Republic of Bulgaria
ECONOMIC
AND SOCIAL COUNCIL

OPINION

of

THE ECONOMIC AND SOCIAL COUNCIL

on

THE HEALTHCARE REFORM

(own-initiative opinion)

ESC/2/018/2010 – Commission for Social Policy

Commission for Budget, Finance, Insurance and Social Security

The 2010 action plan of the Economic and Social Council envisions the elaboration of an own-initiative opinion on the topic of: "**The Healthcare Reform**."

With his Letter № 023- РД-06/08.02.2010, pursuant to Art. 15, Paragraph 1, Item 9 of the Regulations of the Economic and Social Council the President of the Economic and Social Council, Professor Lalko Dulevski assigned the elaboration of the opinion to the Social Policy Commission together with the Budget, Finance, Insurance and Social Security Commission.

Pursuant to the decision of both Commissions, issued at their joint meeting, held on 26.02.2010, Dr. Evgeni Dushkov, Member Group II of the Council – Organizations Representing Workers and Employees, was appointed rapporteur on this opinion.

The following independent experts in the area of healthcare management and health insurance were consulted for the purposes of the project: Dr. Rumyana Todorova – former Director of the National Health Insurance Fund (NHIF) and Dr. Dimitar Iliev – former Deputy Director of the NHIF.

At their joint meeting, held on 31 May 2010, the Commission for Social Policy together with the Commission for Budget, Finance, Insurance and Social Security discussed and approved the draft of this opinion.

At their Plenary Session, held on 29 June 2010, the Economic and Social Council approved this opinion.

INTRODUCTION

The issues of health insurance and healthcare in Bulgaria have so far been the subject of three[1] specialized opinions and one Resolution[2] elaborated by ESC, whereas the issue of healthcare reform has been discussed as part of a number of other opinions and resolutions issued throughout ESC's six-year history

The aim of this opinion is to provoke a serious public debate in Bulgaria and evaluate the present state, problems, and directions for reforming the existing model of healthcare from the perspective of civil society. The biggest challenge is that now – in the context of a global economic and financial crisis and its effect on Bulgarian economy – more than ever it becomes clear that structural reforms are urgently needed.

What are our recommendations?

1. The budget of NHIF should be separated from the Consolidated State Budget. The practice to pay contributions owed by the state directly into the Fiscal Reserve Account should be discontinued.

2. The solidarity principle of the health insurance system should be preserved and the state should be a solidary contributor alongside other insurers. The state should be treated equally to other insurers with respect to the owed amounts, as well as when determining the size, scope and procedures for the payment of health insurance contributions.

3. Contributions paid by the state for the persons insured by it should correspond to the actual value of the services and should be at least equal to those paid by other insurers.

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[1] Cf. „Current Issues of Health Insurance" – 07.04.2004 (http://www.esc.bg/download.php?group=3&id=9); „Project for a National Health Strategy 2007-2012 prepared by the Ministry of Health (analyses, evaluations, recommendations)" – 25.07.2006 (http://www.esc.bg/download.php?group=3&id=24); „Health Act Amendment Bill (№ 754-01-50, submitted by a group of Member of the National Assembly)- prepared at the proposal of the Chairman of the 40th National Assembly" – 06.07.2007 г. (http://www.esc.bg/download.php?group=3&id=50) and

[2] „Resolution on the updated Project for a "National Health Strategy 2008 – 2013" – 18.07.2008. (http://www.esc.bg/download.php?group=3&id=58).

4. Persons simultaneously receiving income under employment contracts and from other sources should pay health insurance contributions on the total sum (with a provision that this should be the case when such sum exceeds a predetermined threshold!)

5. New additional minimum insurance thresholds should be introduced for some categories of self-employed persons, e.g. doctors, attorneys, notaries, etc.

6. The principles of management of NHIF should be reconsidered. The management should correspond to the public nature of the institution. A tripartite form of management corresponding to the actual contribution of the parties financing the system should be established.

7. The rate of health insurance contributions should not be increased without effectuating any real reform in the healthcare system.

8. Health insurance contributions should be paid out of the budgets of each respective public institution instead of being included in the common transfer made by the Ministry of Finance every three months. Health insurance contributions for every ministry or public institution should be paid on a monthly basis and the respective statutory deadlines should be duly met.

9. In case of delay or default ministries and public institutions should be liable to the same fines and sanctions as all other employers.

10. A set of legislative, economic, socio-psychological, information measures should be developed concerning the persons who choose not to pay health insurance contributions.

11. There should be a broad public debate concerning the problems and perspectives for development of the healthcare system with the participation of all stakeholders. The public should receive answers to the following questions:

- How are the funds, including NHIF's reserve fund, utilized?
- What is the actual cost of quality healthcare services during the period of reforming the system?
- What is the actual cost of maintaining the system after the reform is complete?
- How is public funding used for the benefit of the insured, the people providing healthcare, the infrastructure: for buying new equipment to the medical establishments, for the introduction of modern technologies and treatment methods?

- What are the priorities in the area of healthcare? What is the Ministry of Health's agenda for combating cardiovascular diseases, cancer diseases as well as the growing traumatism and its consequences?

- What are the main principles of Bulgaria's drug policy? What should be done to alleviate public discontent over the exorbitant prices of drugs and the low reimbursement rates that NHIF can afford to provide?

- What should be done to overcome the ever increasing inequality in the access to medical care caused by the restrictive mechanisms of NHIF necessitated by the limited financial framework?

- How does the Ministry of Health plan to deal with the increasing overconsumption of medical care – a challenge to all European nations?

- What are the main priorities concerning the people with disabilities and those in disadvantaged position?

12. Role and place of the voluntary health insurance funds – what legislative changes are needed to grant them access to the medical services market?

13. Consensus should be reached and decisions should be taken on important issues such as:

- Does the proposed model for health insurance reform have an alternative or it should be transformed radically?

- How could the financial stability of the health insurance system during the following decade be guaranteed?

- What are the economic, political, and socio-psychological risks implicated in the impending reform?

14. Information and transparency should be guaranteed to the public regarding the state and behaviour of the health insurance system. There should be a system of uninterrupted monitoring the regularity of incoming health insurance contributions and transfers, the amount and structure of expenditure. When problems related to the financing and functioning of the healthcare system arise they should be communicated to the public.

15. Privatization of healthcare should be treated as a part of the whole pack of solutions and initiatives proposed by the healthcare reform. This pack should include legislative provisions ensuring greater freedom and autonomy of hospitals and other medical establishments with respect to financing and attracting investment, they should be

allowed to manage their own resources, negotiate their terms directly with NHIF and the voluntary funds, as well as participate in the determination of the prices for the services they offer.

16. The state should formulate more strictly its criteria for the opening of medical establishments and for entering into a contract with NHIF. A National Health Map should be created based on the mean European consumption of medical care by regions. This map will function as a framework for determining the extent of public financing earmarked for healthcare.

17. Real competition among the providers of healthcare and dental care should be created.

18. A national programme and strategy concerning the human resources engaged in healthcare should be created. Serious attention should be paid to specialists that are already in high demand as well as to the shortage of nurses.

19. Patients' rights should be clearly regulated and brought in line with European standards and their day to day social needs. The purpose should be to guarantee the safety of patients and to improve the quality of the service by means of monitoring and supervision.

20. There should be a broad discussion at all levels concerning the problems of continuous treatment and rehabilitation, drawing especially the attention of politicians to that issue. An in-depth analysis of the incidence rate of diseases demanding such treatment should be made, as well as financial calculations to determine the price of these services and the just remuneration of the personnel of such facilities. Close attention should be paid to evaluating the performers of medical and social services as well as the facilities themselves, and especially to the professional training of practitioners who will provide services not particularly popular in Bulgaria.

21. The tasks and criteria laid down by the Europe 2020 strategy should be adapted to the Bulgarian realities in order to undertake long-term measures for the fulfilment its goals.

1. MACROECONOMIC FORECASTS

1.1. The economic forecasts for 2010 expect Bulgarian economy to shrink. The insecure economic situation should make economic agent reconsider their plans for investment. This process will be additionally reinforced by the more difficult access to loan financing

due to the worldwide low liquidity and recalculation of risk on part of the financial institutions.

1.2. Unemployment will rise and the growth of wages will be close to that of labour output. The global financial crisis had a negative impact on the financial account flows that Bulgarian economy managed to attract. The decrease in internal demand and internal investment activity in 2009 and 2010 had a negative impact on the labour market during these tow years. Total employment drops. The level of unemployment is expected to go up in 2010. Reduced economic activity in the medium-term period gives rise to the expectation of a significant slow-down in the increase rate of real wages.

2. IMPACT OF THE POLITICAL CYCLE ON THE PERFORMANCE OF THE NATIONAL REFORM PROGRAMME

2.1. The last regular parliamentary elections in Bulgaria were held in mid-2009. As a result a new parliamentary majority was constituted. The new government took office in the end of July announcing its determination to effect radical reforms in the public sector directed mainly to curbing corruption at all levels of the state structure and improving the efficiency of state administration. Other important priorities of this government include the restraining the grey economy, ameliorating the business environment, and removing all obstacles to the efficient utilization of European Union (EU) funds.

2.2. Updating the National Reform Programme the government focused its policy on the fulfilment of key measures and programmes, in areas covered by specific opinions issued by ESC, aiming at increasing the efficiency of state administration and overcoming the negative consequences of the crisis in Bulgaria.

2.3. An important condition for successful reforms is the achievement of better coordination and more agreement within the Council of Ministers. The election of the Minister of Finance for Deputy Prime Minister responsible for several government policies (including the administrative reform, healthcare, education, management of European funds) should be a step in this direction.

2.4. Having taken office in the eye of a global economic crisis, the government states that one of its major political priorities is to overcome the consequences of the global economic downturn and put Bulgaria back on the trajectory of sustainable economic growth. The main instruments to achieve this effect are the fiscal policy and structural reforms.

2.5. With respect to the reform in Bulgarian healthcare system, the most urgent concerns and goals are: measures for guaranteeing long-term sustainability of public finances; preservation of short-term and long-term macroeconomic stability; combating corruption; more efficient management of cash flows; speedy improvement of administrative

capacity and fiscal policy aiming at controlled minimal budget deficit for 2010 in the context of weak economic activity.

3. MAJOR PROBLEMS OF THE HEALTHCARE SYSTEM AND HEALTH INSURANCE

3.1. As a result of the healthcare reform which started years ago but has stopped for the time being, the scope of services, activities and drugs that are paid by NHIF has been expanded. The conditions of work of the general practitioner doctors (GPs) in unfavourable areas have improved. The hospital infrastructure has been ameliorated and the investment in high-tech medical equipment has been increased. There has been a restructuring of state aid. Unlike inpatient care, outpatient care has developed as a field dominated by healthy competition. There have been an increase number of private health insurance establishments but the funds accumulated by them are still insufficient to cover the costs. A new type of health map is being developed.

3.2. In the countries of Central and Eastern Europe, the main goal of governments when engaging in healthcare reforms is to improve the health-state of the population so that the significant differences with respect to mortality and the incidence rate of disease between them and the countries of Western Europe could be ultimately overcome. In order to achieve this, governments turned to optimizing the system for providing medical care and mobilizing additional resources of society and the private sector. Following the example of other EU countries as well as that of countries from the western hemisphere (North and South America), they chose to move away from centralized pre-planned healthcare systems where the budget is formed on the basis of strictly determined (fixed) parameters. Instead, there is a move towards a market competition system in which medical professional are rewarded for the products they actually provide as well as, whenever possible, for the evaluated results of their services.

3.3. Historically, healthcare in the countries of Central and Eastern Europe has been financed by means of a budget estimated on the basis of the resources invested during the previous period. Therefore, there is a strong tendency to focus on input (i.e. the invested resources). The control on output (i.e. invested resources plus results) should be the main starting point for forming opinions about the necessary financial resources in the healthcare system. Regulation is a valuable idea only when: i) it can be confidently expected that it will achieve its goals, and ii) this can be done without risking serious economic and financial deformations in the structure or quality of the provided services. To achieve it goals, regulation should be flexible and take into consideration many

differences (technological, geographic, demographic) which often exist in a democratic society within the restrictions imposed by national legislation.

3.4. Of paramount importance is that effective regulation is concentrated on the control and the evaluation of results – not solely on stipulating the invested amounts. Effective regulation remains an important concern while reforming the economies in transition. Payment systems have direct as well as indirect stimuli. Defining the results and determining payment tariffs for recompensing the achievement of these results often gives rise to conflicting stimuli.

3.5. Bulgaria, for instance, chose to define the results of a hospital in terms of numbers of cured patients or “cases.” The payment per “case” is based on a pre-determined treatment cost estimated using the best practice for treatment of such a case in Bulgaria as described in the respective clinical pathway. A positive result of using clinical pathways is that they make possible the standardization of medical practice up to the highest possible level for the time being, which is negotiated with experts in different fields, including family medicine, for primary care, prophylactics, and coordination of specialized care. Moreover, the introduction of the clinical pathway system allows the choice of establishment that can offer best quality treatment as defined by the clinical pathways. In case of patients with serious and complicated conditions, treating them at hospitals where they can receive the best possible care increases the probability that their health will improve. This leads to satisfaction for the patient, the doctor and the institution paying for the treatment.

3.6. Clinical pathways and negotiations with hospitals

3.6.1. The National Framework Contract (NFC) of May 2001 stipulated 30 clinical pathways connected with the respective Diagnosis-Related Groups (DRG). For years the National Centre of Health Informatization (NCHI) has been collecting data for all Bulgarian hospitals about the number of treated patients according to type and existing equipment, as well as the capacity of hospital staff. This data can be used to find in what conditions and at which hospital the most effective treatment has been achieved. This finding can be used as the basis of a rational process of negotiation between the Regional Health Insurance Funds (RHIF) and individual hospitals. Nevertheless, the use of clinical pathways may also have negative effects on the development of a hospital. For instance while negotiating with RHIF the hospital may be tempted:

1. to exaggerate the capacity of its staff regarding diplomas, certificates and licenses;

2. to try to acquire new equipment, which would bring it in line with the requirements of certain clinical pathways, even if the expenses are not economically sustainable;

3. to be discouraged when “license” for a specific treatment, that the hospital based on previous results feels qualified to offer, is denied – which in turn may lead to problems for the negotiation process or PR; or

4. to disallow innovation with respect to quality and/or economy of funds – as this is not required by the clinical pathways.

In order to reduce to the minimum these potential conflicts the Ministry of Health (MH) and NHIF must give priority to the creation of a detailed plan for capital investment in the hospital sector as well as maintain perfect communication between NHIF management and hospitals. Rewards for achieved goals and standards may be used to stimulate advancement. If the information about these rewards is published, it may have positive effect on the behaviour of other hospitals.

3.6.2. In the context of market competition the emphasis is on choice. The consumer should be free to choose which doctor to consult and in case hospitalization is necessary – which hospital to go to. Ultimately, patients’ choice together with appropriately formulated statutory guarantees will determine where and by whom treatment should be provided. If however choice is used as a criterion for subsidizing medical care, *consumers should be trained to evaluate the quality of the services they receive*. Thus, the informed consumers will become the main guarantors for the quality of medical care.

3.7. One or many payers (institutions paying for healthcare services)

The choice of institution which pays for healthcare services is connected with the higher expenditure, especially at the early stages of the reform, when the whole infrastructure for marketing, subscription, negotiation, systematization of processing the invoices, and the training of personnel is being developed. Subject to its effective management the system using one payer – one fund – may be more efficient as compared to a system using many payers for healthcare services. The one-payer system may benefit from economies of scale with respect to everyday expenses for administration, investment in reserve funds, insurance against risks – due to the sheer size of the organization. These economies mean that more funds will remain for the actual payment of the services. Decentralization, like in Poland for instance, may have unforeseeable negative effects. Similarly, the lack of communication between the institutions paying for healthcare services, due to the existence of many national funds, may impede the process of cost reduction, thus threatening the stability of the whole system. Serious problems were observed in relation to the registration of the insured in different funds and the income deduction data submitted by employers to the National Health and Social Security Institution. To avoid such problems, systems for accurate data collection and data sharing are necessary which requires time and experience. The resulting competition, however, also has considerable advantages. When competing with other health

insurance funds, the managers of each fund will be stimulated to offer better service to consumers. They will also be stimulated to use innovations and optimize administrative expenses, so that the market share of the fund is maintained. At the same time, effective self-administration and strong consumer representation may reduce the tendency of a single payer (fund) to abuse its monopoly position or become overloaded with unnecessary bureaucracy and administrative expenses.

3.8. Subsidizing beneficiaries with low income

Another advantage of the consolidation of resources is that states selected for comparison have developed systems subsidizing the treatment of beneficiaries with low income. The system based on the combination of general tax payments and contributions provides the opportunity for the pooled funds to be allocated on the basis of everyone's need for healthcare. The contributions of the retired, unemployed, and persons on social benefits are paid by the Ministry of Finance, the unemployment funds, and municipalities (using funds coming from the national budget).

4. Financial stability

4.1. To guarantee financial stability, the budget for healthcare is "closed." This is necessary in order to avoid the explosive increase of expenses which would occur if and "open" budget model is used – as, for instance, in the Czech Republic where the method "fee for service" was used during the period 1994-1998 both for outpatient and inpatient care. The budget ceiling may be determined by centralized budgeting as it is in Bulgaria. In 1999 Hungary imposed a ceiling on the budget for the only component that was so far unlimited – the expenses for drugs – due to arising deficits which emerged in spite of the use of drug lists. Having in mind the quick increase of some drug prices offered by all main producers, it is hardly surprising that from the point of view of forecasting and limiting expenses the expenditure on drugs is one of the most difficult components of NHIF's budget, as well as the fast rate of emergence of hospital healthcare establishments – the only unregulated sector of national healthcare.

4.2. The amendments to the Bulgarian Health Insurance Act (HIA) restricted the possibility of making new contracts with new medical establishments during the current financial year, which to a certain extent stabilized the parameters in the expenditure part of NHIF's budget. At the same time, after launching the national health map, the state should regulate the emergence of new medical establishments (predominantly in the private sector) depending on the necessities of the respective region – taking into consideration types of diseases, demographic particularities, endemicity of the region, etc. This should be done to ensure the rational and equal utilization of the public resource of NHIF applied for by all newly emerged private hospital structures.

4.3. In 2010 one of the main problems concerning the financial stability of the system is the NHIF Budget Act. Since 2009 the statutorily determined rate of health insurance is 8%, pursuant to the NHIF Budget Act, in 2009 6% were used in practice, while in 2010 this percentage will be 5. These funds come mainly from the contributions of employees, who are the most faithful payers in the system unlike the state, which has the obligation to insure 4.1 million citizens – not based on 8% of their income but on 4%. In other word for 2010 the total sum owed by the state to the national system for health insurance is BGN 941,129,000. In reality, the transferred sum will be BGN 111,347,000 while the remainder will be deposited in the Bulgarian National Bank in order to keep the balance of the Consolidated State Budget. In this way, through the Ministry of Finance, the Bulgarian state abdicates from its obligation under Art. 52 of the Bulgarian Constitution to provide medical care to its citizens and its general obligation to finance the healthcare system. Over the last few years, the state retains considerable amounts that should be transferred to NHIF's budget and redirects them to the Fiscal Reserve Fund instead of investing them in healthcare. In the end of 2010 the total reserve of NHIF within the Fiscal Reserve Fund is estimated to be BGN 1,690,067,000 including BGN 829,799,000 for 2009 and 860,268,000 for 2010. NHIF had to unnecessarily stop payments for December 2009 for actually performed services although there was an operative reserve fund held for such purposes. Instead of making the payments to the medical establishments, as of 31.12.2009 NHIF reports reserves of BGN 860,000,000. The day-to-day financing of the health insurance system is actually achieved from the contributions of the actual employees. Funds transferred from the State Budget to insure the retired, unemployed, children, military conscripts, etc. are exclusively directed to the creation of a current reserve for NHIF and to the accumulation of the planned budget surplus. At the end of the year the surplus is transferred to the fiscal reserve and is not used for the purposes of healthcare. Thus, the state is not an equal insurer with respect to the size of the health insurance contributions and its participation in the health insurance system. The size of the health insurance contributions it is supposed to pay for the citizens it insures in reality cannot cover their consumption of healthcare. For 2010 the average size of the contribution for such citizen is BGN 19 as compared to BGN 38 for the actual employees. This is why the latter contribute 57% of NHIF's budget although they account for only 33.4% of all insured persons.

4.4. At the same time the owner of each medical establishment has the obligation to provide for its maintenance (electricity and water supply, replacement of obsolete assets, repairs) – expenses accounting for 30 % of the total costs. HIA provides that by means of the clinical pathways NHIF finances only the medical care, i.e. no maintenance expenses are included in the payment made by NHIF. The financial reports of medical establishments providing hospital care show that the owner (the state or the municipality) with a few exceptions does not provide means for the maintenance of the medical establishment, i.e. the average percentage of coverage for the country is 2%.

4.5. The main conclusion that can be made with respect to this situation is that although the statutory health insurance contribution is 8% of the income of every citizen, the healthcare system actually receives less than 5% - a great portion of the resources being accumulated in the fiscal reserve of the state. When drafting the NHIF Budget Act for 2010 the generated automatically an enormous financial deficit – instead of taking into consideration the reserve of BGN 860 million accumulated by the end of 2009 and deciding that the budget for 2010 should be more balanced and all funds, both contributions and transfers from the State Budget, should be directed to the healthcare system.

4.6. Serious attention should also be paid to the fact that each year over one 1 million people choose not to contribute to the health insurance system and this generates additional deficit. As a result, the quality of the healthcare available to conscientious contributors suffers, which in turn discourages them from making regular payments. For two years now the healthcare system has not been able to feel the effect of the 8% insurance rate. Against this background, we constantly hear speculations whether there should be “co-payments” on part of the patients or whether the health insurance rate should be further increased. The measures for reducing the number of uninsured persons evident in the amendments to HIA made in 2010 are mainly coercive and administrative and therefore unlikely to achieve the desired effect. No action is undertaken to make insurance more desirable to people who choose to avoid it. Moreover, no methods are proposed to provide for a more sensitive account of the classes of people who are financially incapable of contributing to the healthcare system but have not officially fallen under the categories of unemployed or poor.

The opinion of ESC is that since the effect of the 8% health insurance rate is unclear, since the state has still not managed to collect contributions from over 1 million people, and since NHIF has an enormous reserve deposited with the Bulgarian National Bank at the very low interest rate of 2.6%, to discuss the increasing of the insurance rate is immoral, illegal and financially illogical.

4.7. One of the major problems connected with the financial stability of the healthcare system is the management method of NHIF. Pursuant to the latest changes in HIA, NHIF is managed by a Supervisory Board with nine members: five of which are appointed by the Council of Ministers (one of which is the Chairman of the Board), two are representatives of employer organizations, and just one is representative of the insured appointed by the two most popular labour unions. The result is an evident domination of the state in the management of NHIF and the public resources it administers – at the same time it is obvious that the main part of the actual contributions is made by the employees and the employers, approximately BGN 2.5 billion, while the state only contributes BGN 111 million. It is evident that those who pay the most and the most

regularly, the insured, are practically excluded from the management of the funds. Conversely, the state which contributes the least not only has the privilege to manage the public resource, but blocks a significant portion of the money in the fiscal reserve so that it is never used for the purposes of healthcare. The dialogue necessary for the consolidation of society and reforming the healthcare system never took place. There is no unifying concept of how to combine the efforts of the state, employers and the public to foster a new attitude to healthcare and the health insurance system with its major principles: solidarity, equality, achievement of good health status that will motivate the people, guarantee high productivity of their labour, and a new quality of life.

4.8. The existing practice in the states of the European Union is different. There the funds collected by the health insurance funds are managed according to a tripartite principle, in many cases even according to a bipartite principle, i.e. by the insured and the employers. In Europe patient organizations do not participate in the management of funds, but in the control.

The opinion of ESC is that if during the course of the reform the method of management of NHIF is not changed substantially and it does not become a public institution managed according to a tripartite principle – by those who actually contribute the funds, its financial stability will always be threatened due to fact that the state can always choose to use the financial resource of NHIF for purposes other than healthcare.

5. The role of the municipalities

5.1. The countries from Central and Eastern Europe rely on the municipalities for supplementary funding of many medical establishments. A common aspect of their various healthcare reforms is transferring ownership of these establishments from the state to the municipality. A specially appointed division of local government is responsible to control such establishments and receive regular reports from the director and managing board. Thus, although these non-financial public establishments are regulated by the Ministry of Health, ownership and control of them is completely left to local authorities.

5.2. In reality municipalities depend on the country's government for funding which can be used for healthcare of other purposes. In Bulgaria municipality support for hospitals varies greatly from region to region. In many places there is virtually no such support. Although the law stipulates that in their capacity of owners of municipality medical establishments municipalities should participate in funding healthcare on the local level, this obligation is not performed, or is performed insufficiently. The percentage of expenses that should be borne by the owner but are not remitted to the hospital (about 30% of the establishment's expenses) automatically generates deficit.

5.3. Usually, the funding allocated per treated patient by the insurance fund, as is the case in Bulgaria and Poland, does not include amortization costs, i.e. the yearly depreciation of investments made in the building and equipment. Now that the countries of Central and Eastern Europe have developed capital markets and the municipalities have independent sources of income, it should be easier for them to take responsibility for financing long-term improvements in the healthcare establishments owned by them. Nevertheless, amortization costs should be included in the total cost of the services.

6. Funding medical care / Negotiation and agreement

6.1. Health insurance funds in Bulgaria, Hungary, Poland and UK Health Services pay for healthcare services on the basis of prospective contractual agreements with the performers of medical care (PMC). Insurance funds in the Czech Republic and the Netherlands negotiate individually with performers for whose services there are definite cost limits regulated at the national level. Payment for physicians providing primary care and specialized care, as well as payment for the hospitals is covered by these contracts.

6.2. A comparison of the methods of funding healthcare and negotiating conditions shows that a common point in all countries is experimenting with new methods of funding, in particular the introduction of case payments and general contracts including elements of case-mix. As pointed out above, in July 2001 Bulgaria introduced a case payment scheme encompassing 30 “priority” medical conditions which led to the formulation of the clinical pathways. At the moment the clinical pathways are 298. The Czech Republic and the Netherlands distribute funds on the basis of DRG. Hospital budgets in these countries still show historical costs and the number of patients per covered area.

In Bulgaria every year NHIF enters into contracts with the performers of medical and dental care. There is a tendency to make long-term contracts in most European states. This reflects their desire to avoid the high expenses incurred in the negotiation and agreement process. Lately, practice shows that a significant increase in quality and efficiency is necessary to cover the expenses incurred every year in the negotiation process. To reduce such expenses some health insurance funds started making two-year contracts with PMCs.

6.3. A major problem in the negotiation process over time has been the issue of control on performed medical care and its cost. It was discovered that it was not efficient to negotiate the mechanisms of control and sanctions with the ones subject to such control and sanctions – the performers of medical care represented by the Bulgarian Medical Association. Many states are increasingly concerned about measuring the results of medical care and developing mechanisms to guarantee its quality. The UK has expressed the desire to make the quality of medical services an essential element of the

contracts. In Bulgaria, quality indicators should also be a major concern and should become an essential part of the National Framework Contract.

The opinion of ESC is that such mechanisms of control should be regulated by means of a special Act of the National Assembly, prepared in accordance with European and international practice, which should leave no opportunity for diverting money from the system.

6.4. Pursuant to the latest contractual models, the case flow follows the patient's choice. This is why the availability of information is of crucial importance for giving patients the opportunity to make a rational choice of PMCs. In states introducing healthcare reform, and this applies to Bulgaria too, there is resistance on part of providers of medical services to the collection and dissemination of information, as well as tendencies to manipulate existing information.

6.5. In Bulgaria, the so called Integrated Information System of NHIF is still incomplete. The missing link is the connection with the patient. What is needed is the speedy introduction of the Electronic Health Card, which should be in line with all recent developments and requirements, and can guarantee the connection between patients, doctors, and the insurance establishment. While using it, patients will always be informed about their health status, all medical services performed in the course of their treatment, all prescribed medication, and will be able to control themselves the system. This will lead to the more efficient use of public funds and will reduce to minimum fictitious activities and abuse of funds on part of the performers of medical services. A web-based solution would eliminate quickly all problems related to health files, citizens' insurance status, control, and access to information.

6.6. No patient rights are stipulated in the HIA, so citizens' rights are inferred from the NFC depending on the current budget of NHIF. Thus, patients are not guaranteed in any way the access to and quality of medical care. According to the provisions of HIA the whole population of the country has the status of insured persons. Yet, health insurance contributions are actually paid by merely 2.5-2.7 million people. The contributions of the remaining part of the population should be paid from the national budget by means of money transfers to NHIF. This is not done regularly and the amounts do not correspond to what is provided by legislation. A considerable part of the Bulgarian population is compelled to pay health insurance contributions but is not guaranteed appropriate medical care. Many economic, social and moral principles have been infringed in this way. In order to obtain access to quality healthcare services Bulgarian citizens are making a number of payments:

1. they pay taxes part of which should be used to finance the healthcare system;

2. they pay health insurance contributions;

3. they pay service fees when they go to see the doctor;

4. they make co-payments for many healthcare services, treatments, drugs, and consumables;

5. they make considerable in amount and scope informal payments;

6. they pay obligatory “donations” or “sponsorships” to the medical establishments.

The existing model of health insurance is clearly devoid of logic. Citizens’ obligations are regulated by the law, yet their rights are formulated in NFC contingent to the accumulated funds. NFC pre-emptively guarantees the interests of doctors, dentists and pharmacologists, before considering the interest and rights of the insured persons. There is a clear paradox – performers of medical care are the main agents and their interest is the main factor in the use of the instrument NFC regardless of the provisions of HIA.

7. Ownership and management of hospitals

7.1. In order to meet the specific requirements of the institutions paying for healthcare services (control on expenditure, efficient use of resources and higher quality), hospitals must be more flexible in terms of organization, human resources, and financial aspects of their services. Contracts based on real work performance aim to stimulate a new generation of independent hospital managers to improve the quality and efficiency of hospital and provide ever better care to their patients and those who pay for their services. The countries of Central and Eastern Europe show progress in this area. Hospitals there are public-private property and their owners include: the national government, regions and municipalities as well as private commercial companies and non-profit organizations. Regardless of ownership, however, a hospital’s contract with the health insurance fund should guarantee medical care to the insured.

7.2. In Bulgaria, the Medical Establishments Act of 1999 defines most medical establishments as independent enterprises which in the future will be responsible for their own financial standing. When the hospital registers as an independent entity it should assume responsibility for its finances. In the countries of Central and Eastern Europe many hospitals, however, have accumulated large debts to their suppliers. This in conjunction with the accumulated deferral of investments in buildings and equipment, as well as the poor maintenance, makes them unattractive for private investors and turns them into fiscal calamities, which, in turn, are neglected by the municipalities, who have now become their owners. Only the National Health Map could provide information about

the actual need for medical services and could direct public funds towards these services. The rest is market economy and competition.

8. Fairness of the tariffs to the insured and the performers of medical care

8.1. When allocating healthcare resources it is necessary to take into consideration the differences in expected healthcare consumption of individual patients or groups of patients in order to achieve equality in both the access to healthcare and the payment to the providers of such care. If prices are used for the allocation of resources, it is important that these prices reflect as accurately as possible the actual costs of the provided services. Otherwise, the capitation rate, payments per hospital case or the price of a given service may be too high or too low as compared to the actual costs. If the price is too low, there is a greater chance of inadequate or poor quality of services. If the price is too high, this means that the institutions paying for health insurance are wasting the resources entrusted to them by employers, employees and other text payers.

9. Payment and risk compensation

9.1. Generally, payment methods fall into two broad categories: prospective and retrospective. The models used for risk compensation also fall into these two categories. When the tariff for a clearly defined service package is determined before the treatment takes place – the payment method is prospective. Prospective payment methods, such as capitation and payment per hospital case, increase the efficiency stimulus because performers are facing greater financial risk. Retrospective payment (or reimbursement of incurred expenses) is applied when the respective tariff is adopted while or after the service has been performed. The tendency observed in relation to retrospective payments is towards the increase of costs not towards their reduction. Prospective as well as retrospective risk compensation may be based on a selection or a combination of the following indicators, which to a certain extent also show the rate of use of the services: age, sex, geographic location (together these indicators are called “demographic” variables). The most easily accessible data is the demographic information and the consumption of services for a past period according to diagnoses. Demographic data usually contain: age, sex, and sometimes geographic distribution of the population. This means that, for instance, regions lacking ageing people will receive a greater deal of the available resources for continuous treatment and rehabilitation; people living in isolated parts of the country will also receive a greater portion of the funding so that better communication may be organized to facilitate their access to quality medical care, as well as to stimulate medics to work in places that offer less comfort. Similarly, people with high consumption for a past period are more likely to require more medium-level services in the future. In every combination of these

circumstances a higher payment per capita should be made in order to recompense the provider of medical care for the expected extra services.

9.2. Tariffs for hospital payments may also be corrected so they would reflect more accurately all risks. The most widespread method for hospital payments using risk compensation is based on DRG. By adjusting the payment in such a way as to reflect patients' expected consumption of resources, estimated by analyzing a large number of patients with similar diagnoses and other characteristics (e.g. accompanying diseases, complications, sex, age, or disease advancement stage, etc.), each hospital will be more or less fairly recompensed for treating their patients. Besides fairness, another advantage of grouping patients according to estimated use of resources is that it provides a system for classification with manageable number of tariffs for payment. If diagnoses alone are used for the classification of patients, the number of tariffs grows quickly, while differences in the expenses owing to other patient characteristics are not registered. The importance of risk compensation and the difficulty in estimating accurately actual costs go hand in hand. The initiatives undertaken by the states reviewed in this study are presented and discussed below.

10. Development of human resources

10.1. In a quickly globalizing world the development of knowledge, infrastructure, technology and, above all, human resources that have an adequate combination of skills and competences, requires long-term planning and investment in accordance with the changing demands of the field of healthcare and the organization of the servicing process. An important task is also to stimulate research and use efficiently and ethically innovations in terms of medical technology and drugs. The evaluation of healthcare methods should be based on factual data and rely on providing sufficient information for the decision-making process.

10.2. Investment in the professional resource in the area of healthcare is also of paramount importance because it affects not only the investing party but other parties as well. Solutions of issues connected with the mobility of healthcare specialists should be based on the principles of ethics and international solidarity and should be codified in a common European Code for Conduct and Principles.

10.3. Against the background of the serious staff crisis in area of healthcare, the issue of migration has been approached with a fair amount of urgency in all documents of the WHO following 2004 (special attention has been drawn in the Tallinn Charter of 2008, the Green Book, etc.). A poll held in Bulgaria in the end of 2006 and the beginning of 2007, based on international experience, shows a considerable migration potential among Bulgarian medical doctors and graduating medics, especially among the younger, which does not depend on whether they have a specialty or where they come

from. There seems to be a real threat that Bulgarian healthcare system may become a “donor” of doctors for the healthcare systems of older members of the EU. This kind of migration has negative quantitative and qualitative effect in Bulgaria and makes the preservation of domestic human resources a matter of national interest.

10.4. Amendments in legislation connected with postgraduate studies continued in 2008: Ordinance № 15 of 2 July 2008 for the acquisition of specialty “General Medicine” by general practitioners was adopted and Ordinance № 34/2006 for acquisition of specialty in the system of healthcare was amended. The analysis of student admission in 2007/2008 and 2008/2009 academic years shows that annual university intake for medicine, dental medicine, and pharmacology remained constant: 405 for medicine, 170 for dental medicine, and 140 for pharmacology. The intake of students for state-regulated professions is determined each year by the Council of Ministers acting on a Recommendation by the Ministry of Education. For the period 2005-2008 the recommendations of the Ministry of Health have not been fully taken into consideration. In academic year 2007/2008 the total intake of nurses and nurse-midwives is 645, while the number of the enrolled is 505 (352 nurses and 153 nurse-midwives). 1/5 of the places remain unoccupied – 140 (21.71%). Despite the newly adopted Ordinance for specialization the acquisition of specialization continues to be a problem. The total intake of interns in 2007 (the selection procedure was held in 2008) is 3430, of which 823 for clinical ordinature, 760 for specializations under the provisions of Ordinance №34 of 2006, 1600 places for paid studies and 247 places for foreigners. Of the approved 3430 places were taken only about half – 1950 (56.85%). The planned state funds for financing this intake amount to BGN 10 million. The total number of places approved in 2008 for the specialty “General Medicine” is 2220. Of these were taken again about half – 1253 (56.44%). The planned state funds for financing this intake are BGN 2,592,000.

10.5. The problems of human resources in the context of the healthcare system are not well defined. Not enough attention is paid to the considerable emigration of qualified specialists, who find in other EU countries better career opportunities and better payment, and to the fact that this may lead to shortage of such professionals in Bulgaria. Controlling this tendency has not so far been pointed out as an important challenge, nor has the idea of developing the system of postgraduate studies and education ever been considered urgent enough. The insufficiency of standards has been put forward, but no one has proposed a transparent mechanism for their creation and continuous education to ensure their implementation – so that there can be equal access to standardized care and services. The problems of human resources in healthcare are mainly related to: regional disproportions, giving rise to unequal access to medical care; insufficiency of nurses and unfavourable proportion between doctors and nurses which causes organizational problems; reduction tendencies in the number of certain specialists; relatively high mean age of the doctors-specialists; unoccupied medical positions,

especially in remote parts of the country; financial and organizational difficulties in obtaining specialty and postgraduate training as well as relatively high percentage of unoccupied places for specialization; inadequately low payment.

10.6. Bulgaria has scored a positive result in just 4 out of 38 indicators observed by Consumers Health. They are: availability of register of licensed medical doctors; a high number of registered GP practices which use computer to store patient information; online access for patients to their individual data concerning the insurer's expenses for their treatment; possibility to access the Personal Physician during the whole day when the patient is in need of examination. The negative results include: (a) patient rights protection – there is no law providing for the protection of the patients; decisions are taken without the participation of patient organizations, there is no mechanism for the compensation of patients without involving the court; the funds allocated for treatment elsewhere in the EU are insufficient, there is no classification of medical establishments according to the quality of their service; (b) restriction of the direct access to a doctor-specialist; informal payments for treatment; poor mechanisms of transferring information between specialists; (c) access to medication – low % or reimbursement of prescribed drugs, limited use of innovative oncological drugs; financially difficult access to new drugs. (d) a number of health indicators: high child mortality, high mortality of malignant diseases, etc. Based on the findings of the research, it is recommended that Bulgarian healthcare should start working as a normal service oriented industry in which doctors and nurses earn adequate salaries in the hospital (and not for supplementary services) and patients may pay all costs related to their treatment "over the counter." This reform is possible without increasing the amounts that Bulgarians actually pay for healthcare at the moment.

10.7. It is claimed that healthcare-related expenses in Bulgaria are 4.3% of the GDP while in the EU they are 8.8% and therefore they must be increased. This is, however, not true – in Bulgaria the state really pays about 4-5% of the GDP for healthcare, but there is also a private sector, there is a market for medication, predominantly financed by the patients, there are informal payments, etc. If all these expenses are taken into consideration, the percentage for Bulgaria may reach even 10% - more than in the EU.

11. Healthcare reform

11.1. Despite assurances promising improvement, restructuring, etc. continuously heard over the last few years, it remains still unclear what reasonable reform will be made with respect to the healthcare system. Instead of outlining the guidelines and the legislative steps for restructuring the sector, it has been declared that it will be improved by increasing the collectability of contributions. Nothing is mentioned about the privatization of hospitals.

11.2. The choice and political confirmation of the healthcare and health insurance model that is appropriate for Bulgaria has been delayed for a very long time. This is prerequisite for increasing problems and public tension. Even with a greater financial resource it is doubtful that the healthcare system will function better unless important structural reforms are made quickly. It is the failure to address serious problems concerning health insurance and the related legislation that is the main reason for the considerable underfunding of the system. Financial issues must be solved simultaneously with reforming it. Funding is the final stage of a whole chain of interconnected processes. If the entrance of the system is not well regulated, this surely will affect the funding. The lack of a National Health Map, which could show the number of hospital bed according to type and the availability of different specialists by region, results in their uneven distribution across the country and the concentration of similar activities in the same place.

11.3. Creation and licensing of medical establishments is extremely facile and there are almost no criteria for this. Licenses are issued only on the basis of documents. The owner has the freedom to decide what services should be provided by the establishment. This leads to the emergence of hospitals, mainly private, offering just services that guarantee quick profit.

11.4. There is no consideration of how persons working abroad will be protected in case of the occurrence of a health insurance event – it is known that fees and prices abroad are very different from those at home. In this respect the healthcare strategy of 2000 was far more insightful although it preceded in time the Lisbon strategy.

12. Overview of the fulfilment of the National Strategy for Health and Long-Term Care

12.1. The Strategy correctly outlines the medical problems and their relative significance for the incidence and prevalence of diseases. Insufficient attention is paid, perhaps due to insufficient observations, to the lack of knowledge about the social aspects of disease in elderly people and people in disadvantaged position, as well as to the lack of programmes for social adaptation of people that have suffered difficult diseases, survived their spouse, received treatment at mental institutions, etc.

12.2. Gerontology and geriatrics are medical disciplines that are not taught, in practice only 1-2 people per year are directed to work with old people.

12.3. A system of policies and actions able to attract the attention of society should be developed. Its aim should be to achieve a mechanism of public monitoring which will stimulate municipal and central administration to locate people in need of care, regardless of their domicile, and offer them “packages of standardized services.”

12.4. Medical help in acute cases and diseases is part of the system for social protection and social inclusion but it is not the main part of it. There is little concern about the development of social-medical services with the participation of physiotherapists, kinesitherapists, psychologists and psychiatrists, who can help for the re-integration and integration of people in disadvantaged position.

12.5. One of the worst situations is probably the issue of drugs, consumables and aids. They are generally treated as subject to market regulation and everyone is expected to manage the problem alone. The aids provided by the state have the design and quality of something made in the 19th century. There is a great number of NGOs that are dedicated to helping people but they function without the support of the state and, more importantly, without a system of control or standardization developed by the government. There is little transparency in the price formation concerning drugs and aids as well as the choice of type and quality requirements. The problem of access to medical and long-term care in remote places remains unsolved despite the fact that it has been raised and debated for a long time.

12.6. A developed country, which wants to expend effectively the funds it accumulates and to achieve optimal effect in the social sphere, first, takes care to standardize services and activities, then, organizes their production and supply. No such priority policies were described in this section. There are no plans for training and specializing in caring for old people. No action is taken to make this specialization attractive to young people.

12.7. The Executive Agency “Medical Audit” was created to audit and monitor the efficiency of medical care. Due to the lack of legislation prescribing universal quality criteria and standards for medical and long-term care, this agency would be inadequate to contemporary practices in the healthcare and social systems. The Ministry of Healthcare is working hard on this issue but the final word will be that of the government.

12.8. Expenses for healthcare are growing every year. One of the major problems is informal payments which often make specialized medical care inaccessible to certain groups of people – those with very low or without income. It is believed that informal payments amount to 70% of public expenditure on healthcare. The money forwarded to medical establishments by NHIF are often insufficient and often in the end of the month there are not enough referrals for specialized consultations and analyses. This is an interesting topic to consider. A question frequently asked by inspectors is why there are medical establishments where shortages of referrals and money are never discussed, and others where this is a chronic issue which constantly creates tension among the insured. Is this shortage due to unnecessary or unjustified consultations and analyses? Why in 2008 a significant part of the appointed analyses we not performed? What made the patients choose not to go to the laboratories? Did the patients themselves decide

that the analyses were unnecessary? The established algorithms for hospital treatment have a restrictive character and often patients “are treated” with the best paying clinical pathways. This leads to over-expenditure and ineffective use of funds. At the same time the reliability of statistical information, used for the planning of further budget policies, is seriously undermined.

12.9. **Concerning the intentions to create a three-pillar health insurance system with two obligatory – main and supplementary – and a voluntary pillar, this may be a real “contribution” to the history of health insurance in Europe.** This is an attempt to transfer mechanically the principles of the three-pillar pension system to the area of health insurance, which could put the latter in serious danger. The use of financial resources in the health insurance system begins with the acquisition of insurance rights. The lack of bold measures for restructuring hospital care, for closing down of inefficient hospitals, for transforming them into modern socialization homes for old or terminally ill people, leads to the ineffective spending of resources, imitation of activity so that budgets can be preserved, and overall demoralization of the people witnessing all this. At the same time there are ideas that there should be competition between NHIF and voluntary health insurance funds, as well as among the establishments providing medical care and services. We think that this will only lead to overcoming the difficulties and speed up the modernization of care. If there was a normal market for medical services, this might be a good measure, but for the time being in Bulgaria there is no such thing. Creating real competition between funds at the moment in the context of a serious economic crisis involves a fair amount of risk both for the insured and for the funds themselves.

12.10. Long-term medical care is provided everywhere in Bulgaria. Its organization is mainly the responsibility of the municipalities. Funding is of a mixed type: central funding is provided by the state on the basis of criteria approved by the Ministry of Labour and Social Policy; local funding which covers mainly social home patronage and a public catering service. The issue of long-term care in Bulgaria is not only unregulated by the law, but there is hardly any comprehensive concept about it. Taking into consideration the fact that Bulgaria’s population is ageing fast, there is a huge number of chronic diseases and also of disabled and terminally ill people, the issue of long-term care becomes very important and urgent. An extensive analysis of the situation is needed which would reconsider the logic of the healthcare system with a view to providing both specialists and financial resources. The private sector has already invested in homes for old people which work without any support on part of the state. The services offered there include “full board” and “daily care” services. The care provided by such centres is mainly financed by the families of the guests. Fees paid by the state are minimal. The average price of a month’s stay exceeds 4-5 times the amount of the average Bulgarian retirement pension. There is no comprehensive standardization and monitoring of the

care and services provided at such centres. In total, there are over 100 private homes which shows that the structures and funding of the state in this area are definitely insufficient. At the same time, most state institutions are decrepit in terms of facilities and equipment, they do not correspond to contemporary standards for quality of life, often are situated in isolated far off places, where hiring qualified personnel and providing maintenance is almost impossible. Over the last few years there have been demands to close down such homes and move their inhabitants to new more suitable buildings. It is obvious that not everybody in need of long-term care has access to it. Over the last years, many forms of organization were proposed – daily care, personal assistant, home assistant, etc. These forms have been successful and the administration has declared its intention to turn them into mass practice and organize them on a national scale. The coordination of long-term care with physiotherapy, rehabilitation and other social services exists mainly in institutional establishments. Very rarely such services are provided at the recipient's home. Generally, the quality of long-term care reflects the financial state of the respective municipality. Naturally, there are homes for disabled and old people situated in less well-off municipalities which are funded from the national budget. The major problem with them remains staffing as it is virtually impossible to find qualified workers on the spot. Bulgarian legislation in this area should be fundamentally rebuilt. It is not sufficient to transform financially inefficient hospitals into long-term care and rehabilitation facilities. It is necessary to define clearly these concepts and to provide for the education of qualified personnel. Long-term care is a virtually unfamiliar concept in Bulgarian healthcare and the risk of misinterpreting it is substantial.

12.11. The main problem in the proposed strategy is that it does not envision the creation of a system for the education of specialized staff, motivation for the work with people in disadvantaged position, improvement of the system for defining those in need, and a system for developing clear criteria and monitoring for long-term care. No action is taken to invite feedback in order to study the effect of the implemented measures and plan better future actions. Occasionally, NGOs participate in different discussions of these problems. In this respect the role of NGOs is very important.

12.12. Evidently, the system needs more finances, but also an effective mechanism for allocation and control. The strategy contains not estimations concerning the funds that will be planned during the period, so it is not possible to comment on whether the proposed actions are financially guaranteed. What can be inferred from the statistical data is that the poverty rate in elderly people grows steadily in time. This means that more and more people will become totally dependent on state benefits. This tendency should be taken into consideration alongside the general idea of population ageing and new approaches to soling it should be studied.

12.13. An admirable pursuit is to bring the care for people in disadvantaged position outside institutions. The good leading examples of providing care at home and in the neighbourhood should be developed into standard practice. A considerable social resource is still lost because many of the people in need of long-term care depend on one or more members of their family in order to obtain it. Many people care for their relatives at home and rely on minimal support from the state. NGOs participate actively in this process trying to provide physiotherapy and mental rehabilitation as well as other services.

12.14. The “personal assistant” initiative is helpful in two important respects – it increases employment and provides care for those in need. The major problem is related to the education of personal assistants: so far none of them has received any professional training or developed any professional skills. There is no programme for the training of personal assistants, nor are there clear definitions of terms such as “sick person assistant,” “personal assistant,” “long-term care,” “terminal care,” etc. There is no data about the gender structure of personal assistants.

12.15. **In conclusion:** there are many good sides to the National Strategy. It contains an accurate description of the present state of the system of health and social care. Implemented good practices that have given clearly positive results have been outlined. Good policies that may significantly improve the situation and lead to easier access to better health and social care have been proposed. Available statistical information has been used to show important tendencies over the past 10 years. Promising solutions have been suggested with respect to many of the identified problems.

12.16. The major weakness of the strategy is that it focuses on administrative measures and the engagements of state institutions. The issues raised in this strategy concern major functions of contemporary civil society. It would have been considerably more productive if the proposed policies are directed towards mobilization of social resources, engagement of society as a whole as well as in its voluntary organizational forms, decentralized approached using the support of local authorities, transferring more rights, obligations and resources to where the problem are – to the community, to the associations of people affected of suffering from the problems. It is possible to consider and develop policies stimulating public discussions and transparent working out of consensuses – which will be supported by the public when implemented and thus achieve greater effect. Little attention is paid to personal and private initiative – its potential use has been underestimated.

12.17. Health insurance should be based entirely on its two fundamental principles – solidarity and equality – which should be subjected to a long-term vision for the development of the healthcare system, existing social benefit elements should be discarded. Equal participation of the contributors in the management of NHIF should be

guaranteed by the law: the current domination of the state in this should be discontinued. NHIF should be an independent institution protecting the public interest, i.e. the interest of the insured, as intended in the health insurance system. The principle of people's responsibility for their health, which is formulated in HIA, should be developed into a system of rules that would stimulate people to care for their own health. The emphases of NHIF's budget should be outpatient care, prophylactics, and the promotion of health. It is necessary to re-establish the link between outpatient and inpatient care by defining the role of general practitioners in this relationship. The role of GPs has not been sufficiently regulated so far in Bulgaria. In order for them to be able to undertake successfully a significant deal of the services pertaining to outpatient care, higher qualification as well as opportunities for postgraduate education are needed – another issue that has so far not been adequately addressed by the Ministry of Healthcare. A streamlined policy is needed with respect to long-term care and treatment, as well as with respect to terminally ill patients which demands close cooperation between the Ministry of Healthcare and the Ministry of Labour and Social Policy. The relevant practice in EU states that have already developed traditions in this area may be studied. In conjunction with ageing, which is also a challenge for healthcare systems in the EU, these problems will become more and more urgent.

13. CONCLUSIONS

13.1. Although Bulgaria is facing the same problems as the other Central and East European countries it is being compared with, **it has to look for solutions with less than a third of their resources at its disposal**. Among the achievements of the reform ranks **the beginning of a difficult change in the state of mind and behaviour of the patients and the performers of medical care**. Considering the scope of the problems and what has already been done to address them, public discontent can be used as a success indicator for the ongoing reform. Incessant explanation and repetition of the goals and achievements of the reform – **the education of both patients and PMC** to keep the course towards a modern healthcare system – is crucial for maintaining the necessary stimulus. Despite the 10-year history of the health insurance model in Bulgaria, **there is still considerable misunderstanding of the logic of health insurance** mainly on part of the patients.

13.2. Bulgaria has achieved a lot in developing and applying the payment system based on case-mix. When combined with efficient quality guarantees, this system is highly appreciated by economists and well received by doctors. The complex nature of the negotiation process can lead to increase of the time and expenses as more and more hospitals and more and more cases are brought to the table. The practice of countries with higher income shows that such administrative expenses may become a burden. With the accumulation of more experience it will become difficult to defend these

expenses every year. **Bulgaria should get prepared to gradually turn to two-year or three-year contracts**, containing clauses that anticipate budget fluctuations and unforeseeable changes in demand and supply of goods and services over the following years.

13.3. **Hospital managers are much more efficient in modernizing their establishments when given the opportunity to manage their income and when clinicists are not subject to conflicting stimuli.** In this respect it is important that Bulgaria follows the example of the Czech Republic and give to the management a high level of responsibility. Like their Czech counterparts Bulgarian hospitals are managed by Boards of Directors including representative of the national and the local government. The inability of the state and hospital administration to curb effectively informal payment (payment under the counter) to hospital doctors is one of the major factors for the limited efficiency of the official system of payment for hospital care. Thus, the director of the hospital who is answerable to an independent Board and applies the National Framework Contract becomes the most important success factor in the hospital reform in Bulgaria. Lately this principle has been considerably disregarded in many medical establishments. Informal payments became a fact after the amendments in the Ordinance guaranteeing the right of access to medical care of 2006, which provided for the "choice of preferred medical team" and legalized the payment for expensive consumables on part of the patients – yet stipulated no legal definition of the involved terms.

13.4. The current approach adopted by NHIF for capitalization payments with risk compensation is comparable with that used by the countries of Central and Eastern Europe. The bottom-to-top budgeting process applied by NHIF allows regional differences in the allocation of NHIF funds. This process will become more complex if Bulgaria introduces competing insurance funds. It is important that the capacity to effect even more complex analyses is maintained and developed – in preparation for the increasing role of private voluntary insurance, for example. It remains debatable whether, in the context of economic crisis and chronic shortage of funds, as well as the lack of reform of the healthcare system, private funds can be sufficiently competitive on the market and in what form they may participate in the distribution of the health insurance resource.

13.5. **There is limited experience and insufficient research of the effect of payment methods** adopted by different countries from Central and Eastern Europe. Conducting such research will become a priority when those countries acquire experience and allocate funds for the evaluation and improvement of the payment systems used by them. Hungary and the Czech Republic which have a longer history of healthcare reforms (reforms in Hungary started in 1986) already began to implement a number of

modifications and even more fundamental changes in the payment methods. Bulgaria has the advantage of choosing only these elements of the reform that have historically proven useful over the period of 10 and more years. Healthcare systems often use a combination of payment methods. This allows the advantage of one method to compensate for the disadvantages of another. In Bulgaria GPs are paid on the basis of a combination of a service fee and capitation. The first of these methods aims at stimulating the access and quality, the second – greater efficiency. Until 2007 hospital care was funded from two sources – the Ministry of Healthcare and NHIF. Analyses showed that differing methodologies led to not entirely adequate payment, so it became crucial to move on to single-source funding. This method guarantees better control of funds. On the one hand, payment on the basis of work performance stimulates access medical establishments providing better care, but on the other, it leads to a tendency of attracting more patients with not so serious diseases who do not require substantial expenses. In time, there was an "adjustment" of the system to the requirements so that these cases could be presented as more serious and therefore more costly – which put in risk the funding system.

13.6. **Competition among providers of medical care aims to improve the functioning of payment methods**. Competing for clients stimulates medical establishments to maintain quality standards and care about their patients' satisfaction. **A well devised legislative framework should provide for a method of keeping patients informed about the quality of services as well as other financial and managerial aspects that could inform their choice.** In Bulgaria GPs and specialists should compete for patients. Since NHIF funded hospital patients are given more freedom to choose, hospital directors and their staff will also understand that their financial success depends on the satisfaction of their patients.

13.7. Although Bulgaria offers some of the lowest prices of drugs in Europe, the patients' personal expenses for drugs are among the highest in Europe – 56% of the total expenses fro drugs. In comparison, the average rate of personal expenses for drugs in the EU is 17.9%, while 82.1% are borne by public funds.

All countries of the European division of the World Health Organization (WHO) are facing major challenges in the context of demographic changes, increasing socio-economic inequality, limited resources, the development of technology and the growing expectations of people.

13.8. The improvement of public health stimulates public welfare. Well-functioning healthcare systems contribute to economic growth and the increase of wealth. Today, it is not acceptable for someone to be impoverished because of failing health. Healthcare systems are not limited to providing medical care: their services also include prevention

of disease, promotion of health, and pressure on other sectors to address the protection of human health in their own policies. With respect to this the state should:

i) cooperate for the achievement of the common values of solidarity, fairness and broad public participation in healthcare policies, in planning and allocating resources with special attention to the needs of less affluent social strata, as well as in the practical implementation of such plans;

ii) invest in healthcare systems and in other sectors guided by factual data that confirms the relationship between economic growth and healthcare;

iii) encourage transparency and accountability for the functioning of the healthcare system to achieve measurable results;

iv) provide that healthcare systems are more responsive to the needs of people, their preferences and expectations, including those that are not expressed openly, while at the same time recognizing their rights and obligations concerning their own health;

v) involve stakeholders in the process of formulating and implementation of policies;

vi) encourage the international exchange of experience in the field of planning and performance of reforms in the healthcare system at the national and sub-national level.

13.9. Healthcare systems are different but nevertheless they share some common functions which can serve to identify the following goals and activities:

i) Providing healthcare services at the individual and the public level.

ii) Persons determining state policies should strive to provide better services to everyone (especially to more vulnerable social groups) which correspond to their needs and enables them to choose a healthier way of life.

iii) Patients should demand easy access to high-quality medical care and should be confident that medical specialists are aware of the latest developments in medicine and use the most suitable equipment to guarantee efficient treatment and patient safety.

iv) Patients should also demand that their interactions with medical personnel should be based on mutual respect, dignity, and confidentiality.

13.10. Great importance for the achievement of these goals has the **effective primary medical care**, which provides a platform of interaction between healthcare services and local communities and families, as well as opportunities for inter-sector and interdisciplinary cooperation, and the promotion of health. In order to achieve better

results, healthcare systems should try to integrate into their existing structures and services programmes for combating specific diseases.

13.11. Healthcare systems should develop an integrated approach to their agency, including coordination between different providers of services, medical care institutions and establishments, regardless whether they are in the public or in the private sector, i.e. primary care services, acute and chronic disease establishments, care at home and other types of beneficiaries.

13.12. Under current legislation in Bulgaria, the NHIF funds raised to finance the system are managed by the state. This management is not in the best interest of the insured citizens because substantial financial resources are diverted to the national fiscal reserve and remain in the Bulgarian National Bank at very low interest rate. The European and international practice is different. Public resources levied through health insurance contributions are managed using a bipartite or tripartite principle, i.e. the funds are managed by the contributors. Subject to the decision of the Management the funds are deposited and invested so as to earn profit for the insurance fund. Unfortunately, the situation in Bulgaria is reverse. A great deal of the funds earn profit not for NHIF but for the state and through the Ministry of Finance perform other functions in the state budget. Thus, Bulgarian citizens are forced to accept from the healthcare system a product of much lesser quality than what they have paid for.

13.13. A tendency of steady and sustainable increase has been observed in healthcare expenditure over the last ten years. For the period: 1998-2008 total expenditure for healthcare have expanded threefold: from BGN 923.5 million in 1999 to BGN 2,672,000,000 in 2008. The main factor for this increase of the financial resource of the system is the compulsory payment of health insurance contributions by employers, employees and the state, for the persons insured by it. Their amount in the budget of NHIF for the period 2002-2008 has increased approximately three times. This increase has been achieved while there has been an almost insignificant increase in the rate of funds dedicated to healthcare in the state budget. The state funds dedicated to healthcare for the period are between 3.7% and 4.3 of the GDP. Average expenses for healthcare per person for the last 10 years have increased at least threefold: from BGN 55 to BGN 155 for 2008. The rate of increase of healthcare expenses for the period surpasses the rate of increase of wages.

13.14. Although significant financial resources have been invested in the healthcare system, the expected improvements in the quality and quality of medical care have not been achieved. The efficiency of the healthcare system is low – at higher costs healthcare indicators are constantly becoming worse and worse. The healthcare system has become increasingly bureaucratic. The inequality between different social groups,

with respect to their access to medical care, has deepened due to strong disproportions in the quality of performance and the possibilities of medical establishments.

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