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.