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 But the situation is worst in hospital care, which in addition to coverage and access problems, is saddled with outdated equipment and inadequate financing by the National Health Insurance Fund.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.