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.