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%).