund. As responsibility for the poor service quality is being passed onto the hospital management, the half-way measures that are still largely hinged on state-run health insurance have brought the reforms to a standstill.

In the context of partial reforms, anticorruption policy does not stand much of a chance. It is necessary to liberalize healthcare and to give both the employers and the insured the opportunity for broader choice of health plans by more insurers. Hospitals would then be able to work with more contractors and to compete for their patients. Naturally, competition in this market can hardly be expected to solve all problems. Although Bulgaria has the advantages of a small country and in the future will benefit from the positive aspects and competition in the internal EU market for health services, consumer choice is to some extent regionally limited. However, this can hardly be an argument in favor of a centralized insurance and hospital system but quite the opposite. Government health policy should combine social responsibilities with more competition among providers and greater consumer choice. Taking the reverse course of tightening regulations

and control in the context of deficit and central distribution of the scant resources is a recipe for corruption and abuse at all levels of responsibility.

The fact that the key to reducing corruption in the hospital sector lies in bolder and more far-reaching structural measures to complete the reform does not imply that hospitals should put up with corruption while waiting for the government to bring the reform process to a successful end. The hospital management is the chief driver of restructuring and is largely responsible for the prevalence of corruption. There are a number of measures entirely within its competence and which can be undertaken as part of structural reforms. These include regulation of the additional payments; the refusal to pass the burden of current expenditures for medical supplies and medications onto the patients; fostering intolerance of unethical and unprofessional conduct with regard to patients, etc. The here-outlined matrix for corruption risk assessment in Chapter 5 can be useful in developing anticorruption measures at all levels of governance.

Anticorruption policy needs to take into account several existing risks. The first one is the lack of political will. In this respect it is quite revealing that for more than a year now, the latest National Healthcare Strategy, which is saddled with the same symptoms of the half-way reforms to date, has neither been amended nor endorsed as it is. It essentially encapsulates the present state of the sector: lack of political will to reach a consensus; lack of administrative capacity to implement optimal instruments for improving service quality, consumer choice, and patient satisfaction.

One of the reasons is probably the fact that the health reform was not among Bulgaria's accession priorities. There being no *acquis communautaire* in this area, it was relegated to the background in the negotiation process. The exceptions are the food and workplace safety regulations, as well as the environmental standards, which are of utmost importance for the protection of public health and, if implemented effectively, are likely to have a positive impact in the long term. As for outpatient and hospital care, these are European concerns largely in terms of the free movement of people rather than with regard to addressing the problems in the healthcare sector. This means that the greater opportunities for Bulgarian medical staff to work abroad may in the short term aggravate the shortage of specialists and physicians in some areas. In turn, this would be even more conducive to corruption, particularly if the public sector remains the chief hospital service provider. This is the second risk facing health policy in the short and medium term.

Last but not least, there is a significant risk of continuing along the lines of increased government intervention and control of the insurance and health service markets instead of seeking balanced solutions in terms of clearer regulation of the social responsibilities of the state, with consumer choice and quality improvement being entrusted to the private sector. Such an approach implies sharing the financing between the public insurance system and patients. It would not increase the burden already borne by the patients. It is high enough in international comparative terms even as it is. The problem is that it remains unregulated. The development of the market for health-insurance plans with the equitable participation of private and institutional insurers would most probably reduce

these costs and would bring out of the shadow economy a significant portion of the personal incomes of medical workers. In turn, this would make it possible to further ease the compulsory health-insurance burden.