Republic of Bulgaria
ECONOMIC
AND SOCIAL COUNCIL

O P I N I O N

on

HEALTH ACT AMENDMENT BILL

(No. 754-01-50, proposed by a group of national representatives)

(drawn up at the suggestion of the Chair of the 40th National Assembly)

Sofia, 6 July 2007

In compliance with Article 5, Paragraph 1 of the Act for the Economic and Social Council and by letter of 31 May 2007, the Chair of the National Assembly proposed to the Economic and Social Council to draw up an Opinion on the “Health Act Amendment Bill”, submitted for discussion by Dr. Iva Stankova and a group of national representatives .

After consultations held with representatives of the movers of the bill, the Ministry of Health, Ministry of Education and Science, Ministry of Finance, the National Association of Municipalities in the Republic of Bulgaria and UNICEF, a working group consisting of two representatives of each of the three groups in the ESC prepared a draft opinion.

On 6 July 2007, in conformity with Article 33, Paragraph 6 of the Rules of Procedure of the Economic and Social Council, the President of the ESC, Prof. Lalko Dulevski, submitted and presented for discussion by the Plenary Session a draft of opinion. The Economic and Social Council approved this Opinion.

I. INTRODUCTION

The issues of health insurance of population and children in particular are one of the main issues in the activity of the Economic and Social Council (ESC). The Council advocates the right to equal opportunities for access to quality health services and medical service of all citizens of society. The problem of providing such quality services is especially serious when we talk about the health of children. In its work so far the Council has stressed over and over again the need for a focused state policy for protecting the rights of children and the need for undertaking specific measures in that direction.

In its opinion on "Demographic Trends and Challenges to the Demographic Policy of Bulgaria" the Council insists on:

- improving the attitude towards children and cultivating the values of modern society;

- guarantee for the physical and mental health and development of the intellectual potential in the first seven years of children's growth;

- developing and implementing policies and measures against smoking, drug addictions and social exclusion;

- introducing compulsory sexual education from the third-fourth form at school and training in family planning and good parentship from the eighth form.

In its last Opinion on "Family, Good Parenting and Equal Gender Opportunities", the ESC stressed the necessity of promoting and assisting the responsible parenting and guaranteeing the support for children at state level through: child allowances for each child without income test; providing access of each child to kindergartens and day nurseries; new social services for raising children; equal access to healthcare; equal access to education and introducing all day instruction in schools; promoting talented children.

II. CHILDREN'S HEALTH STATE

Children's health state in the last ten years indicates decrease of its indexes especially as far as adolescents are concerned. 37.2% of the children have chronic diseases. There are distortions in the formation of their skeletal and muscular system. Among children, a reason for hospitalization at the first place in 2005 were diseases of the respiratory system (37.4%) followed by infectious and some parasitic diseases (8.3 %). The third place was occupied by traumas and poisoning – 6.1%, and the forth – diseases of the digestive system (5.4%). There is an enhancement of the indexes of general contagious diseases in the country.

Behavioural factors (unhealthy nutrition, smoking, law physical activity, alcohol abuse, etc.) constitute 50% of the mortality risk factors. The nutrition model of the population, including

children and adolescents, is unhealthy: the consumption of fats is high; the intake of fresh fruit and vegetables in the winter and spring is insufficient; the consumption of milk and dairy produce, fish, etc. is low, higher is the consumption of salt. This leads to a higher relative share of overweight pupils, which is higher with 7-10 years old children (18-19%) and in the age group of 10-14 (20.3% with boys, 18.5 % with girls). From 5% to 14% of pupils in Bulgaria have been diagnosed with chronic noninfectious diseases related to nutrition; 51% of pupils diagnosed with hypotonic disease are overweight and obese.

The physical activity of adolescents is low. It has been established that about 80-90% of them do not follow the recommendation for moderate physical activity for at least 1 hour daily.

Although in the recent years the child mortality in Bulgaria is constantly decreasing, it still is higher than that in European countries.

The great morbidity among pupils requires the joint efforts of various specialists – school and GPs, doctor's assistants, nurses, school psychologists, parents and teachers.

III. THE STATE AND PROBLEMS OF SCHOOL HEALTHCARE

Bulgaria is one of the first countries in Europe with the most long standing traditions in the school healthcare. In the country there are around 3000 school health services where prevention and promotion of health activities for children and pupils are carried out by a doctor, doctor's assistant or nurse. These offices also provide medical service for emergency conditions of children and pupils until the arrival of the emergency medical teams.

With the launch of the health reform, the child healthcare is entrusted to the GPs, who perform medical check-ups and immunizations as well. At the same time, the medical specialists in the child and school health offices perform the following activities in compliance with Art. 120, Para 1 of the Health Act:

1. medical supervision;
2. health education and building health habits;
3. providing first medical aid;
4. control over children's hygiene;
5. control over the hygiene of premises and food;
6. preparing and keeping medical records.

In this way the main activities of prevention, health promotion and medical service of children are divided by law between the GP and the medical specialists in the child and school offices.

The development of this new system of child healthcare gives rise to some problems, as well, which are ascertained in the discussions and consultations held with different institutions and experts as follows:

- lack of the necessary link between the medical specialists in school health offices and the GPs. In larger schools the children are registered with a large number of GPs /30-40/, which makes this contact even more difficult. That is why no individual measures can be implemented effectively to pupils with chronic diseases;

- very often children's medical check-ups by GPs are performed only formally and the schedule for conducting these check-ups is not synchronized with the requirements for collecting information by the medical specialists in schools and childcare centres;

- the necessary link and relationships between the medical specialists in school and child health offices, GPs and parents is not established;

- in a number of cases the state and maintenance of health offices in schools do not meet the necessary standard;

- the capacity of medical specialists in schools and childcare centres to carry out reliable control over hygiene and healthy nutrition of children is not used effectively.

As a result, the analysis of health status of children and pupils is unreliable and does not provide the necessary information for undertaking effective measures in the area of prevention and promotion of health.

There still exists a serious issue with the professional identity and the role of medical specialists at school as far as parents' expectations are concerned. In a number of cases parents expect from these medical specialists to do medical check-ups, immunizations, to issue sick notes, as well as to treat some medical symptoms. Reasons for that are both the lack of the necessary awareness of parents and to a certain extent their frustration with the system of child healthcare functioning since the beginning of the health reform.
The presence of all these problems proves the necessity for further development of the legislation and subdelegated legislation of child healthcare including the laws connected to school healthcare.

IV . SUGGESTIONS ON THE BILL

The Economic and Social Council has the following suggestions on the Health Act Amendment Bill, submitted for discussion by Dr. Iva Stankova and a group of national representatives:

- In Art. 120 Para 1, item 1 there should be added "emergency" after "urgently necessary".

- In art. 120, Para 2 concerning the requirements for educational-qualification degree of medical staff "specialist" should drop out since according to the new provisions such educational degree does not exist.

- In art. 120, Para 4, the type of contract that doctors and medical specialists conclude should not be limited only to a labour one. It is better to set specific budget and service norm and providing sufficiently effective control to ensure more opportunities for contracting.

- In art. 120, Para 5 the words “and to those opened in the municipal kindergartens, schools and children’s homes – with funds from the municipal budgets” should be replaced by “as an activity delegated by the state”.

At the same time, in the subdelegated legislation there should be preserved the possibility for change of the minimal standard of opening a health office taking into account the peculiarities of specific regions, childcare centres and schools.

The ESC considers it extremely important that the link and interaction between the GPs and the medical specialists in health offices concerning children’s healthcare should be regulated in a legislative enactment.

In conclusion, the Economic and Social Council supports in principle the Health Act Amendment Bill as a necessary step for improving health education, prevention and rehabilitation of children’s health. The Council believes, however, that the stipulated law amendments could provide the expected result only if a further step is made for the necessary coordination between the whole legislation and subdelegated legislation related to healthcare, education and upbringing of children.

Appendix 1

THE ORGANISATION OF SCHOLL HEALTHCARE IN DIFFERENT EUROPEAN COUNTRIES

This document presents different practices of organising school healthcare in some European countries. The information does not claim to be thorough and is rather a description of existing health services on the basis of various publications on this topic, without making an analysis of countries' legislation in this area.

In the materials reviewed, the school healthcare almost nowhere is considered separately but as a part of the entire healthcare system or children's healthcare. Hence, it is invariably connected to the general structure of health system, and in some cases also to the education system, health insurance system, the organization of public healthcare, measures of health promotion and preventive activities for children, including medical check-ups, which are paid special attention in almost all documents.

Comparative analysis of the school healthcare in Denmark, Germany, Austria and United Kingdom

A comparative analysis is presented of health services provided to children in 4 European countries - Denmark, Germany, Austria and United Kingdom. School health services are considered separately but in the context of the entire organisation of health services for children in these countries.

In Denmark, the municipalities are in charge of medical examinations of all children by the school medical services. In 1982, a new scheme for school healthcare was introduced. The obligatory check-ups by the GPs have been reduced to one when starting school. School nurses are in the centre of the school healthcare system: they examine once a year each child in school until 9th grade checking for: **1)** physical, mental and psychosomatic state of the child, **2)** speech and intellectual development, **3)** screening for behavioural disturbances, **4)** social burden and **5)** chronic diseases and ailments. In preschool and in the first school year about 90% of all children are examined. Except the GP, all health services for children are financed and coordinated by the local authorities and the cooperation between the GPs, health inspectors and school nurses is supported.

In Germany the responsibility of the preventive measures for children and adolescents lies with the paediatricians and the GPs of the Youth Health Service /Jugendärztlicher Dienst/ when the child starts school. A paediatrician of the Youth Health Service provides 3 regular preventive check-ups. A part of these check-ups is the immunization scheme. The focus is not on organic diseases but on psychosocial aspects. The Youth Health Service is assigned the task to provide health education and preventive healthcare to pupils. These services are financed by the local authorities or by Bundesland, responsible for public health. In opposite

to the health check-ups performed by private practice paediatricians, health education and preventive healthcare for pupils are provided by public institutions which is a way to ensure better control over child's health.

In Austria medical check-ups in schools are provided to all children from 6 to 18. As a rule, a regular annual medical check-up is done for this age group. check-ups are controlled by the Ministry of Labour, Health and Social Affairs, they are not a responsibility of the mandatory health insurance. The focus is on testing hearing, sight and physical state of children. According to the Universal Social Security Act, the school health staff cooperates with other preventive health institutions.

According to a publication (Report of the WHO 2006) part of responsibilities of the district medical officials in Austria are also all measures that are servicing public health, including preventive healthcare, school doctors, medical check-ups and advice, participation in health promotion. In parallel with the sanitary control of school premises, a main task of school doctors is the regular examination of pupils. The national check-ups by doctors were introduced in 1964. This programme is in practice a preventive medical check-up held once a school year and its main objective is testing sight and hearing of pupils and establishing their being fit for sport classes. After a pilot phase in 2004 and a following evaluation, in the summer half-year of 2005, 95 000 health check-ups were held for all pupils in eighth form in Austria. Simultaneously with the check-up, all pupils received a leaflet containing health information, internet links on nutrition, physical activity, safety, prevention of accidents and first aid, dental care, immunizations, the sun as a source of life and its dangers; addictions; sexual and reproductive health, contraception and protection from diseases.

In the United Kingdom a doctor, appointed by District Health Authorities, is responsible for the organization of school healthcare together with a senior nurse officer. They should ensure a regular contact and interaction between the members of the primary healthcare. All children go through regular medical check-ups by the school doctor at preschool age, when starting school and at the age of 14. If health problems are established by the school nurses, teachers and parents should ensure further medical check-ups. In particular, school doctors and nurses are responsible for checking for contagious diseases in school, for following the immunization programme, for health education and hygiene.

Child dental treatment

In Denmark, in compliance with the Children's Oral Health Act (1972) consistent dental care for children is provided. According to this act, the municipalities establish child dental centres for dental treatment of all children under 16. Children aged 16-17 can choose between municipal clinics and private dentists. The programmes includes preventive measures, periodical check-ups of the dental development and condition of each child and treatment, if necessary. The periodicity of the check-ups is 10-12 months. The municipalities usually organise their own dental centres and many of them are in the schools.

In Germany, the consistent preventive dental check-ups for children are not part of the mandatory health insurance except for the age group of 6-20 who are entitled to preventive dental treatment once a year. Some of the dental check-ups are carried out in schools by the public youth healthcare services.

In Austria, there is no regular preventive dental programmes for children, providing standard services. Some of the check-ups proposed by the dental scheme of reimbursement are free of charge and can be of preventive character. Within the youth health scheme (Jugendlichenun tersuchungen), dental health is part of the basic health check-ups (Basisuntersuchungen). A voluntary dental health preventive programme has been proposed for schools and childcare centres.

A survey in 1989 for the dental state of children at 6 showed caries in 60 – 80 % of them and as a result some regions have introduced a versatile preventive programme against caries. For example, in Stiria dental nurses visit kindergartens 4 times a year and primary schools – 3 times a year.

In the United Kingdom, children are registered with a dentist who receives a capitation tax and not payment for service. Children under 16 receive free dental treatment.

Table – responsibility and provision of healthcare services for children

		DENMARK	GERMANY	AUSTRIA	UNITED KINGDOM
Preventive examinations	Responsibility of	Local authority	Mandatory health insurance	Mandatory health insurance	district health authority; primary healthcare
	Provider	GP	Paediatrician	Paediatrician	GP – family doctor
Immunizations	Responsibility of	Local authority	Mandatory health insurance	Mandatory health insurance	district health authority; primary healthcare
	Provider	GP	Paediatrician	Paediatrician	GP – family doctor

School healthcare	Responsibility of	Local authority	Mandatory health insurance	Mandatory health insurance	district health authority; primary healthcare
	Provider	School nurse	School doctor	School doctor	School doctor, school nurse
Dental care for children	Responsibility of	Local authority	Mandatory health insurance	Mandatory health insurance	district health authority; primary healthcare
	Provider	Child dentist	Dentist	Dentist	Dentist

The experience of other European countries

In Scotland, the school health service is part of the child health service in the community (the Community Child Health Service). There are various services offered. The employees try to work in cooperation with parents and other people who take care of children, both at schools and in other branches of the health system. Some of the activities, for instance-sight, hearing and speech checks are carried out routinely for all of the children in order that those needing additional examinations and medical treatment are to be detected. Parents are informed of these screening tests and if some of the parents would not like their child to be included in the screening programme they should inform the relevant school at the beginning of the school year. Usually, if medical treatment of a child is needed, parents are informed for getting their agreement. In school healthcare a main role plays:

1. Health inspecting officer or nurses who periodically carry out the inspections of children groups, give advice regarding health issues and hygiene, carry out eye tests and work together with the school doctors. They bring to the attention of the doctor possible problems. In some cases they are assisted by a health assistant. Nurses play an important role also for the connection between children home and the school.

2. The school doctor – they visit the school periodically and meet the school nurses or health inspection officer and teachers for finding out if some of the students need medical treatment. Moreover, the school doctor examines the medical records of students from 1st and 7th grade when entering high school and of all newcomers at the school.

Parents are asked to fill in a medical questionnaire for their children at this age and to respond whether they would like their child to have a full medical examination. The school doctor could ask for parents' agreement to examine the child in case that child's medical

record is not completed. Parents have the right to be present at each of the medical examinations and to be informed of child's state – whether he/she needs a second medical examination from the school doctor or to be referred to a GP or a specialist. Parents could arrange that the GP carries out the medical examination instead of the school doctor but this could require payment of a fee. Agreed with parents, the school doctor could make the immunizations of the child or they could be made by the GP.

In Ireland the health care administration conducts the school screening programmes and immunizations of children at public primary schools. Screenings of students are carried out at schools by a public nurse or by employees in the health care administration when the school headmaster is informed of the exact date and parents can be present, if they wish so. Children's sight and hearing are checked and if parents would like a physical examination is performed. If during these screenings some health problems occur they are treated ambulatory and free of charge.

In Scandinavian countries (data from the report of NOMESCO) health care services are public. These countries dispose of a well developed primary health care system. In addition to the services offered by GPs there are also preventive services for mothers, children and students.

In Denmark the responsibility for health care services is very decentralized. The main principles are as follows: **1)** the State is responsible for the legislation and governance. **2)** Local authorities are in charge of the hospital health services, health insurance and specialized private clinic. **3)** Municipalities – in addition to the other commitments, are responsible for child and school health services. Local authorities and municipalities have the operating responsibility for health services. Child healthcare is carried out in compliance with a law relevant to health inspecting officers and is organized by the municipal health administration. Medical examinations of children are made by GPs who have a contract with the health insurance fund. Health services at schools are regulated by law and are usually provided by doctors of a general practice, health inspecting officers or nurses.

In Finland municipalities are those bearing the responsibility for the health care education, screenings and health care research, services provided by GPs, health care at schools, etc.

In Norway the system for providing health services is based on a decentralized model. The State is responsible for the policy and quality of the health care through the budgeting and legislation. Within the legislation and available financial resources, local healthcare authorities and municipalities are formally free to plan and carry out public health care services at their discretion. In practice, however, their freedom for independent activity is limited by the resources available. Municipalities are in charge of the primary healthcare services, as well as of the preventive and medical activity; here are included: health promotions, diseases prevention, including the organization and management of school

healthcare.

In Sweden the fundamental act is the Health and Medical Services Act. Other important regulations are the Act for the Medical Employees concerning patients' injuries. Primary healthcare services include healthcare centres providing GPs, women and child centres, regional nursing healthcare, regional physiotherapy, municipal dentist centres. The purpose of the primary health care services is to promote public health in a geographically defined territory. Health care services at schools together with the preventive measures are an obligation of the municipality.

In France health promotion is usually performed at 3 social levels: at school, family and public with effective collaboration between these sections. Interventions into the public health for students are traditionally centred on standardized, routine medical check-ups (bilans de santé) when starting school at 6 years of age. The government's evaluation regarding school medical examinations has found that they have not a great effective role for public health if they are made in isolation. Recently, the Ministry of Education has proposed the inclusion of school medical examinations in a wade-ranging political framework oriented to child's interests. The components of this plan (2003) are outlined around 3 points: routine screenings for children who visit child centres and also in the first several years of the primary school development, speech and other impediments, development of screening programs based on local needs.

A report of the WHO (World Health Organization) concerning the healthcare system in France indicates that the Ministry of Education governs school health services by systematic interventions at schools.

In Belgium (report of the WHO) a medical school examination of students up to 18 years of age is mandatory. Every 2 years students go to a school medical centre for a medical check-ups including screening for physical and mental deviations, speech and sight examinations, determination of immunization dates. In addition, a team of a doctor and a nurse visits schools for a check-up for contagious diseases (tuberculosis, lice, etc.) and medical education.

In the Netherlands there is a regional network of municipal services for public health that are responsible for the medical examinations of children, immunizations, health protection and the activities on health promotion. Public health care on a local level includes all controlling aspects of contagious diseases, sanitation, school healthcare and medical education of society.

In Lithuania school healthcare is provided by local authorities who according to their budget appoint a doctor or a nurse at work at school or kindergarten. The primary healthcare service for children up to 14 years of age is provided by paediatrics or GPs.

In Hungary municipalities bear the responsibility for the primary health care service.

They should provide access to services provided by the GPs (family therapeutist or family paediatrician), dental services, health services by the nurse for mothers and children and school health care services. In some cases, nurses from agencies responsible for the health of mothers and children provide also the school healthcare, together with a doctor, for prevention of diseases of children between 3-18 years of age. According to the number of children, local agencies responsible for the healthcare of mothers and children and family doctor/paediatrician could provide the healthcare at school working full or part time. The medical staff at school is appointed from the school management. The exact number and requirements are specified under Decree No. 26 of 1995 (IX. 3.) NM by the Minister of Welfare for school health care services.

If we try to generalize the existing practices for organizing school healthcare, in most of the cases this is done on a local level, region or a municipality, that are in charge of creation and activity of a healthcare system at school. The school healthcare is part of the system of public healthcare and services provided. In most of the cases, main tasks of school healthcare are related to the medical education, health promotion, prevention of diseases, carrying out of medical check-ups and screening of students and not with medical activities. There are various practices regarding individuals providing direct medical services at school; this is performed by doctors, nurses, GPs when in some cases they are permanently at schools and in other cases they are at schools for definite periods.