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Analytical Support
on the Socio-Economic Impact
of Social Protection Reforms

Annual National Report 2012

Pensions, Health Care and Long-term Care

Bulgaria

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GVG

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1 Executive Summary

In 2011 the Bulgarian society continued its efforts on accelerating the next phase of the pension reform with the aim to stabilise the pension system. The action plan adopted in 2010 was amended to a great extent, in particular the time of its implementation. Since the beginning of 2012, the retirement age and the required insurance period have started to increase gradually. The substantial acceleration compared to the initial parameters of the plan was a result of the increasing deficit in the system as well as of the categorical position of the EU Council.

Today, the biggest problem of the Bulgarian insurance model is the inability of the state social insurance (I pillar) to ensure sufficient resources for the insured retirees. The ageing of the population and the worsening of the ratio between workers and pensioners represent a serious test for the financial sustainability of the pay-as-you-go part of the pension system. The financial crisis led to a reduction of economic activity and low incomes for a considerable part of the population.

The major reason for the increasing dependency of the pension system on the state budget is the previous reduction of the social insurance contribution rate. The liberal theoretical presumption that a reduction of insurance contributions will improve the economy, creating new jobs, increasing incomes and leading to a revenue able to compensate the reduction, has not been confirmed and failed in practice. The contribution collection rates did not increase, the competitiveness was not improved, neither it led to the creation of jobs – just the opposite, in January 2012 the level of unemployment increased to 11.1%.

During 2011, changes and additions were made in nine of twelve main laws influencing the national health system. The continuously changing legal frame is one of the main reasons causing difficulties in managing the health care system in Bulgaria. In 2011, the Ministry of Health developed and added five new strategic documents which were adopted by the Council of Ministers: 1) a new funding model for inpatient care – oriented towards the introduction of the DRG's; 2) the National Health Map; 3) the Concept for better health; 4) the Concept of hospital restructuring and its amendment and 5) the Concept of children de-institutionalisation from homes of medical and social care.

Unfortunately, there are no initiatives of the government considering the impact of socio-economic status on health inequalities in the Bulgarian population. The relation between poverty and health has not been considered, nor are there studies or political debates on this issue.

At the end of 2011, the Ministry of Labour and Social Policy issued the first document regarding the issue of active ageing of the population. A national programme for discussion has been published, later withdrawn and revised and in late February 2012 published again for public comment.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2011 until February 2012)

2.1 Overarching developments

The latest economic and financial developments both worldwide and within the Euro zone have resulted in a revision of the macroeconomic projections for Bulgaria towards a more pessimistic scenario. The Government revised the state budget for 2012 with a deficit amounting to 1.3% of GDP.

The crisis is felt mainly through an increased unemployment rate, reduced working hours and lower salaries. Poverty and income disparities increased particularly in the cities and among the minorities. There are indications that households cut their expenditures mainly in the fields of food and utilities, investment in health (prevention) and education. Households the most affected were those among the poorest income quintile and households of minorities.

The unemployment increased up to 11.2% in February 2012. Both the industry and services sector are cutting jobs. According to the Government the stable tax and social security policies during the past several years have contributed greatly to the mitigation of the negative impact of the global financial and economic crisis on the Bulgarian economy.

One of the important documents which will have a long-term influence on the development of the social protection in Bulgaria is the revised in 2011 National Strategy for demographic development of population 2012-2030. The Strategy has been developed by the Ministry of Labor and Social Policy on the basis of an analysis of major demographic parameters in the beginning of the 21st century.

Given the long-term perspective of the demographic processes, a considerable reversal of the ageing trend in Bulgaria by 2030 cannot be expected. A further decrease and the ageing of the population have been already programmed, having in mind the current age structure and the number of women at fertile age.

A realistic strategic objective of the demographic policy until 2030 would be to slow down the decrease of population through a targeted influence on the processes of natural movement (birth rates, mortality rates and migration), along with the achievement of a balance of the population. The Strategy for demographic development prioritises the following issues:

I. Slowing down the negative demographic process and population decline;

II. Overcoming the negative consequences of population ageing and improving the quality characteristics of human capital;

III. Achieving social cohesion and creating equal opportunities for valuable social and productive life for all social groups;

IV. Restricting disproportions in the territorial distribution of population and the depopulation of some regions and villages;

V. Adapting and synchronising the legislation with public needs for a balanced demographic development of the population and the development of the quality of human capital.

The main conclusion, also supported by the authors of the Strategy, is that the full implementation of the demographic priorities until 2030 will only be possible under the conditions of macroeconomic stability, sustainable economic growth and raised economic

activity, employment and incomes of the population. Today, in the beginning of 2012, with a few exceptions, these conditions are not met.

2.2 Pensions

2.2.1 The system's characteristics and reforms

In 1999, Bulgaria started a large-scale pension reform. While preserving the model of insurance by defined contributions, the parameters of the existing system were amended and two additional pillars of pension insurance were established, i.e. a transition from one-pension system to three-pensions system was performed:

1) Mandatory state pension insurance, functioning on the basis of the pay-as-you-go principle (1st pillar);

2) Mandatory supplementary pension insurance with universal pension funds for those born after 31 December 1959 and with occupational pension funds for persons working in the first and second category of work[1], functioning on the basis of the funded principle (2nd pillar);

3) Supplementary voluntary pension insurance, functioning on the basis of the funded principle (3rd pillar).

The pension reform introduced a **new formula for calculating pensions** which directly linked the rate of pensions to the insurance contribution, expressed by duration of length of service and income for the whole working life, not only the income for chosen 3 best years as up to 2000. The **insurance basis** on which the insurance contributions are calculated was also enlarged including the income under employment as well as civil contracts. After 2000 a national maximum threshold and minimum branch thresholds of insurance income, as well as a registration of employment contracts were introduced. The possibility for **early retirement was sharply restricted**. In 2000, by the re-categorisation of labour, the number of those who belong to I and II category of labour and are entitled to early retirement was reduced from 700,000 to 150,000-160,000.

The second pillar *(supplementary mandatory pension insurance*) was launched by two types of funds: occupational funds – for working people belonging to I and II labour category entitled to early retirement, and universal funds - where those born after 1959 accumulate contributions in pension fund selected by the insured.

The pay-as-you-go first pillar and the capital components of the pension model (II and III pillar) are financed by contributions paid by employees and employers.

The main aim of the reform was to improve the overall level of pension protection providing the pensioners with a better standard of living.

The reform also aimed at achieving the following objectives:

- Stabilise the financing of the system in the medium and long run;

[1] According to the ordinance for the categorisation of work for pension calculation all works and activities are divided into three categories, depending on their nature and difficulty and based on the working conditions where they are performed by the insured person. The first category includes those employed in the hardest and most hazardous production and activity conditions. Such are for example: underground and underwater works. The second category of work includes work of those employed in hard and hazardous production and activity conditions. Such are: ferrous and non-ferrous metals production, cement production, chemical industry, transport, etc. The third category of work covers all other works and activities not included in the first and second category. This category involves a normal degree of strain in normal working conditions.

- Achieve a better social fairness of the pension insurance;
- Modernise the architecture of the pension insurance through the transition from a single to a three pillar pension system.

The separation of the state public insurance budget from the state budget, the establishment of specialised funds by social risks and the introduction of tripartite management of the state insurance system are the other aspects of the pension reform

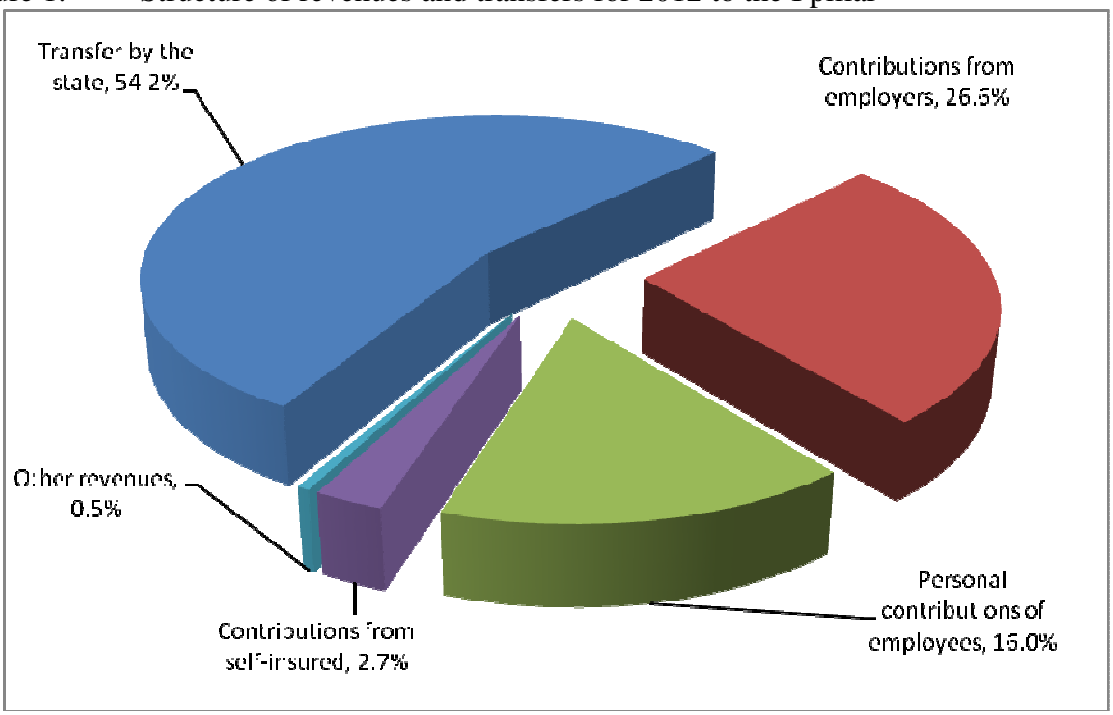
Nearly 11 years after the reform was launched, the analysis reveals that most of the objectives mentioned above have been fully or partially fulfilled.

Regretfully, one of the most important goals – the financial stability of the system in the medium and long run – has not been achieved. This fact itself leads to the risk of compromising the entire reform. Currently, the Bulgarian pension system is financially unstable and strongly dependent on the state budget.

The biggest problem of the Bulgarian insurance model is the inability of the public insurance (I pillar) to ensure sufficient resources for the insured retirees. The current demographic process, the problems caused by the ageing of the population and the aggravating ratio between working people and pensioners represent a serious test for the financial stability of the pay-as-you-go part of the pension system. The financial crisis which led to a reduced economic activity and low income for a considerable part of the population also causes a number of challenges for the pension system.

Presently, the mandatory pay-as-you-go system (I pillar) is strongly dependent on the state budget. Due to the reduction of the insurance contributions by about . 14 percentage points since 2000 (before, pension contributions were 35% for I and II category of labour and 32% for III category) and the continuing economic decline, more than 55% of expenditure for insurance payments in the current year are financed by transfers and subsidies from the state budget. The increase of state participation in the financing of insurance system (mostly through the tax revenue) questions its present and future financial stability. The substantial share of state subsidies in the social insurance funds strongly demotivates workers and their employers to pay contributions, as the link between contributions and pensions is rather weak.

Figure 1: Structure of revenues and transfers for 2012 to the I pillar



Source: National Social Security Institute http://www.noi.bg/

Major structural problems are:

- the trend of long term financial instability of the state public insurance and the high share financed from the state budget (about 60%);
- a decreasing share of insurance contributions in the pension financing from about 97% in 2000 to an estimated 42.6% in 2012 (see figure above).
- twofold increase of the number of disability pensions and threefold raise of the number of social pensions for disability; the number of old age pensions and pensions for long insurance period decreased by 15.5% for the same period.

Following a debate lasting from autumn 2009 until the end of 2010, involving social partners and all stakeholders, and based on financial and actuarial analyses, some decisions with serious implications for the Bulgarian society were taken in order to guarantee the financial sustainability of the pension system and to ensure higher benefits for the pensioners.
The amendments of the Social Insurance Code in 2011 introduced some short-term and long-term measures aiming at financial sustainability and improvement of the pension adequacy.

The following steps were taken in the second stage of the pension reform in 2011:

- As of 2012 the retirement age will start to increase by 4 months in the beginning of every calendar year until reaching the age of 65 for men and 63 for women. Now the retirement age is 63 and 60 respectively.
- As of January the required insurance period will start to increase by 4 months per year. This increase will continue until 2020. By 2020, men will retire after 40 years of employment and women – after 37. Presently the required insurance period was 37 years for men and 34 years for women.
- The retirement age of people with insufficient required insurance period will start to increase by 4 months per year. Now they can retire at the age of 65 if they have

worked at least 15 years. It is envisaged to increase their retirement age to 67 by 2017. The requirement of 15 years of employment remains.

- The criteria for those working under difficult working conditions will be tightened. From 2012 on, the retirement age for the first labour category will start to increase by 4 months per year, reaching by 2014 48 years for women and 53 years for men in I category, and 53 years for women and 58 years for men in II category.
- The policemen and the military will be entitled to pensions after 27 years of employment, not after 25 as it is at present.
- As of 1 January 2011, the requirements for pension entitlements were amended, abolishing the so-called "scoring system", which used to allow more flexibility for pension entitlements by combining age with contributory years.

The amounts and ratios of social insurance contributions in 2012 remain at the same levels as in 2011. The social insurance contributions into the Pension Fund for 2012 are:

- For persons born before 1 January 1960:
- 17.8% for workers in III category of labour;
- 20.8% for workers in I or II category of labour.
- For persons born after 31 December 1959:
- 12.8% for workers in III category of labour;
- 15.8% for workers in I or II category of labour.

The distribution of contributions into the Pension Fund for 2012 is, as follows:

- For persons born before 1 January 1960:
- 7.9% to be paid by the insured;
- 9.9% to the paid by the employer for workers in III category of labour, and 12.9% to the paid by the employer for workers in I or II category of labour.
- For persons born after 31 December 1959:
- 5.7% to be paid by the insured;
- 7.1% to the paid by the employer for workers in III category of labour, and 10.1% to the paid by the employer for workers in I or II category of labour.

2.2.2 Debates and political discourse

In the second half of 2011 and the beginning of 2012 the discussion between the social partners, the government, the parliament and the president concerning the next stages of the pension reform continued.

The employers state that it is necessary to conduct a policy ensuring an equal indexation of all pensions, meaning that when there is an opportunity to raise pensions, all pensions should be raised by the determined percentage. In practice it means that when the state, for example, raises the minimum pension, the same percentage must be used to raise the rest of the pensions irrespective of their rate. Due to financial constraints, it is unrealistic to expect this to happen earlier than in 2013. According to the employers, it is important to introduce a stronger link between the contributions paid and pensions in order to increase incentives to participate in the system.

According to the idea supported by the social partners and the government, starting in 2013, the civil servants are going to pay their insurance contributions to themselves, while having a single raise of the salary.
The representative trade unions proposed to introduce penalties in case of contribution evasion and along with this, to link the penalty interest rate for delays of insurance contributions to the base interest rate plus 10%. The social partners also commented upon the idea to raise state budget funding for early retirement as of 1 January 2013.

The Law on the State Fund guaranteeing the sustainability of the state pension system was adopted about three years ago and the so-called Silver Fund was established. The objectives of the Fund are to achieve and ensure financial stability of the state pension system through accumulation, investment and transfer of additional financial resources to the budget of the Pension Fund. The Fund's major goal is to make sure the state has the necessary resources to support the sustainability of the pension system, especially after year 2025-2030, when the country will experience the biggest demographic "hole". In this connection, a large scale public discussion on how to manage the Silver Fund's resources aroused again in the last weeks.

The Fund's resources, as of 31 December 2011, amount to BGN 1.78 billion (EUR 900 million) including accumulated interest on deposits for 2011 of BGN 10.0 million (EUR 5.11 million). The sources of funding are cash receipts from privatisation and concessions of state property, as well as 25% of the state budget surplus for the relevant budget year.

As provided by the law, the Fund's resources can be invested in seven forms, but only one of those seven has been used so far. Since the launch of the Fund, the accumulated resources have been invested only in deposits of the Bulgarian National Bank. During the three years of the Funds existence, this investment of almost two billion of its resource generated a BGN 43 million (EUR 22 million) deposits revenue. For the same period, the annual inflation (from December to December), measured by the consumer prices index, was above 28%, implying that the financial management of the fund causes a gradual and permanent depreciation of the Fund's money. More and more experts are of the opinion that this practice must be changed. The dilemma is not whether to invest the Fund's resources or not, but how to invest them. Another serious deficit in the Fund's management is the practical lack of planning on how much money has to be accumulated in the Fund, so as to support the foreseen deficits of the pension system. There are virtually no serious analyses regarding the scale of these future deficits.

2.2.3 Impact of EU social policies on the national level

In July 2011 the actions undertaken by the Bulgarian authorities related to the new phase of the pension reform were subject of analyses and comments by the EU Council. One of the important conclusions concerned the weaknesses in the planning of expenditure of budget resources and their control. The extra revenue generated before the crisis was used for additional (unplanned) expenditures and a decrease of the social insurance contribution rate. In order to solve these problems, the authorities took a number of initiatives in order to improve control over the expenditure and introduce a system of monitoring and accounting. Nevertheless, according to the EU Commission, the risks related to the long-term sustainability of public finance are of medium burden.

The assessment of the EU Council is that the pension reform approved in 2010 is not related to life expectancy or health care and long-term care. The reform will be conducted in the period 2011 – 2026, whereas most of the measures will be enforced in the second half of the

period eventually jeopardising the implementation of the reform as well as the sustainability of the first pillar of the pension system.

This alarming signal led to the acceleration of the reform and the implementation of the legislative amendments indicated in 2.1.1.

2.2.4 Impact assessment

Pension expenditures in 2012 amount BGN 7,270.0 million, an increase of 172.6 million compared to the expected expenditures for 2011. The expected average number of pensioners in 2012 is 2,195,220, which is 4.4 thousand less than in 2011, and the expected average number of pensions for 2012 is 2,669,852, which is 8.7 thousand less than in 2011. The relative share of pension expenditures from the GDP for 2012 is 8.9%. The average pension in 2012 is expected to reach BGN 273.32 /2.5 growth/, while the expected average for 2011 is BGN 266.78. The planned net replacement rate is 56% and the gross replacement rate is 44%.

In 2012, the pensions are "frozen" and will not be indexed under the provisions of the Social Security Code. The minimum amount of the old age pension will increase from 1 June 2012 by about 6%.

During the past two years, the members of the Consultation Council on Pension Reform (established by the Minister for Labour and Social Policy) proposed several solutions in order to reduce the financial instability of the public social insurance. One of the important proposals was to introduce a legislation package motivating the employees to voluntarily postpone their retirement.

In the end of January 2012 (nearly two years after the proposal was made), an important amendment to the Labour Code was adopted and became effective, stimulating a longer employment of elderly. In the experts' opinion, this amendment should lead to increased effective retirement age. The Parliament changed one of the most popular, both among employers and employees, manner of terminating the employment – upon the occurrence of the entitlement to old age pension, i.e. retirement. The amendment of Art. 328, paragraph 1, item 10 of the Labour Code revoked the entitlement of employers to pension off their employees. As of 28 January 2012, when an employee meets the criteria of the Social Security Code for retirement, the employer may not terminate at its discrepancy the employment, based on the fact that the employee has become entitled to retirement. This amendment of the Labour Code actually admitted that the right of retirement is a personal right of the employee and only the employee may decide when to exercise such right. This means that if at a certain time the employee decides to retire, it should be the employee who should initiate the termination of the employment, either upon mutual agreement (Art. 325 of the Labour Code) or upon employee's discretion, and upon giving a written notice to the employer (Art. 326 of the LC).

This significant change of both the legislation and the long-standing employer practices does not have an impact on the compensation entitlement of the employee to be paid by the employer. In accordance with Art. 222, paragraph 3 of the LC, upon termination of employment, after the employee has become entitled to an old age pension, regardless of the grounds for termination, the employee shall be entitled to a compensation from the employer amounting to the gross salary of 2 months. If the employee has been working with the same employer for the past 10 years, the employee shall be entitled to a compensation from the employer amounting to the gross salary of 6 months. This right remains intact, even if the employment termination has been initiated by the employee.

The Consultation Council on Pension Reform proposed other incentives for a postponed retirement, e.g. a pro rata increase of the above compensation in accordance with Art. 222, paragraph 3 of the LC (at the expense of the employer and not of the state budget), in cases when the employee makes a choice to continue working. This proposal has not been yet accepted.

Despite the difficult years for the funded pension funds, the data of the Financial Supervision Commission shows that the trust of the insured in the pension funds has been retained. In December 2009, the number of insured in voluntary pension funds was 598,336 persons, in December 2010 - 597,968 persons and in December 2011 - 597,095 persons. The number of members in occupational pension funds was 226,929 persons in December 2009, 234,280 persons in December 2010 and 238,075 persons in December 2011.

According to the Financial Supervision Commission 3,861,468 persons are insured within the four types of pension funds (universal pension funds, occupational pension funds, voluntary pension funds and voluntary pension funds based on occupational schemes) as of 31 March 2011; representing a growth of 2.6% compared to 31 March 2010. By 30 September 2011, the number of insured increased to 3,914,001 persons. The accumulated net assets within the supplementary pension insurance system as of 31 March 2011 amounts to BGN 4.1 billion (EUR 2.1 billion), representing a growth of 24.52% compared to the first quarter of 2010. By 30 September 2011 the average net assets in all capital funds increased to BGN 4.3 billion (EUR 2.2 billion). The arithmetic mean yield of the II and III pillar funds for the period 30 December 2009 – 30 December 2011 ranged from 2.49% to 2.55%.

The actuarial projections for Bulgaria in the ILO survey 2011[2] in general reflect correctly the processes and trends of the Bulgarian pension system. Nevertheless, there is a great probability to fail to achieve these projected figures, due to the multiple delays over several years, now scheduled to take place after 2012, of some of the most important but also least popular measures that would lead to financial stabilisation of the pension system, e.g. equalising the retirement age of women and men.

2.2.5 Critical assessment of reforms, discussions and research carried out

The unsustainable financial situation of the state pension system is caused by inconsistency and some short-sighted managerial decisions concerning revenues and expenditures of the system, including those on raising the pensions by higher rates compared to the wages. The other long term problem is related to the decrease and ageing of the population. According to the NSSI estimations, the population will decrease by more than 1.6 million until 2050. This presupposes a decrease of the number of persons in working age and an increase of the number of elderly. Presently, 100 persons in working age have to support 25 elderly, in 2050 this ratio will be 100 to 56.

The unfavourable demographic development in Bulgaria is characterised by a decline of population, a decline of people in working age and an increase of number of pensioners which will negatively impact the financial balance of the pension system.

According to the expert conclusions of the Consultation Council on pension reform, the following steps are necessary in order to ensure the financial stability of the system:

- Incorporating the objective of financial strengthening of the first pillar of the pension system and improving the adequacy of pensions as a priority of economic and financial policy, employment policy and income policy;

[2] Hirose (2011).

- Restore the role and place of insurance contributions as a major resource of revenue. Terminating the reduction of the contribution rate and determine the rate on the basis of the principles of social insurance and precise actuary calculations. A reduced contribution rate should be well targeted and granted only to employers who have met certain criteria related to the creation of new jobs, payment of wages above the minimum insurance thresholds and employment of some categories of workers (for example older workers, workers having children, etc.);
- Improving the efficiency of monitoring and controlling contribution collection rates;
- Introducing stricter criteria for pension eligibility within the context of ageing of the population and growing life expectancy;
- Raising gradually the retirement age for women to that for men in order to eliminate the discrimination in retirement requirements;
- Restricting early retirement;
- Determining the necessary rate of the contribution for those entitled to early retirement, having in mind the duration of participation in insurance and the period of receiving a pension;
- Terminating the abuse of disability assessment and limiting access to disability pensions. Better administration of medical assessment structures through the introduction of the principle „Who pays the money is responsible for disability assessment";
- Implementation of innovative methods for financing the shortage of resources in the state pension system in the long term, for example by emission of long term bonds, introduction of targeted tax revenue and others;
- Implementation of a flexible mechanism for pension indexation, having in mind the inflation, the GDP dynamics, the insurance income and changes in estimated life expectancy;
- Endorsing the policies for development of a minimum pension linked to the minimum wage in the country, and pensions which are not related to working activity – in compliance with the poverty line.
- Creating opportunities for electronic exchange of documents related to temporary work incapability between the NSSI, health institutions and employers – compensations for temporary work incapability, pregnancy and childbirth;
- Continuing the modernisation of supplementary pension insurance by reviewing the contribution rate for the universal pension funds. The proposed amendments fulfil the strategic aim of ensuring a supplementary pension which guarantees an income replacement within the range of 15-20%;
- Stimulating supplementary voluntary pension insurance through raising the existing tax reliefs from 10% to 15%;
- Development of legal regulations to supplement the risk „old age" by establishing a targeted fund with the NSSI to support long term care policies for the elderlys. The fund could be fed by contributions to be paid in equal parts by the employer and the insured persons. Part of the revenue for that risk could be used to build retirement houses and to support the most needy pensioners;
- Making a critical review of the pension legislation with regard to those regulations which might have negative financial and social impact and are contradictory.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The organisational structure of the Bulgarian health care system is defined by the interaction of public and private players and a mixture of decentralised and centralised structures.

Health care facilities are autonomous. *Outpatient care*[3] is provided by single and group practices, medical and dental centres and independent medical diagnostic centres. Physicians or centres sign contracts with the NHIF on annual basis; any providers that do not sign contracts can provide private services on a fee-for-service basis. *Inpatient care* is provided by general and specialised hospitals, dispensaries[4], nursing homes and hospices, and hospitals providing acute, chronic, long-term care and rehabilitation. Although the health care reforms of the 1990s caused a significant reduction of the number of beds, Bulgaria still has an extensive hospital network throughout the country providing easy access to inpatient care. However, there is also an excessive and unnecessary use of beds.

The main stakeholders in the Bulgarian health system are the Parliament, the Ministry of Health, the NHIF and the Professional Associations (physicians and dentists). A number of other ministries manage and finance their own health care facilities, including the Ministry of Defence, the Ministry of Internal Affairs and the Ministry of Transport. Private practice has expanded significantly, now including dental practices, pharmacies, physician's practices, diagnostic laboratories and outpatient clinics.

A constantly changing legislation

The legal frame of health care can be defined as extensive and complicated. The main laws directly regulating health care are twelve, indirectly related are nine, regulations amount to 200, and the rest – ordinances, instructions, etc. of MH and NHIF are over 300.

During 2011, changes and additions were made in nine of twelve main laws [5] influencing the national health system. Since 1998, health care regulation has been amended many times, with most changes taking place in the last six years (2005 – 2011). The majority of those "repairs" are current i.e., adopted and implemented in one and the same year which raises suspicions for lobbying instead of focusing on strategic decisions.[6]

As a whole, the multiple legal changes, are one of the main reasons causing the experienced difficulties in managing health care in Bulgaria.

In 2011, the Ministry of Health developed and added several new strategic documents which were adopted by the Council of Ministers, namely:

- New funding model for inpatient care – oriented towards the introduction of the DRG's[7];
- National Health Map[8];

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[3] In accordance with the 1999 Health Care Establishments Act

[4] In 2011, after changing the Health Care Establishment Act, these structures were transformed into specialised hospital or medical centres for specialised outpatient care such as Complex Cancer Centres (7 in the country).

[5] The national health system is constantly changing during the last 10 years and the health insurance system itself is a relatively new social system in Bulgaria. The *Annex 1* presents the most important laws influencing directly and indirectly the national health system, as well as the changes made in them throughout the years.

[6] In 2011, 24 new ordinances related to structural changes, were adopted. 93 amendments and supplements to regulations were adopted, related mainly to medical standards, the basic package of medical services paid by NHIF, accreditation of treatment facilities, drug prices, different sanitary requirements for products and cosmetic products and environmental factors, etc. 33 rules and new ordinances, instructions and orders principally related to structures, centres and agencies of MH have been issued and posted.

[7] http://www.mh.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=4226

- Concept for better health[9];
- Concept of hospital restructuring and its amendment[10];
- Concept of children de-institutionalisation from homes of medical and social care[11]

Funding

The total budget for health spending (consolidated state budget) in 2011 is BGN 3 250 896 (4.33% of GDP), while the average spending of the OECD countries was 9.5% (2009). Compared to other European countries, Bulgaria spends the least amount of financial resources for health, being besides one of the poorest countries in Europe.

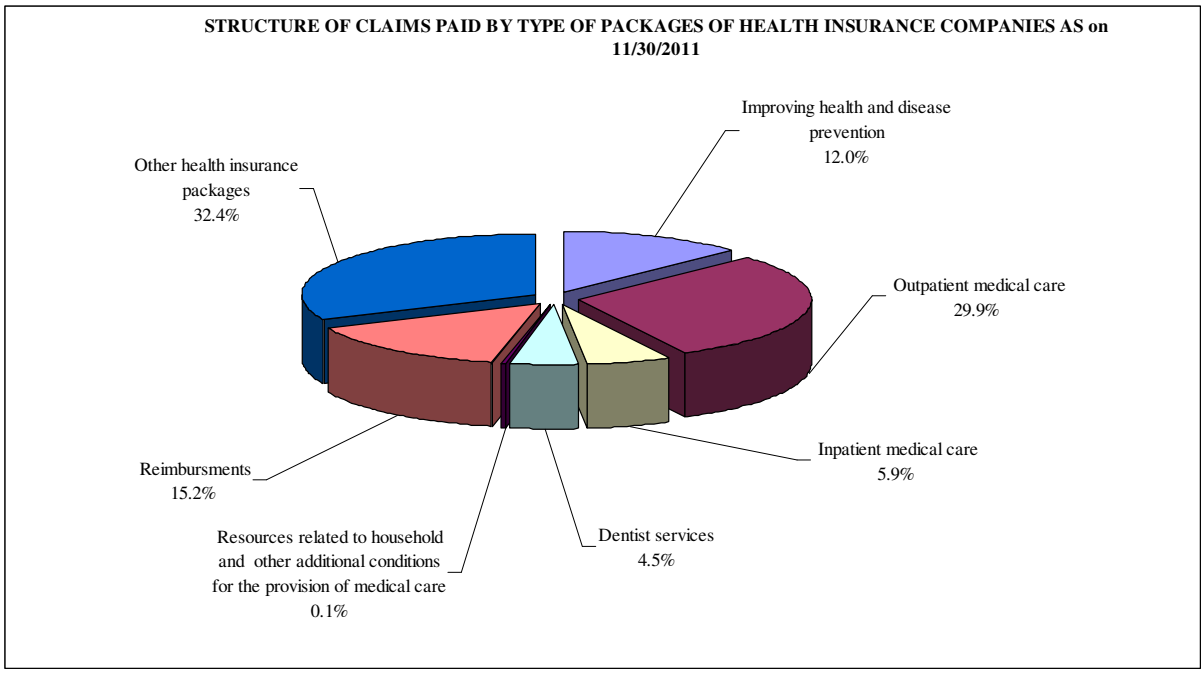
The main source of health care system financing is the compulsory health insurance [12] (70.46% of total costs), state (24.7%) and municipality budgets – for school health services, children's homes and retirement houses (4.11%) (MoF, Salchev, 2012 - see Annex 2).

In the past three years, NHIF has had a positive balance, mainly due to the fact that in 2009 the health insurance contribution was raised from 6 to 8%. These additional contribution was transferred into a special fund in the National Bank. In 2010, BGN 1.4 billion of the additionally collected contributions were taken from this fund by the government to support the fiscal balance and governmental payments causing an outrage in the society. In 2011, BGN 340 of the additionally collected contributions were redirected from the NHIF to the budget of the Ministry of Health. At the end of the year, professional organisations and opposition accused the government of neglecting the commitment of transparency in spending the money for health care.

The sources from voluntary health insurance (VHI) amounted to BGN 36 098 543[13]- 1.1% of the total costs. Claims paid from the VHIF's amounted to 21 305 038[14], and were distributed as follows:

[8] http://www.mh.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=3401
[9] http://www.mh.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=3103
[10] http://www.mh.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=2797
[11] http://www.mh.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=2956
[12] The compulsory health insurance contribution is 8% of a monthly wage, was in 2006 divided according to a 70:30 ratio between the employer and employee and by 2013 is set to reach the ratio 65:35. The compulsory health insurance guarantees a basic benefits package to the insured population, defined by the National Framework Contract.
[13] In the end of December, 2011 - http://www.fsc.bg/public/upload/files/menu/DZO_M11_2011.xls
[14] http://www.fsc.bg/public/upload/files/menu/DZO_M11_2011.xls

Figure 2: Health care expenditures (VHI)



Household expenditure allocated to the system as co-payments, fee for service or out of pocket expenses are presented in the next table.

Table 1: Expenditures of NHIF and personal payments for health care during 2001-2011, (million BGN)

	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**
Expenditures of NHIF	404.1	564.7	755.0	853.2	1069.4	1317.5	1550.9	1745.9	1750.2	2036.3	2290. 6
Personal payments	963.0	975.0	1028.4	1142.9	1298.8	1539.6	1586.9	1803.9	2020.9	1364.1	n/a

Source: Annual reports of NHIF; NSI (2001-2010 (1-9)) Household Budgets (10-15), Salchev

External resources allocated from donor organisations and national and international non-governmental organisations (NGOs) amounted to less than 5%.

Every Bulgarian citizen should be covered by the compulsory health insurance scheme in order to receive a basic benefits package of health services determined and reimbursed by the NHIF. Health care is provided in accordance with the National Framework Contract.

Funds from the Ministry of Health are distributed according to the principle of programme budgeting (*Annex 3*). Presented data (MoF, MoH, 2012) in the Annex illustrates, that austerity programmes have strongly impacted the budget of the Ministry of Health and some programmes have been terminated or financing and implementation responsibilities have been transferred to the NHIF (for example the programme "Dispensaries" – terminated; the programme "Haemodialyses" – transferred to NHIF).

2.3.2 Debates and political discourse

The main goals in the governmental programme (2011) to ensure public health are:

- Policies in the field of promotion, prevention and control of public health, through strict control and prevention of non-communicable and communicable diseases, reduction of the demand of drugs;

- Policies in the field of diagnosis and treatment in order to ensure free access to all types of care and quality assessment of health care services;
- Policy in the field of drugs and medical devices – quality standards, safety and effectiveness.

The main points of political debate and the actions taken were analysed in several publications (D. Ninov [15], E. Sacheva[16], T. Vekov[17], Dimitrov G.[18] etc.). In summary they are:

- The predominance of extreme neo-liberal theories and practices in all areas of social development, including health care, representing the market as a panacea to the unsolved or unsatisfactorily solved problems; The process of decentralisation could be considered as the transfer of state functions to local political and administrative levels. It originated outside the health sector and was motivated by political rationale. Nevertheless, the health sector was affected in many ways, i.e. by changes in the ownership of providers and a gradual shift of revenue collection from central to local levels. However, in Bulgaria, as in some other central and eastern European countries, the resulting institutional restructuring created more problems than it had solved. The main rationale for decentralisation in the health sector is to bring health services closer to local needs and to improve accountability, although it also fragmented the revenue pool and exacerbated geographical inequity.
- An inefficient financing system (especially hospital care), a lack of clear and unambiguous rules regarding the rights and obligations of participants in the design of health care reform [19] and a proper controlling;
- Continued understatement of prevention, and from this perspective - an inefficient allocation between health care, treatment and rehabilitation;
- Low health, social and economic efficiency of rapidly increasing total costs (both public and out-of-pocket), which is overall neglected or significantly underestimated in official analyzes and reports of MoH and NHIF;
- A dominant position and role of corporate interests of manufacturers and suppliers of medicines and medical devices in the health care system - a leading cause of rapidly increasing "needs" and demands for more funds on the one hand, and inadequate health and social efficiency of their allocation on the other;
- A dominant role of medical representatives in the design of health reform, organisation and management of health care - without the necessary systematic and thorough preparation, knowledge and expertise in health economics and an understanding of the complex relationships in the health care system – an immediate cause of the many gaps and weaknesses of the current health legislation, management and operation of the Bulgarian health care system;

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15 Ninov D. http://www. union-econ.com/includes/download.php?id=168

16 Sacheva D, 2011: Health at a Crossroads, http://www.zdrave.net/Portal/WeekTheme/Default.aspx?evntid=fF6z%2fi6tLwg%3d

17 Vekov T. INFORMAL PATIENT PAYMENTS UNDER CONDITION OF A FINANCIAL CRISIS – BULGARIA, 2011. Medical Review, N 3, 2011, *ISSN 1312-2193 УДК 61*

18 http://www.zdrave.net/Portal/WeekGuest/Default.aspx?evntid=cC4yVFx8FE8%3d

19 Since 1999, consumers (patients), providers (outpatient and hospital care health facilities) and agents (third-party payers – public and private health insurance organisations) have become key players in the health system, with relative autonomy in generating and using health resources, bringing the system towards a more market-oriented health system. Increasingly acute in the last year were debates on the role of the NHIF, Ministry of Health in the financing of health services, community participation in financing / as owners / and voluntary health funds in the financing of health services.

- A widespread corruption in health care and monopolistic high prices of medicines and medical devices;
- The lack of regulation and regulatory policies with regard to the purchase of medical devices (implants, rigs, lenses, artificial joints, etc.);
- Unwarranted variations in clinical pathways with no connection between the prices of clinical pathways[20] CPs and other health services, quality, health, social, economic impact and effectiveness;
- Unresolved and annually aggravating problems concerning the medical personnel in the health system - unreasonably large differences in income of doctors with different specialties, leading to growing unrest, emigration and shortage of physicians in certain specialties;
- A governments' decision to pay for the "choice of doctor" or "team", which further impedes financial payments for patients. The Ombudsman of the Republic sent a letter to the Prime Minister stating that this was illegal and should be repealed;
- Indisputable heated events of 2011: scandals and media debates on medical errors and the media "war" between patients and doctors about the quality of health services particularly provoked by several deaths of children and mothers;
- Measures to preserve the solidarity model of the health insurance. The main debate was whether to maintain the solidarity model of health insurance, the role of the NHIF, and resolving issues on voluntary health insurance funds - provision relating to application of The Solvency II Directive 2009/138/EC. So far there is no agreement between politicians and business about the place, role and requirement for voluntary health insurance funds;
- A hot debate in the beginning of the year was again the financial reserve of NHIF. The government transferred again the accumulated money to the general budget, using a part of them (0.3 billion) to increase the subsidy of MoH. The opposition and the Physicians Association reacted sharply, but the decision was justified by the Minister of Finance with the economic crisis and the lack of any reforms in health care. This parliamentary decision (in the Law of State Budget-2011) was forwarded by the opposition to the Constitutional Court for revision ;
- The sharp political debates on outpatient care have focused again on: 1) How to ensure real 24-hour access of the insured to medical care and medical specialists without burdening emergency services[21] ; 2) How to limit the access to narrow specialists - administrative restrictions on access to narrow specialists on the basis of regulatory standards for GPs is a constant reason for dissatisfaction expressed by patients and doctors[22] and 3) Reforms in the dispensary[23] - financing by NHIF.

[20] Accepted method of payment for hospital services (Australian model), similar to the case- mix approach.

[21] 24 hour placement is not possible in practise, since the majority of practices are individual - 94.8% of their total number. Filtering role is also questionable due to an increasing number of emergency hospital admissions.

[22] Despite the growing number of first visits, patient dissatisfaction remains, as well as doubts about the effective use of directions and a lack of patients' interest to control the costs. It is therefore necessary to consider changing the administrative regulation in favour of patients including the aspect of controlling costs.

[23] Special health establishment with specific function for patient with chronic diseases – cancer, dermatology, pulmonology and mental disorders.

2.3.3 Impact of EU social policies on the national level

The authorised structures for the implementation of the NSRF are the Directorate National Health Policy, Directorate Management of Projects and Programmes, Directorate International Affairs and Protocol, Directorate Investment Policy. Currently, the country implemented several EU funded projects (see annex 7).

There is almost no debate on the OMC in the field of health care in Bulgaria. The real impact of the OMC on Bulgarian debates and reforms seems to be even lower in health care than in the area of pensions.

The EU 2020 strategy has not yet impacted on health reform debates. The challenge of improving access to a high-quality health care and long-term care services has been addressed in the objectives of the Bulgarian NRP 2011 (pp. 31-34) aiming to improve society's health state by means of its promotion and adequate prevention measures as well as to increase the accessibility and the quality of health services and also to create safe working conditions. What, however, has not been yet mentioned in the area of health care is the low expenditure on health care, especially public expenditure.

Unfortunately, there are no initiatives of the government considering the impact of socio-economic status on health inequalities in the Bulgarian population. The relation between poverty and health has not been considered, nor are there studies or political debates on this issue.

At the end of 2011 the Ministry of Labour and Social Policy issued the first document regarding the issue of active ageing of the population. A national programme for discussion has been published, later withdrawn and revised and in late February 2012 published again for public comment.

Demographic processes in the year 2011

Bulgaria is facing a serious demographic crisis. The number of the population is declining and this process began already before 1989. According to the census of 2011, the population in Bulgaria amounts to 7 364 570 persons. 3 777 999 persons (51.3%) are women and 3 586 571 persons (48.7%) are men, or 1 000 men accounted for 1 053 women. Within the period between the two censuses 2001 and 2011 Bulgarian population decreased by 564 331 persons and the average annual decline rate is 0.7%. Two thirds of the decline is due to the negative natural increase (more deaths than births) and one third (31.1%) to migration with estimated 175 244 persons.

The overall analysis of the results regarding the demographic development shows that the fundamental reasons for a negative demographic development are a high mortality level, a relatively low life expectancy compared to other European countries as well as a negative external migration balance.

In general, the mortality rate in 2010 (14.6%) has increased by 0.4% compared to the previous year. Mortality rate remains higher for men (15.8%) than women (13.5%) and is also higher in rural (20.7%) than in urban (12.2%) areas.

The life expectancy at birth for the period 2008 - 2010 was 73.0 years[24], being 70.0 years for men and 78.8 years for women. The life expectancy in Bulgaria is the lowest in the EU. (EU-27 average is 73.5).

Healthy life years female/male[25] were respectively 65.5/62.0, which is equal to the EU-27 average 65.6 (61.9).

[24] Eurostat, 2010

Regarding the death causes, traditionally heart diseases and cancer are still most common, with strokes causing 31.4% deaths and ischemic heart diseases - 20.2%. Despite the decreased mortality caused by heart diseases, the standardised mortality ratio in Bulgaria remains significantly higher than in the EU and is revealing an increasing trend; the same goes for cancer.

One of the main problems caused by an ageing population in Bulgaria is the increased pathology. Official statistics on the morbidity of hospitalized patients between 2005 and 2010 show, that the number of hospitalised cases increased from 1,614,313 to 2,080,000 people (NHIF, MoH, 2011).[26] [27] The group with the highest incidence of hospitalisations is that of elderly aged over 65 (39.85%). Among the leading causes of hospitalisation were diseases of the circulatory system, respiratory diseases and factors affecting the health of people through contact with hospitals, which constituted a total of 40.2% of hospitalisations (NCHI, 2010). Clinical pathways (used as a method for hospital reimbursement) influence the level and the structure of the patients, so that some of the indicators should be considered as provisional. Chronic non-communicable diseases have stated for decades a significant and unresolved socio-medical problem. Diseases of the respiratory system are widely spread (38%), followed by diseases of the nervous system, of the circulatory system, injuries and poisonings.

The analysis of the distribution of the socio-economical and behavioural risk factors among the population, does not only explain the high morbidity and mortality caused by the listed diseases, but leads to an estimation that these will increase in the future.

Permanent disability increased significantly in 2010 compared to 1995 (21.2%). In 2010 the main causes of disability where cancer, diseases of the nervous system and diseases of the eye and appendages (NCHI, 2011). Chronic diseases are on the rise, together with increased disability and multiplicity of diseases, mainly due to social stress from poverty and unemployment, and other external factors.[28]

[25] Eurostat, 2010
[26] National Health Insurance Fund, 2011
[27] MoH, Concept for better health 2010-2015. http://www.mh.government.bg/Articles.aspx?lang=bg-BG&pageid=419
[28] See also the discussion of an increase in disability pensions in the pension part of this report.

Restructuring the health system

As a result of the restructuring of the health system and administration since 2009, the number of staff in the Ministry of Health has been reduced from 17,301 to 16,165.

By the end of 2011, the number of persons with suspended health insurance was more than 1,200,000. The number of uninsured persons rises in relation to unemployment rates[29]. Thereby, one important factor is the distribution of unemployment between the private and public sector, as well as between small and large companies, which influences the insurance coverage and the size of the average monthly insurance income.

The current situation of hospital care in Bulgaria is as follows[30] :

- The total number of hospital beds decreased from 50,041 in 2009 to 45,906 in 2011. The number of hospital beds for active and intensive care in Bulgaria is 36,686.

Table 2: Beds in inpatient health establishments by type of beds, 2009[1]

Bulgaria [2]	**2001** [3]	**2002** [3]	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
	56 984	**51 030**	**49 171**	**47 709**	**49 626**	**47 719**	**48 749**	**49 507**	**50 041**
Curative care beds	45 395	40 650	37 785	36 586	38 024	36 539	37 480	38 016	38 506
Psychiatric care beds	5 611	5 149	5 022	5 021	5 245	5 150	5 138	5 120	5 179
Long term care beds	.	.	1 674	1 552	1 372	1 093	991	988	871
Other beds	5 978	5 231	4 690	4 550	4 985	4 937	5 140	5 383	5 485

[1] According to the Eurostat statistical grouping.

[2] Beds in health establishments attached to other offices are included in the total number but not included in the distribution by statistical zones and regions.

[3] 2001 and 2002 data on long-term care beds are not available as a separate numbers and are incl. in the number of other beds.

Source: National Statistical Institute

[29] There is a special scheme covering health insurance of those persons who become unemployed. These persons hey insurance coverage for a few months and then remain outside the scheme without any health insurance

[30] NHCI. 2011 http://www.nchi.government.bg/Eng/download/healthcare_10A.pdf

Table 3: Hospital discharges by diagnosis (ISHMT), inpatient, total number

Country	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Belgium	:	:	1 669 773	1 674 395	1 806 670	1 684 221	1 685 870	1 755 950	:	:
Bulgaria	1 185 919	1 256 557	1 333 698	1 473 631	1 614 313	1 653 264	1 735 341	1 825 488	1 958 897	:
Czech Republic	:	2 327 708	2 417 072	2 432 527	2 283 791	2 216 952	2 218 515	2 193 047	2 182 739	:
Denmark	927 571	918 314	909 548	937 321	941 220	947 966	950 213	:	:	:
Germany	:	:	:	:	:	18 156 546	18 682 871	19 083 769	:	:
Estonia	263 533	254 339	252 822	254 221	241 264	245 959	247 146	246 821	235 443	:
Ireland	:	:	:	:	:	:	:	:	:	:
Spain	:	:	:	:	:	:	:	:	:	:
France	11 299 020	11 091 796	10 983 509	10 979 599	10 964 740	10 973 722	10 906 385	10 956 373	10 989 464	:
Italy	:	:	9 173 423	9 104 770	8 972 007	8 930 908	8 685 758	8 544 350	8 412 032	:
Cyprus	:	:	:	:	:	:	:	:	:	:
Latvia	:	:	:	:	:	:	:	:	:	:
Lithuania	814 155	789 808	778 469	779 178	769 281	737 368	743 513	744 786	747 775	736 013
Luxembourg	:	:	:	:	:	:	:	:	:	:
Hungary	:	:	:	2 413 838	2 453 943	2 405 525	2 068 989	2 033 003	2 018 659	:
Malta	:	:	:	:	:	:	:	:	48 826	54 843
Netherlands	:	1 516 107	1 574 894	1 655 707	1 699 565	1 747 192	1 790 678	1 850 715	1 914 839	:
Austria	:	:	:	:	:	:	2 275 417	2 295 924	2 328 867	:
Poland	:	:	6 648 257	6 787 419	5 461 371	5 696 558	5 563 024	5 637 067	6 193 892	:
Portugal	:	:	:	:	1 052 072	1 097 078	1 607 904	1 867 188	1 943 921	:
Romania	5 104 213	5 381 114	4 968 724	4 927 758	4 392 853	4 955 196	4 635 453	4 899 574	5 349 049	:
Slovenia	:	:	:	:	:	334 626	339 782	341 626	354 197	:
Slovakia	1 137 647	1 088 935	1 054 366	1 062 519	1 066 907	1 075 097	:	1 018 656	1 015 428	:
Finland	1 080 551	1 065 241	1 055 999	1 042 646	1 028 543	1 004 927	979 833	972 342	955 320	:
Sweden	1 413 962	1 402 318	1 406 948	1 416 005	1 428 401	1 449 843	1 473 933	1 492 115	1 510 374	:
United Kingdom	7 827 723	7 874 767	8 136 799	:	8 157 540	7 501 919	7 850 111	:	8 352 924	:
Iceland	50 841	52 180	48 447	49 666	51 015	48 712	48 636	:	45 010	:
Norway	:	:	:	796 485	809 962	824 410	811 638	819 136	855 705	856 870
Switzerland	:	1 125 931	1 147 271	1 175 478	1 188 683	1 217 855	1 258 248	1 292 864	1 306 613	:
Croatia	544 836	556 365	587 667	592 620	592 288	628 974	:	762 560	:	:
Former Yugoslav Republic of Macedonia,	170 101	174 758	177 262	185 129	201 261	201 500	202 993	:	:	:
Turkey	:	:	:	:	:	:	7 401 952	7 959 181	9 652 387	:

Source: Eurostat, 2012
http://epp.eurostat.ec.europa.eu/portal/page/portal/health/public_health/data_public_health/database

The hospitalisation rate during the year remained nearly in the same range as in previous years – 1,700,000 patients. The basic data for hospital care are presented in the *Annexes 5 and 6*.

Despite of the increase in the budget, the system of emergency medical care suffers from a serious financial deficit, related to the growth of prices of the main products and services – fuels and energy, medications, insurances, etc., and the need to offer financial incentives in order to increase staff motivation.

2.3.4 Critical assessment of reforms, discussions and research carried out

The global financial and economic crisis exerts a strong influence on the socio-economic development of the country and respectively, on the health system. This is related to the policy of economies on behalf of the government, reduction in direct foreign investment, growing unemployment and the loss of credit for undertaken reforms among the population. Despite the remarkable stability of the financial system, due to the currency board, the economic activity in the country is declining.

The main critical moments in the health system reform can be summarised as follows:

- The restructuring of the administration and the health system has started last year and are mostly expressed in the following components;
- Reduced staff number in the Ministry of Health – Central Administration from 346 to 276;
- Upon closing, the National Medical Coordination Centre has reduced its number of personnel by 26 positions;
- Upon closing of the home for medical and social care for children in Teteven the number of personnel was reduced by 28 positions;
- In the end of 2011 Regional Centres for Protection and Control of Public Health and Regional Health Centres were transformed (united) into the Regional Health Inspectorates and the number of personnel was reduced by 447;
- 454 positions were transferred from the Ministry of Health to the Ministry of Agriculture and Food, reducing number of personnel of the Ministry of Health accordingly;
- The National Centre for Public Health and the National Centre for Health Information have merged into the National Centre fro Public Health and Analyses. The personnel of the Ministry of Health was reduced by 110 positions.
- According to the amendments to the law for health establishments in 2011, the existing 31 dispensaries - oncology, psychiatry and dermatology & venereology - have been restructured into 9 Complex Cancer Centres with 1334 beds, 10 centres for dermatological and venereal diseases with 163 beds and 12 mental health centres with 1450 beds. After this restructuring, the number of beds was reduced by a total of 426 bench press;
- 8 municipality hospitals have been closed, as these were not able to meet the requirements of the NHIF contract or due to financial problems.

One of the problems of this restructuring is the issue of maintaining the stability of the health system. A second major problem is release of the health personnel and its reassignment to another position or into another sector.

- Strategic papers are available – the programme of the government, the concepts and strategies of the Ministry of Health - but they all lack clear and measurable results..
- The replacement of three health ministers in the course of two years shows the instability of the system and not constant political priorities.
- Regarding the political management of the system, scandals continue to circulate among the main stakeholders; those are related to the misunderstandings between the health minister and the governor of NHIF, rejection of part of the minister's drafts from the parliamentary commission on health care, constant differences in opinions among professional associations and the government.

- The lack of decisions and measures concerning the declining amount of medical specialists due to growing emigration and searching for better perspectives in other sectors.
- Training of managers in health care – especially at the "operative" and "mid" management levels - remains very theoretical, detached from the real problems of the system; study plans and programmes are out-dated being at the level of the 90-s. This leads to an overall reduction of the administrative capacity of the system making it impossible to obtain a qualified personnel.
- Plans for dedicated education in public health are absent – the faculties of public health established in the beginning of the century are not implementing their tasks and don't comply with expectations. Educational plans and programmes envisage only theoretical studies of health promotion, project management, epidemiology and epidemiological studies. There is no correlation with the new strategies of the EU or WHO. This influences the mobility of the students and professors and leads to a very low participation in the Erasmus and Leonardo programmes.
- The new NHIF rules on the reimbursement of activities and the new requirements for contracting with NHIF affected negatively the incomes of hospital physicians which in turn lead to demoralisation and renewed practices of out-of-pocket payments.
- The governmental decision to issue an ordinance regulating the payments in hospitals for choosing a particular physician or team had caused a heated public discussion and after being forwarded to the Bulgarian Ombudsman it was proclaimed illegal and immoral in an official letter.
- There is no dedicated policy to solve the problem with uninsured persons, especially with groups at risk – ethnic minorities, unemployed, etc.
- The economical crisis and inadequate funding, combined with the debt burden of hospitals lead to the closure of many municipal hospitals or their restructuring in centres for primary care.
- Public disillusionment regarding the health system is growing, manifested in periodically emerging media scandals related to the so called "medical errors".
- Medical education is not developing in the direction of growing knowledge and skills of the graduates and specialists, but has instead developed into a framework of autonomous medical universities which very often do not adhere to the national standards and requirements. There is an essential discrepancy between the state requirements and actual programmes and no unified policy and actions on this issue.
- The prestige of the nursing professions is at its historically lowest level, leading to a significant emigration of professionals.
- One sustained debate is related to the ongoing initiatives for restructuring the system from a social-insurance model into a market based insurance model. Various interest groups propose under the disguise of the requirements of **Solvency II Directive** 2009/138/EU the abolishment of the "monopoly" of NHIF and promotion of a free competition of insurance companies. A main political weakness on this topic is the reluctance of politicians to take any definitive actions on developing the current model. Hopes about the development of the insurance model raised expectations among the public and participants of the insurance services' market. In reality, there is lack of clear vision for the future of voluntary funds, in particular the harmonisation of legislation with the requirements of EC in this area (Solvency II).

- The restructuring of dispensaries into centres and the shift of the funding responsibility for cancer and haemodialysis patients to NHIF lead to organisational problems and worsened the access of patients to quality services.
- The absence of strong decisions on the future development of emergency care leads to a growing public distrust and a loss of qualified personnel. This also affects the possibilities for real investments in this system.
- One positive tendency is the improvement in spending of the European funds during the last year, which positively affects the overall policy in health care.
- There is no real research in the field of public health, and the government as well as the Ministry of Health does not allocate any funding for studies in this field;

On the basis of these facts we must consider the following main risks for the health care system in Bulgaria:

- ***Financial risks***
  - Cutting the free cash resources of both the state and households to meet basic health needs
  - Economic pressure on hospitals may lead to a contraction of their activities, respectively, reducing their staff and lowering incomes of their workers
  - The collapse of the pharmaceutical market and focusing of both hospitals and patients on cheaper drugs - bankruptcies of distributors, pharmacies etc.
  - Cost reductions in the system leads to a reduction of social protection of citizens and the increase of informal payments
  - Decreased sustainability of the health system
- ***Risk related to manpower***
  - Emigration of the greater part of medical professionals and pressure on the labour market leads to uncertainty
  - Demotivation of the workers in the health sector often leads to errors and reduction of quality and safety
- ***Risk related to health care access and public health***
  - Increased morbidity of the population for many reasons - both of medical nature and due to influences of economic, social and psychological factors, especially diseases of modern life, associated with poverty, malnutrition, stress, unemployment, etc.
  - Increased pressure on National Health Insurance Fund, performed by both hospitals and doctors as well as by patients, leading to discontent and protests
  - Restricted access to highly specialised medical and health services.
  - Increased expectations of the population will exert continuous pressure on the Ministry of Health, which will be a constant target of discontent
  - Increased turnover of the population to the system, especially emergency medical care will be under pressure thus causing more errors, hence the dissatisfaction of the population will also rise.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care and social services in our country can be categorised in two main types – in community institutions and specialised institutions[31]. Their funding is based on the principle "money follow the provider". This leads to inefficiency of public spending and (as a rule) to insufficient quality of services. An alternative model of financing is based on the principle "money follow the client". This model is applied in many countries and is discussed among social experts as an option for change in our country as well.

Long-term care and other social services for elderly are provided through two distinct systems. Social services, defined as "activities which assist and expand the opportunities of persons to lead an independent way of life and which are carried out at specialised institutions and in the community" [32] are regulated by the Social Assistance Act (SAA) and Rules for the Implementation of Social Assistance Act (RISAA). Long-term social care is defined as social services provided for a period of more than three months. There is no separate definition of LTC services in the Bulgarian legislation at this time, nor an official classification of who qualifies for the entitlements.

Health services, on the other hand, are regulated by the Medical Treatment Facilities Act and are provided by different types of institutions such as hospitals for further and continuous treatment, hospitals for rehabilitation and hospices. Unlike social services, the legislation does not provide a definition of long-term health care.

As is the case in many countries, the social service sector and the health care sector do not have an official mechanism of coordination with regard to LTC services. Bulgaria has identified better cooperation and coordination between the health and social services as one of their priorities in the next few years. This includes concrete steps such as including health consulting rooms in homes for the elderly and disabled.

The reform undertaken in recent years in the provision of long-term care and social services is targeted towards deinstitutionalisation. This is a process of replacement of institutional care with care at home or environment close to family environment in the community. The quantitative goal of the reform is to close all specialised infant institutions in a 15-years period,[33] and to provide various forms of social services through the communities. The results from the restructuring of services for the period 2008 – 2011 demonstrate this tendency.

[31] See Article 36 of the Regulations of social support (State gazette, Issue 133/1998; this report is based on the variant from July 2010). In general terms, community services are those outside specialised institutions for social services, regulations envisage 19 such types (e.g. personal and social assistant, home assistant, social patronage at home, day care, center for social rehabilitation and integration, shelters, public dining rooms, etc.).

[32] SG No. 120/2002 of Social Assistance Act of 1998 (2002 Revision).

[33] One of the targets of the National strategy "Vision for the de-institutionalisation of children in the Republic of Bulgaria" is to close the existing 137 infant institutions in the course of 15 years, counted from the date of the adoption of the paper.

Table 4: Number of places in the institutions providing social services, as planned in the financial framework for the respective year

Types of services	**2008**	**2011**	**Growth rate**
In institutions	19361	16984	-12.3%
In the community	10140	14373	+41.7%

Table 5: Capacity of services (number of places), which are subject to this study and change in the following manner:

Types of services	**2008**	**2011**	**Growth rate 2011/2008**
In institutions	8227	7347	-10.7%
In the community	4481	5831	30.1%

Unfortunately, Bulgaria does not have a national register of clients of social services, which does not allow to calculate the degree of satisfaction with the current capacity. The statistics presented in the journal "Development of social services"[34] reveal inter-regional differences in the degree of covering services for impaired children, offered by day care centres. These range between 0% or values close to zero for Razgrad, Targovishte, Sofia, to over 80% for Blagoevgrad, Vidin, Veliko Tarnovo.

In the field of long-term care there is no dedicated policy on behalf of the Ministry of Health and efforts are primarily directed towards providing medical services to terminally ill patients. In case if the patient decides to claim the services in hospices, he/she shall be reimbursed by NHIF.

In terms of service delivery, more than 90% of services are public, provided by either the state or the municipal government. While institutional care is almost entirely public, NGOs and charities are increasingly involved in providing services in non-institutional centres for social rehabilitation and day care centres for adults. Home-based services are provided by individuals contracted by municipalities or the state, depending on the type of the service.

In order to access social services, beneficiaries must submit a written request to the appropriate municipal or national authority for public services or to the manager of a private service provider. Based on the request, the relevant authorities conduct a social evaluation and make a recommendation for services to be provided to the beneficiary. Access to health services is based on the insurance status of the beneficiary, however every Bulgarian woman aged over 60 and every Bulgarian man aged over 65 has full health insurance coverage paid by the state.

Bulgaria does not have a cash-based LTC allowance system for family members who care for their elderly relatives. Instead, the state supports a system of personal assistants and home helpers who are paid to provide basic cooking, cleaning, personal hygiene and shopping/errand help for people who do not require institutionalisation but cannot meet these basic needs on their own. This system was originally established to provide relatives of elderly and disabled residents in need of constant care with a salary and insurance coverage but it is open to third parties as well.

[34] See journal "Development of social services", Number 1 from July 2010, page 10.

Clients of social institutions are entitled to: accommodation and all related services – furniture, clothes, heating, illumination, hygiene, nutrition, medications, health services, etc.; vocation, rehabilitation, free time management.

Clients of day care centres are entitled to the already listed services, minus the ones related to shelter and habitation. This allows the conclusion that services of the specialised institutions are a combination between shelter and day care.

Centres for social rehabilitation and integration perform training, consultations, rehabilitation, prepare and conduct individual programmes for social inclusion, i.e. in opposite to day care centres, from the point of view of expenses, no food is being offered.

Financing of LTC and Social Services

LTC and other social services for the elderly are financed primarily from public funds. There is no LTC insurance and private payments are minimal. In general, LTC and other social services for the elderly in Bulgaria are financed by the following methods:

• **State services**: Financed by the state and paid directly to the service provider.

• **State delegated services**: Financed from the state budget based on established standards

but funds are transferred to municipalities which then pay and manage the services. Municipalities are obliged to provide these services.

• **Municipal services**: Financed from local budgets and paid directly to the service provider. Provision of these services depends on local conditions and needs.

• **User fees**: Paid to municipality or state, depending on the service. All but one service (personal assistants) require user fees based on the particular service and the user's income.

• **Private services**: Financed by private organisations (NGOs, foundations, firms) that are registered with the Social Assistance Agency.

In terms of expenditures, the bulk of services are state-delegated, which means they are funded by the state but managed by the municipalities. While this ensures a minimum amount of funding available to meet local needs, it does not ensure high quality and universal coverage.

Table 6: Expenditure standards for the period 2008-2011 (in BGN) per person

Types of services	2008	2011	Change 2011/2008
Homes for adults with impairments	6270	6351	1.3%
Homes for infants with impairments	6768	6952	2.7%
Day care centres for adults with impairments	3217	5244	63.0%
Day care centres for infants with impairments	5079	5244	3.2%
Centers for social rehabilitation and integration	2253	2328	3.3%
Relation between:			
Homes and day care centres for adults with impairments	1.95	1.21	-37.9%
Homes and day care centres for infants with impairments	1.33	1.33	-0.5%

2.4.2 Debates and political discourse

Long-term care and social services by their nature cannot be put entirely on the market principle according to which the client pays the provider, due to the fact that there is a reverse dependence between the customers needs and their ability to pay. The provision of social services from the public sector imposes a figure of the financing institution (the state) to emerge in between the client and the provider.

The presence of the state is inevitable, but the lesser its interference in the relations client-provider, the better it is for keeping the good features of the market: services matching the needs of the people and provided on the basis of free choice of the customer; strive for production and offering of effective and high quality services – a matter of survival for the provider.

One can notice that in Bulgaria, on the operative level of offer and demand of long-term care and social services, the state entirely dominates the relations customer-provider. The customer and the provider do not enter any transactions. They enter into relations with the state that controls the process in which one side has to offer, and the other to utilise certain services. Two important issues remain outside the scope of the state activities. One is related to the range of needs. The legislation regulates that a register of clients of LTC or social care is maintained by the provider. For the purposes of policy planning in this sphere a national data base of clients is necessary. The second issue is related to the initiative for establishing a material base and opening of institutions for LTC and social care. This is done by municipalities. The state only allows[35] the opening or closure of activities.

The main problem to MH is that it does not have a long term and clear strategy regarding LTC. Still, the concept for LTC is based on care for the terminally ill – opening of hospices for terminally ill, creation of clinical pathways to be financed by NHIF, etc. The lack of joint action and collaboration between MoH, MLSP, Social Protection Agency and NHIF makes the solving of this socially important problem impossible. The lack of adequate understanding

[35] According to information of the MLSP the Ministry has to approve the establishment of a social services institution, but there is no procedure to refuse the establishment of a new social services institution if the mayor presents all the necessary papers.

of LTC as a process related to the continuity and collaboration between multi-professional and institutional teams in providing this service is the leading obstacle to the establishment of a united national programme. From the perspective of the MoH, long-term care is a social service with some small medical components. The MoH is responsible for the so-called "dolekuvane" which is a long-term treatment after a certain disease, rehabilitation or hospice care.

The change of the financing principle from "money follows the provider" to "money follows the client" is not a technical task which could be solved by a mere change of address to where money is "directed". It is more a question of a new philosophy of relations between institutions. Changes are required in the environment, mode of financing, functions of the institutions, as well as establishing of new and closing of existing institutions.

The system may be restructured to finance not capacity e.g. number of beds or number of persons, but end results, if *clients have the right to chose the provider and providers compete for clients*. The establishing of predispositions for that to happen also presumes efforts for change, particularly at a central level. The minimally required conditions for adoption of a new system for services provision requires the establishing of (Shopov, 2011):

National register of clients for services, which are subject to a state policy /appraisal of needs for this type of services. The state could not implement a new policy for provision of social services without knowledge of the scope, structure and content of needs from them.

An independent commission to evaluate the individual needs of clients. The commission has regional offices and is not a structure of MLSP. It defines the types of services, the mode and time of utilisation of services by entitled individuals. Such a commission is already established and functions in the Netherlands.

The last months discussions on the possible models of social services provision took place. The first one is called in relative terms state. The state plans the volume of services of each type for the respective area in accordance with the financial resources at disposal. It processes the requests of clients and serves as a mediator between them and the service providers. The second model, which could be defined in relative terms as regional, predisposes an enhanced role of the municipality with a regional city as a centre. The state delegates to the municipality the right to organise and manage the respective social services for the region. The third model is the municipal. It assumes the participation of all municipalities of the region as service providers. Municipalities establish their own structures for service provision and/or run contracts with companies and NGOs, registered in the Social Protection Agency. Municipalities compete for a state quota for social services provision. Common between the three models is the fact that clients chose providers, providers are designated through competition and operate on the territory of the whole region.

At the moment – as already noted, the role of the state is all pervasive. It has entirely replaced relations between the rest of the subjects in the process. Clients and providers interact not directly, but through the state. They are entirely dependant on its executive and financial decisions.

2.4.3 Impact of EU social policies on the national level

The main projects and influences of European social policy are directed predominantly to the problems of persons with impairments, social exclusion and the deinstitutionalisation of such individuals, which is an element of the common policy for LTC, unfortunately not covering their full aspects.

On the one hand, there is almost no discussion on the OMC in the field of long-term care in Bulgaria.
On the other hand, it seems that the idea of long-term care included in the Social OMC indirectly contributed to the initiation of discussion on this issue. It may be argued that the Social OMC had an impact on the concept of integrated long-term care.
The EU 2020 strategy has not yet affected the long-term care reform debates. The challenge of developing a long-term care, in the context of ageing of the population, is mentioned in the Bulgarian NRP 2011.

The main projects implemented in 2011 with EU funds are presented in Annex 8.

2.4.4 Impact assessment

In recent years, especially during 2011, a clear and an ongoing restructuring of social services takes place, aimed at replacing institutional care with various services in the community. Unfortunately the barrier between the two leading institutions dealing with LTC – MoH and MLSP – remains.

A uniform state policy in the field is still missing, one that could help overcome the fragmentation of services and provide interaction of all state institutions.

The degree of meeting the population needs from LTC and adequate social services is extremely low on national level.

There are significant regional differences in the localisation of activities, which gives the impression of the absence of aimed policy for development of services.

Table 7: Social services, provided in specialised institutions in 2008 by districts

	Establish-ments	Places (capacity)	Persons in social establishments as of 31.12		
			Total	Male	Female
Bulgaria	**299**	**19794**	**17253**	**8077**	**9176**
Blagoevgrad	**9**	**567**	**508**	**229**	**279**
Burgas	**16**	**929**	**828**	**397**	**431**
Varna	**12**	**700**	**657**	**354**	**303**
Veliko Tarnovo	**18**	**1124**	**1039**	**477**	**562**
Vidin	**14**	**807**	**661**	**416**	**245**
Vratsa	**14**	**920**	**810**	**352**	**458**
Gabrovo	**10**	**612**	**596**	**260**	**336**
Dobrich	**8**	**579**	**548**	**212**	**336**
Kardzhali	**2**	**80**	**43**	**22**	**21**
Kyustendil	**7**	**504**	**430**	**200**	**230**
Lovech	**7**	**346**	**235**	**114**	**121**
Montana	**15**	**967**	**835**	**439**	**396**
Pazardzhik	**11**	**724**	**597**	**279**	**318**
Pernik	**4**	**344**	**265**	**99**	**166**
Pleven	**6**	**344**	**306**	**146**	**160**
Plovdiv	**20**	**1282**	**1105**	**499**	**606**
Razgrad	**9**	**570**	**517**	**233**	**284**
Ruse	**10**	**893**	**778**	**373**	**405**
Silistra	**7**	**618**	**540**	**302**	**238**
Sliven	**9**	**833**	**772**	**390**	**382**
Smolyan	**4**	**350**	**343**	**177**	**166**
Sofia cap.	**31**	**1953**	**1452**	**617**	**835**
Sofia	**10**	**530**	**483**	**192**	**291**
Stara Zagora	**18**	**1164**	**1057**	**498**	**559**
Targovishte	**5**	**353**	**284**	**120**	**164**
Haskovo	**9**	**568**	**526**	**246**	**280**
Shumen	**8**	**630**	**575**	**307**	**268**
Yambol	**6**	**503**	**463**	**127**	**336**

Expenditures in this area, allocated by the state, demonstrate an insignificant growth. If inflation is taken into account, most probably a drop in real expenditures will be observed; expenditures for a place in the day care centres grow a little faster than those in "institutional" homes. As a result, "the price of a place" in the two types of facilities is drawing near. This happens even before taking into account an important circumstance – at institutional homes care is provided 365 days in the year (mainly living expenses), whereas day care centers function only during the working days – about 220 days in the year.

2.4.5 Critical assessment of reforms, discussions and research carried out

The following summarised evaluation can be made:

- *A change of paradigm* is necessary in LTC and social services provision in the community, as well as in the presently existing model of providing social services as a whole. The customer /client/ should be put at the centre of the new model. His/her "empowerment" is a key principle and guiding light for the direction and appraisal of the change.
- Changing the schemes of payment, oriented towards the customer and not towards the institution, is only one of the financial *instruments* for replacing the model, but a goal in itself. The successful adoption of this instrument is possible with a number of external and

internal (for the social services sphere) *preconditions*, including a system for evaluation of individual needs from LTC and/or social services; equality and competition between various providers of services; clearly defined roles of the three leading parties in the servicing process: financing party (state/municipality) – provider – client; building institutional capacity, etc.

- The introduction of a personalised budget /PB/ for receiving LTC and/or social services in the community for persons with impairments could be used as a *pilot project* for testing the model "money follows the client".

The possible risks for LTC and social services systems are:

- The unfavourable current economic and financial situation in the country – secure financial resources are necessary, to guarantee the right of access for beneficiaries to respective services.
- The absence of institutional framework which could provide the normal administration of the process – regulations, institutions with clearly defined roles and present material, technical, financial and labour capacity.
- The simultaneous implementation of other foreseen reforms. The overlay of a multitude of serious changes puts strain on the systems and hinders their effective functioning.
- Insufficient administrative capacity in the structures of MoH, MLSP and the Agency for Social Support /ASS/ for the application of the *personal budget* /PB/ model, which in combination with the preceding risk additionally hampers the capability for change.
- The unsatisfactory condition of the whole sector for social services (e.g. institutional LTC), as well as of other elements of the system for social protection (e.g. low pensions can limit the individual participation in financing PB).
- The limited ability of persons in need of this type of services to take autonomous decisions on managing PB.

In this aspect it would be a realistic intermediate option to search possibilities for optimising the current practice for financing LTC and /or social services in the community by looking for ways to introduce some new elements from the schemes of payment directed towards the customer.

2.5 The role of social protection in promoting active ageing

The main changes with regard to the age structure in Bulgaria is the decline of the young population (persons aged under 20) and the increase of the elderly(persons aged over 60). The share of the population aged over 65 has grown from 16.8% in 2001 to 18.5% in 2011, while that of the young (aged under 15) has decreased from 15.3% in 2001 to 13.2% in 2011.

The largest share of population over 65 is observed in regions Vidin - 25.5%, Montana and Gabrovo - 24% each, Lovech - 23.3%, and Kyustendil - 22.8%. The lowest share of elderly is recorded in the regions Blagoevgrad, Varna and Sofia - 16%.

The total age dependency ratio is 46.5%, i.e. 47 persons under 15 or over 65 per 100 persons aged 15–64. This ratio is more favourable in the cities – 41%, compared to villages - 63.1%.

In less than 20 years, the ratio between the young (aged under 15) and elderly (aged over 65) will deteriorate from 85.6% to 67%.

In Bulgaria, social protection policies or legislation with regard to active ageing does not exist yet. The legal framework for protection of elderly from violence is the Law on Protection

against Discrimination (in force since 2005), Law on Protection against Domestic Violence (in force since 2005) and the Penal Code.

Other European and international documents which have been ratified by Bulgaria in this field are: the UN mechanisms for human rights protection, e.g. the UN Convention on the Elimination of All Forms of Discrimination against Women, the International Covenant on Civil and Political Rights (and its Optional Protocols), the EU Charter of Fundamental Rights and the revised European Social Charter, etc.

The topic of active ageing is as yet present mostly in documents but not in practice or daily activities of the institutions and elderly. This is valid to a full extend for the "National programme providing opportunities for active ageing, fulfilling participation of retirees in social life and prevention of their social exclusion".

This programme started in 2009 and was expected to have a timeline through 2011, but was terminated earlier. Its main aim was the prevention of social exclusion of pensioners and creating opportunities for their active participation in the social life even after retirement. The programme's objectives were to ensure equal access for pensioners to all services, providing opportunities for more active social life, providing conditions for ageing in good health and for using the opportunities for personal development in old age.

The programme provided access to services for pensioners aged over 65, who are able to take care of themselves. The programme was open to both pensioners without social support and pensioners receiving social services at specialised institutions for elderly.

The services were free for the beneficiaries and the financing was provided by the Social Assistance Fund.

2.5.1 Employment

New measures were introduced to encourage later retirement. The amount of the length of service and old age pension is determined by multiplying the income on which pension is calculated by 1.1%, and starting from 01.01.2017 – 1.2% for each year of contributory service.

If a person has length of service exceeding the required service for pension entitlement and continues working after reaching the pension age, without having been granted a pension, for each year length of service after that age the income on which the pension for these years is calculated will be multiplied by 4% starting from 1 January 2012.

62.2% of Bulgarian population is in working age, representing 4 576 904 people with 52.5% of them being men, and 47.5% - women. The larger share of working age population lives in cities - 75.8%, and 24.2% - in villages. 65% of the urban population is in a working age, and in villages - 54.7%. Almost a quarter of the population in the country (23.7%) is over working age - 1 747 717 persons. The share of persons over working age is lowest in cities (15.6%) and highest among women in villages (38.0%).

Table 8: Labour force aged 15 years and over, in thousands

Age	2003	2004	2005	2006	2007	2008	2009	2010
Total	**3283,1**	**3322,0**	**3314,2**	**3415,7**	**3492,8**	**3560,4**	**3491,6**	**3400,9**
By age								
15-24	306,2	307,4	291,9	298,8	294,3	300,8	286,2	269,9
25-34	827,8	805,8	795,7	798,7	783,1	781,6	742,2	699,8
35-44	897,9	921,0	927,8	961,7	1006,3	1009,3	1021,8	1018,8
45-54	876,9	894,0	895,7	901,0	920,2	933,4	908,9	903,6
55-64	323,4	347,5	367,9	416,2	444,1	479,6	482,3	464,2
65 and over	50,8	46,2	35,3	39,4	45,0	55,7	50,1	44,5

Source: NSI. http://www.nsi.bg/otrasalen.php?otr=51&a1=2038&a2=2044&a3=2045#cont

The data from the Census, which took place on 1 February 2011 shows that 3 282 740 of persons aged between 15 and 64 are economically active.

As of 1 February 2011 the employment rate, calculated as a ratio of the number of employed persons to the population aged between 15 – 64, is 55.5%. The employment rate is higher among men than among women, respectively 56.9% and 54.0%. The unemployment rate is 15.0%, 16.4% for men and 13.5% for women.

Reproduction of working age population is best characterised by the coefficient of demographic replacement, which expresses the ratio between the number of people entering working age (15-19) and the number of people exiting working age (60-64). According to this, in 2001 every 100 persons exiting working age have been replaced by 124 young persons. After 2008 this ratio is reverse - 100 persons exiting working age have been replaced by 91 young persons, in 2009 by 82, and in 2010 by 74. The data from the population census of 2011 demonstrates a ratio of 70, which speaks of a stagnation regarding the replacement of the working age population. The deterioration of the age structure of the population reflects on the size and quality of labour resources. The ageing of workforce in a dynamic labour market with constantly changing requirements regarding qualifications and professional skills of occupied persons, evokes a need for a higher overall effectiveness of the workforce and need for lifelong learning. The increasing share of aged persons (65+) place serious challenges to the social security system, the system for social support, health care, and education. As a whole, social transfers to persons over 65 will be on the rise.

In remote future, when mortality – both infant and total – enters a steady decline, a much greater need of elderly care especially for those over 75 will appear. In 2010, 437.6 thousand persons aged 15 - 64 took care of ill persons, elderly, persons with impairments and other persons aged over 15 and in need of care. Out of the persons caring for adults, 59.8% are employed, 8.5% - unemployed, and 31.7% are inactive. 44.6 thousand or 25.3% of the unemployed aged 15-64 who are taking care of adults stated their willingness to work, provided there are suitable care services for ill and elderly people. 41.7% of those unemployed willing to work point out the over-priced care services for elderly as the main barrier towards employment.[36]

The following barriers to active working life of the elderly can be listed:

- Unsuitable labour conditions;
- Restrictions in the sphere of employment - taxation and social benefits;

[36] Ministry of Labor and Social Policy, 2012

- Age discrimination;
- Restrictions or incapability to participate in the system for lifelong study;
- Omnipresent limitations for handicapped persons – unfit buildings, transportation.

According to a national representative study conducted in 2010, age is the most common cause for refused employment, as stated by 15.5% of respondents. Other causes are: ethnicity (5%), gender (3.9%), childcare (3.3%) and impairment (1.6%). In 30.6% of cases, persons aged over 50 state ages as the main reason for unemployment. Likewise, 18.8% of respondents aged 18-29 and 19.1% of respondents aged 40-49 also state age as the main reason for unemployment. Discrimination of elderly employees is almost 2 times higher than in other age categories. Refused employment based on age affects mostly persons with primary or lower education – comprising 44%. For persons with higher education (college and university) refusals based on age are significantly rarer – respectively 28% and 16%.[37]
Adapting the social security system to the ageing of the population and the necessity of raising the quality of life of elderly people includes the following issues:

- Promoting a positive attitude of the employees towards the social security system;
- Increasing the insurance incomes;
- Enhancing the role of the second and third pillar of the retirement system;
- Improving the control of insurance payment and not allowing improper pension benefits (especially regarding disability pensions due to disease);
- Increasing the scope of insured persons while limiting informal economy;
- Improvement of the Bulgarian retirement model and provision of financial stability of the retirement system by introducing fairer and flexible forms for participation in the retirement system;
- Support of the demographic investment fund — The Silver fund for financial backup of the retirement system;

An Euro Barometer survey[38] shows the following results:

QB13. Thinking about the job you have currently, until what age do you think you will be capable of doing the work you are doing today?

Average	EU27	BG
TOTAL	61.7	59.3

QB20. Would you like to continue working after you reach the age when you are entitled to a pension?

Yes	EU27	BG
TOTAL	33%	36%

[37] The national representative study is a terrain work of NCSPO and the analysis of data is performed by a team of the Institute for Studying Societies and Knowledge under a project of EU and MLSP „Progress to equality: national, effective and innovative practices for prevention and fighting discrimination“. 1000 adults in the whole country, have been interviewed in the period 23 September - 7 October, 2010.

[38] http://ec.europa.eu/public_opinion/index_en.htm

In this relation the government proposed in an official paper[39] regarding the demographic development of Bulgaria the following measures:

- Adapting the labour market to the ageing of the population and the necessity to raise the quality of life of elderly persons
- Development of measures for the preservation and development of the labour potential as an element of the whole concept for development of human resources in the country;
- Promotion of lifelong learning and activities pertaining to vocational training on the workplace;
- Introduction of flexible forms of employment for persons in retirement age, without creating disproportions on the labour market and inter-generational conflicts;
- Overcoming the negative attitudes of employers to aged persons and promotion of a longer utilisation of their labour experience and skills;
- Development of social entrepreneurship, silver economics and sectors of the economics with the potential of opening new positions, adequate to the capabilities of the present ageing workforce.

2.5.2 Participation in society

Bulgaria is a country with the fastest shrinking population in the EU. Not only the number of working age population declines, but also the number of those able to care for the elderly is decreasing. Especially endangered is the group of elderly women, who live on average approximately 7 years longer than men and are more likely to live in isolation and poverty, after their spouses die.[40]

Elderly in Bulgaria are vulnerable and often marginalised. With the advancement of age the job opportunities decline. It is a broad opinion that with ageing people become less useful, non-productive and require more care. This negative perception of elderly influences their self-esteem as well.

Elderly persons, in particular those of the "Baby-Boom" generation, should expect a longer healthy life. More opportunities for active ageing will allow them to continue to contribute to society, even after retirement. An important aspect would be to raise the occupation levels of aged employees through improving labour conditions, investing in lifelong learning and eviction of barriers to employment, including those related to discrimination. It is also important to promote access of elderly to education, information and communication technologies, which will enable them to stay active ad participate fully in the society and to promote initiatives for volunteering, initiatives aimed at achieving ties between generations, as well as volunteer activities specifically targeted at elderly people. All these measures requires the cooperation of regional and local authorities, social partners and other stakeholders.

In order to overcome social exclusion of elderly persons and provide conditions for their participation in the public and social life, the government proposes the implementation of the following measures[41] until 2020:

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[39] NATIONAL STRATEGY FOR DEMOGRAPHIC DEVELOPMENT OF THE POPULATION IN THE REPUBLIC OF BULGARIA (2012 – 2030), December 2011, Sofia, www.mlsp.government.bg/.../DEMOGRAPHIC%20STRATEGY

[40] "Bulgarians: old, older, oldest", data from a World Bank report, http://www.dw-world.de/dw/article/0,,14840693,00.html

[41] See 33

Adaptation of the system of education to the ageing of the population and the necessity to raise the quality of life of the elderly:

- Developing a long-term programme of lifelong learning allowing all age groups to access training institutions and universities;
- Promoting the access of elderly to education, information and communication technologies allowing them to stay active throughout their entire public lives. Enhancing measures aimed at developing computer and technological skills for the elderly as an opportunity to improve the possibility of attaining a knowledge based society;
- Promoting learning at the workplace.

Development of volunteering, solidarity among generations, a positive public image and the understanding of the social value of the elderly:

- Stimulating the voluntary participation of retirees in the social life of their community and the development of the civil society
- Promoting voluntary activities of youngsters which benefit and support the elderly.

2.5.3 Healthy and autonomous living

The health status of the population is an integral indicator of the socio-economic development of the country, the quality of life of the population and the quality of development of the labour force.

Some forecasts for the growing expenditures for health care, related to the ageing of the population and other demographic challenges, raise the need for the formulation of policies for their limitation on national level, as well as of methods to evaluate their relative efficiency.

The impairment of health is an important factor in the relations among generations and sexes. It affects the professional and reproductive activity of both - persons with impairments and members of their families/households and leads to limiting financial abilities, deforms the structure of expenses, changes inter-family relations and affects the demographic development of the population. The sociological study of generations and genders (BAS) shows that 4.5% of all households members have some form and degree of impairment and in 14.6% of all households the problem of impairment is present. The simultaneously registered share of impaired persons in the general population is 6.4%. The problems of these households raise issues related to aid offered to the specific impaired person and his/her carrying relatives.

Measures proposed by the government[42]:

Adapting the education system to the ageing of the population and the necessity to raise the quality of life of the elderly:

- Optimisation, modernisation and rationalisation of the constantly growing expenses for health care, while taking into account the needs of the elderly workforce;
- Financing and development of complementary health services designed for the elderly;
- Introduction of a multi-profile health service for the elderly;
- Raising the health awareness of the elderly;

[42] See 33

- Promoting a healthier lifestyle throughout the entire life, especially considering persons aged over 50;
- Building-up a closer collaboration between the system for health services and the system for social protection in the provision of social services for the elderly.

Adapting the system of social services to the ageing of the population and the need to increase the quality of life of the elderly:

- Priority development of social services at home and in the community at the expense of services in specialised institutions;
- Development of the so called "silver economics" for provision of services to elderly persons;
- Improvement of the quality of life of elderly persons, living in specialised institutions;
- Provision of opportunities for recreation, sport, tourism and participation in the cultural life for the elderly;
- Priority development of the training of social workers, specialised in elderly care;
- Promotion of the participation of NGOs in the care and social services provision for the elderly;
- Building-up territorial complexes for the elderly, with the provision of all necessary types of services for sustaining their activity, working skills, health, education, knowledge, communication skills, etc.;
- Development of public-private partnerships in the provision of care for the elderly.

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WHO (2011): Health Expenditure. World Health Statistics, 2011, http://whqlibdoc.who.int/publications/2011/9789241564199_eng_ii.pdf.

3 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R] Pensions

[R5] BULGARIAN CENTER FOR GENDER RESEARCH FOUNDATION, „Проект Стоп на насилието над възрастни жени STOP VI.E.W", retrieved from: http://www.novini.bg/news/35759-%D0%B1%D0%B8%D1%8F%D1%82-%D0%BD%D0%B0%D0%B9-%D0%BC%D0%BD%D0%BE%D0%B3%D0%BE-%D0%BF%D0%BB%D0%BE%D0%B2%D0%B4%D0%B8%D0%B2%D1%87%D0%B0%D0%BD%D0%BA%D0%B8.html

"Stop violence against elderly women STOP VI.E.W"

The project is implemented under the DAPHNE porgrammeme JUST/2009-2010/DAP/AG/0992. The research is focused on studying the violence against elderly women in Bulgaria. Data shows that in the past few years there is an increase in number of elderly victims of domestic violence. People 65+ are between 8 and 10% of all victims of domestic violence. Between 6 and 9% of complaints filed in the police concern violence against elderly women. Trends show that cases of women 70+ victims to mental and physical violence from children and grand children are becoming more frequent. This violence is mostly related to property disputes, division of property, fighting for heritage, etc. The social and economic environment in the country, the unemployment and financial instability are factors provoking the outburst of violence in all its forms – physical, mental, emotional, financial and sexual.

[R1; R2; R3] HIROSE, Kenichi [EDI], "Pension Reform in Central and Eastern Europe in times of crisis, austerity and beyond", ILO 2011, Geneva, 338p

http://www.ilo.org/wcmsp5/groups/public/---europe/---ro-geneva/---sro-budapest/documents/publication/wcms_171551.pdf

This book is organised in two parts. Part I reviews the recent trends in pension reform in Central and Eastern Europe and discusses the key issues related to pension reform in general, focusing in particular on the future direction of pension reforms in Central and Eastern Europe. Technical and statistical annexes supplement Part I with explanations of technical issues and detailed actuarial and statistical analyses. Part II comprises the case studies of Bulgaria, Croatia, the Czech Republic, Hungary, Poland, Romania, the Slovak Republic and Slovenia. These national reports review the performance of the current pension systems, in particular during the global economic crisis, outline recent reform experiences, and highlight the long-term challenges facing these countries. In addition to the issues of benefit adequacy

and financial sustainability, particular attention is given to the problems associated with undeclared work and the importance of social dialogue in the process of pension reform.

[R2] HRISTOZKOV, Yordan, „Реформите в социалното осигуряване (предизвикателства и решения)“, publication of VUZF University, page 420, ISBN 978-954-8590-11-2

The monograph discusses the major theoretical issues and principles of social insurance and its market and reviews the reforms in Bulgaria, carried out since the early 90-ies. This is used as basis to analyse the various solutions in the field of social insurance policy and to make proposals for its improvement. The document also discusses how far certain political actions take into account the established and working best practices in other countries, as well as important EU documents. Together with the main terms and principles of the social insurance market, the monograph reviews the modern challenges before this new industry from the non-banking sector and gives proposals for its development.

[R4] METROPOLITAN MUNICIPAL COUNCIL, „Стратегия за развитие на социалните услуги за хора от третата възраст в град София 2010 – 2013 г.”, retrieved from: http://sofiacouncil.bg/?page=ordinance&id=123

“Strategy for development of social services for people in the third age in Sofia 2010-2013”

The strategy is based on the vision of fulfilling life for the people 65+ in the community, accounting for their dignity and right to choose. The protection of dignity and improving the quality of life of the people in third age in the capital city can be achieved through the provision of quality, accessible and effective social services, taking into account the needs of people and the community. The document formulates clear and realistic goals, whose achievement will contribute to the improved quality of life of elderly, prevention of social exclusion and achievement of social cohesion. The prevailing number of people in the third age in Bulgaria are in need of adequate health care and income. To that effect, linking the care for elderly with integrated services for their overall support would be most efficient, effective and comprehensive solution.

[R1] NATIONAL STATITISTICAL INSTITUTE, “Преброяване на населението и жилищния фонд, 1-28 февруари 2011”, retrieved from: http://censusresults.nsi.bg/Census/

“Census of population and housing, 1-28 February 2011”

As of 1 February 2011 Bulgaria’s population is 7,364,570. Women are 3,777,999 (51.3%). Men are 3,586,571 (48.7%). People above working age (women 60+ and men 63+) are 1,747,717 (23.7%). Out of these men are 648,031 (18.1% of all men) and women 1,099,686 (29.1% of all women). Bulgarian citizens in the age 65+ are 1,361,397. Out of these economically active are only 46,943, i.e. 3.4%.

[R2] SHOPOV G., IVANOV St., “Provision and financing of social services in the community – international experience, Bulgarian practice and opportunities for change” JEL I38; D69

The aim of this study is to systematise and propose scientific arguments to support Bulgaria’s transition from model to fund social services, based on the principle “money follows the supplier” to the alternative model based on the principle “money follows the client”. Subject of study is the financing of social services in the community. The paper focuses on the consistent extraction of lessons from international experience (The Netherlands, UK) and the Bulgarian practice, and offers possible solution for changing the model for financing social services.

[H] Health

[H3] IANEVA, R., BORISOVA, B., "Position of the patient in the triangle ethics-medical-economics"

http://zdraveonline.com/images/stories/pdf/spisanie%20mm%207-8.pdf

The patient is the axis around which develops the overall activity of the medical team. Of particular importance are the relationship and the relations between doctor and patient. Currently, all national health systems implement policies protecting patients. The introduction of mechanisms to protect the rights of the patient contributes to the greater sensitivity of medical services to the wishes of patients. Economics and politics affect the economical arguments and above all the realisation of ethical principles in practice. Key ethical concepts in determining priorities in health are equality, fairness and honesty. The market in medicine helps create both a public need for innovation and professional aspiration among doctors who want to do the best for their patients. By its very nature the market primarily to meet individual needs, desires and preferences, and not necessarily those of the public good.

[H4] KATZAROV, Vasko, "Strategic improvisation - the new alternative in hospital management." **http://zdraveonline.com/images/stories/pdf/spisanie%20mm%207-8.pdf**

Due to the unpredictability of today's global economy, strategic improvisation is more desirable real-time alternative of the fixed in advance (dogmatic planned) strategic thinking. For the first time in Bulgaria is justified and applied the model of real-time planning (strategic improvisation) in the practice of the Fifth

Municipal Hospital in Sofia. The author discusses the outstanding issues and make relevant conclusions for management activities.

[H1] KOMITOV, G., GENEV, Str., "Financing of hospital care."

http://zdraveonline.com/images/stories/pdf/spisanie%20mm%207-8.pdf

The article outlines new approaches for financing the health care system as key areas in modern health care reforms. The authors develop and present conceptual model of financing of the hospital care. A detailed overview is made for all components of the financing system in Bulgaria. The emphasis is on public reporting and analysis of the health effects of resource spent by an irrevocable, binding and socially significant element of this system. Principal scheme is presented for structuring the DRG - system and its definitions of basic concepts and elements. A review and presents the main characteristics of other systems classify patients.

[H2] NINOV, Dimitar, "Healthcare system in Bulgaria – unsolved problems, heir main reasons and possible decisions"

www.union-econ.com/includes/download.php?id=168

This article presents the main unsolved problems in the Bulgarian health care system in the last 20 years. The author proposed the analyses of the legislation and decision making in the management of the system. The author makes some recommendation for alternative solution for the future

[H2] SALCHEV P., GEORGIEVA L, HRISTOV N., KUDNURDJIEV J., DIMITROVA D., "Primary Health Care in Bulgaria – Facts and Analyses" Open society Institute, Sofia, 2011, *ISBN 978-954-2933-12-0*

Despite the hardships and mistrust which accompanied the introduction of the general practitioner (GP) as a key figure in the national health service from 2000 on, this model started to function and was accepted by both physicians and society. Unfortunately, in recent

years the academic community did not perform any studies (save for a few sociological studies on patient satisfaction) on the efficiency and quality of functioning of the new model. This was the challenge to our collective – to collect and analyse the available data on GP activities in the country and assess what is achieved so far. Based on the available data from NHIF our collective focused on presenting a momentous picture of the organisation, functions, activities and efficiency of primary health care, provided by GPs in Bulgaria. The year 2009 was chosen due to the following considerations – available comprehensive data, a sufficiently long period after the onset of the reforms and stabilisation of the system, accumulated experience in the analysis of the system, etc. The following monograph is arranged in the following manner: Presented first is a general description of the socio-economical and political state of the country, as well as the health status of the population for the respective year and a brief depiction of the national health system of Bulgaria. The second chapter presents the legal frame and organisational forms of primary health care, the basic package of delivered health services and the payment mechanisms for GPs. The next chapter presents and analyses the state of funding, manpower availability, and performed activities by GPs. The last chapter presents the results of the application of a specific model for efficiency assessment of GP activities, where as main units of comparison we used the administrative regions.

[H3] VEKOV, T., "Factors of excess hospitalisation and induced demand for hospital medical services in Bulgaria."

http://zdraveonline.com/images/stories/pdf/spisanie%20mm%207-8.pdf

Changing the management & financing system in the Bulgarian health care after 2000 led to many new problems in organisation and management of medical activities. A particular problem was over-hospitalisation. For a period of ten years the cost of hospital services grew six times while GDP grew in real expression only by 47%. The main reasons for this are induced demand for hospital services, inefficiency of the system for targeting treatment of chronic diseases in hospitals for acute diseases, mistrust of patients to outpatient care, low efficiency of primary health care, inadequate supervision and regulation by the NHIF. Wrong health policy and weak hospital management led to consumerist attitudes in health care that works more for medical doctors but less for patients.

[H1] VEKOV, T., "Medical doctors' opinion of the health care reforms in Bulgaria"

http://www.pro-brook.com/images/pdfs/journal%20vol45.1%20lowres.pdf#page=11

At the time of the ongoing organisational changes in health care, the medical professionals' opinions regarding the reforms are the most critical since, as medical professionals, they are the main participants in the health care reforms. In this article the opinion of 1,015 medical doctors is given regarding their awareness of the aims and essence of the reform, their level of preparedness and willingness to support and implement the process, their perception of patient-doctor relationships and public health system change, the financial resources, payment of medical work and the overall satisfaction with the reform.

[H6] VEKOV, T., Study of the economic results of pharmaceutical policy on cancer in 2011.

http://www.medun.acad.bg/cmb_htm/CML_Journals_Fulltext/med-4-2011.pdf#page=53

The article discusses results of the change (at the end of 2010) made by the decision of the Ministry of Health (letter 91-00-229/23.12.2010 to directors of hospitals) in the way of negotiation, supply and use of medicinal products intended to treat cancer (regulation by Decree № 34/25.11.2005). Provided is a comparative cost analysis. A warrant disturbing fact to note is that due to implementation of changes all the controls to ensure effectiveness are

removed – limited drug quantities consistent with the budget, reference price (based on the lower price of eight reference countries and the price of the previously negotiated and legislated specification products through Ordinance № 34/25.11.2005). As a result of the reforms on oncology anticancer drug prices increased by an average of 68.64%. Direct consequence of the increased prices is the increased value of the same quantities of medication in 2011 compared to 2010 by approximately BGN 12.5 million (16.17%). It should be noted that for the increase of prices in 2011 there are some additional factors as the inclusion of new proprietary and expensive products to the specifications of the hospitals, as well as mostly overall replacement in therapeutic protocols with similar proprietary therapeutic products from the same pharmaceutical manufacturers, whose prices are much higher..

[H5] VEKOV, T, Medical doctor's qualification – a problem or advantage of the health care reform in Bulgaria.

http://www.medun.acad.bg/cmb_htm/CML_Journals_Fulltext/obshta-medicina-1-2010.pdf#page=25

The article presents the results of a study of the correspondance between medical doctor's qualification and quality of medical practice. The author used an anonymous questionnaire containing therapeutic questions related to the requirements of medical standards and pharmacological questions related to the application of certain medicines among 550 medical doctors. The study has confirmed the author's hypothesis that medical doctor's qualification in Bulgaria is low and results in poor quality of hospital and outpatient medical care, lacking control on chronic diseases, excess number of hospitalisations and high invalidisation and mortality levels.

[H5] VEKOV T. at al. "Induced demand for hospital services in bulgaria - trends and contributing factor".

http://journal.managementinhealth.com/index.php/rms/article/viewfile/207/598

Background. Changing the management and financing in Bulgarian health care system after 2000 led to many new problems in organisation and management of medical activities, especially in hospital care, after the adoption of the Health Care Establishments Act in 1999. Serious problems in hospital care occurred in relation to the induced demands for hospital services which contribute to over-hospitalisation and over-expenditures.

The aim of this paper is to explore the trends of hospitalisation and to analyse the main determining factors for over-hospitalisation.

Methods. The analysis is based on the Annual financial reports of the National Health Insurance Fund (NHIF) in Bulgaria, the Annuals of Public Health Statistics published by the National Centre of Health Informatics, and corresponding data for European countries the European Health for All Database for the period 2000-2009.

Results. For a period of ten years, the expenditures for hospital services have increased by 390% while the GDP has grown in real terms only by 47%. The number of hospital admissions since 2004 to 2009 has increased more than twice (from 738 978 to 1 769 230). The critical point of increase was observed between 2005 and 2006 when all the financing of hospital services was totally undertaken by the NHIF.

Conclusion. The main reasons for the enormous increase in hospital admissions have been mainly related to the increased induced demands for hospital services, ineffective referrals and treatment of chronic diseases in hospitals for acute diseases, patients' mistrust to outpatient care, low efficiency of primary health care, inadequate supervision and regulation

by the National Health Insurance Fund. Improper and ineffective health policy and hospital management led to consumerist attitudes in health care that contribute more to health care providers than to the patients in need.

[**H5]** ZLATANOVA, R., BOJILOVA, M., ZLATANOVA, T., "Accreditation of medical laboratories – quality assurance"

http://zdraveonline.com/images/stories/pdf/spisanie_mm_br_2_2011.pdf

The accreditation of the medical laboratories in Bulgaria is a upcoming problem. As a member of the Union Europe our country must no lag behind the development trends in the clinical laboratories. The article addresses the need for accreditation to the BS EN ISO 15189:2007 "Medical Laboratories specific requirements on the quality and competence" standard as a guarantee to achieve better results and quality in laboratory activities. Also presents the main source of errors in the laboratory research and highlights the fact that the human factor has a major role at every stage of research and it's a potential source of errors. For these reason the personnel management is an important requirement and element and of the standard.

[H2] ZLATANOVA, T., ZLATANOVA-VELIKOVA. R., "Assessment of communication gps skills from patients."

http://zdraveonline.com/images/stories/pdf/spisanie%20mm%207-8.pdf

In advanced countries, communication skills are an integral component of training of GPs. In this study, we conducted a questionnaire survey among 629 patients in the country in May 2011 to assess the communication skills of their personal physicians to: mood that supports their personal physician in a conversation with them, the attention of GPs during the conversation and how to inform its patients. The data obtained showed that 10.7 percent according to the mood is indifferent, but is pessimistic as 7.5% of participating in the survey patients. According to 10.4% of patients surveyed their personal doctor listen carefully to one degree or another. Therefore, in the training programmes of general practitioners is necessary to emphasise the importance of communication skills and techniques and their timely implementation and application in practice.

4 List of Important Institutions

Асоциация на доброволните здравноосигурителни дружества – Association of Licensed Voluntary Health Insurance Companies

Address: 1000 Sofia, 5 Dondukov Blvd, entr. 1, fl. 3

The Association of Licensed Voluntary Health Insurance Companies (ALVHIC) is a civil nonparty and non-profit organisation. Its goals are to popularise voluntary health insurance and to facilitate the development of the health insurance services market yet abiding by the law, ethical norms and competition rules. The association is open for all other licensed health insurance companies who accept its chart and goals. In the course of its efforts to fulfil its goals the Association looks for opinions, arguments and correctives from all institutions, the legislative authorities, medical practitioners, citizens and employers, in order to develop voluntary health insurance as an important element of a health system that is reforming with difficulties but is very important to the society.

Българска асоциация за закрила на пациентите – Bulgarian Association for Patients' Protection

Address: Sofia, bul. „Patriarh Evtimij“ № 18, fl. 3, ap. 6
email patients_bg@abv.bg

Non profit organisation. Field of activity - improvement of existing health legislation with European standards and practices involved in the preparation and adoption of the Law on Protection of patients in Bulgaria have a qualified legal assistance to citizens on issues related to health, protect the rights and interests of citizens before state authorities and public organisations, reporting the views of patients to assess the quality of health and WHO criteria as an indicator of areas needing improvement, introduction of mechanisms to ensure access of patient organisations to adequate mechanisms for implementation of their rights, the introduction of procedures and mechanisms for conciliation and mediation as part of formal mechanisms and procedures for lodging complaints by the Association in the judicial system, the introduction of independent mechanisms of institutional and other levels to facilitate the process of handling complaints.

Българска асоциация на професионалистите по здравни грижи - Bulgarian association of professionals in health care

Addreess: Sofia 1680, Kazbek Str № 62
Webpage: http://www.nursing-bg.com/

Non profit professional organisation. Bulgarian Association of Professionals in Health Care (BAPHC) is an independent professional non-profit association registered under the law that unites nurses, midwives and associated medical specialists of the Republic of Bulgaria, regardless of their educational level and profession and working in the health system, medical science and education, health services and social, private and public sector in Bulgaria
Association:
Organise seminars and lectures and other events promoting the objectives;

- *Establish contacts with similar organisations at home and abroad;*
- *Hold lectures, discussions, exhibitions, meetings with prominent professionals in the field and exchange of experience;*
- *Made expert and consulting with other organisations;*
- *Attract-known experts from home and abroad to support the activities;*
- *Organise, fund and carry out other activities authorised by law relating to the objectives of the Association;*

Български зъболекарски съюз – Bulgarian Dental Association

Address: 1000 Sofia, 1B Rayko Daskalov Sq.
Webpage: http://www.bzs-srk.bg/en/contacts.php

The Bulgarian Dental Association, named briefly "the Association" or "BgDA", is a professional organisation of the physicians in dental medicine in the Republic of Bulgaria. Its main objectives are:

- *To represent its members, and defend their professional rights and interests;*
- *To represent its members in concluding the National Framework Contract in the obligatory health insurance;*
- *To adopt a Code for Professional Ethics;*
- *To adopt Rules for Good Medical Practice;*
- *To create and keep national and regional registers of its members;*
- *To participate in the Supreme Medical Council at the Ministry of Health;*
- *To submit opinions on draft regulations concerning health care*

Български лекарски съюз – Bulgarian Medical Doctors' Union

Address: 1431 Sofia, Bul. "Academic Ivan Geshov" 15
Webpage: http://www.blsbg.com

The Bulgarian Medical Doctors Union (BMDU) is a professional organisation of medical doctors in the Republic of Bulgaria. BMDU is a successor of the union established in 1901 and follower of its goals, traditions and functions. It is a private legal entity. Its main objectives are:

- *To represent its members, and defend their professional rights and interests;*
- *To represent its members in concluding the National Framework Contract in the obligatory health insurance;*
- *To adopt a Code for Professional Ethics;*
- *To adopt Rules for Good Medical Practice;*
- *To create and keep national and regional registers of its members;*
- *To participate in the Supreme Medical Council at the Ministry of Health;*
- *To submit opinions on draft regulations concerning health care.*

Съюз на фармацевтите в България – Bulgarian Pharmaceutical Union

Address: 1421 Sofia, 115 Arsenalski Blvd., floor 2
Webpage: http://bphu.eu/

The Bulgarian Pharamceutical Union (BPU) was established at the foundation congress of the professional organisation of pharmacists in Bulgaria, which was held on 10 February 2007 in Sofia. BPU was established as the sole legally represented professional organisation, uniting all pharmacists in Bulgaria. The membership of the BPU is a necessary and mandatory condition in order to exercise the profession of a pharmacist. Presently the BPU counts over 5,000 members. The main tasks of the BPU are:
Establishment of a strong professional organisation which unites all pharmacists in Bulgaria;
Protection of professional rights and interests of its members, regulation of relations among the members, as well as with external institutions and organisations;
Introduction of a new system for training and upgrading all Bulgarian pharmacists;
Annual event "Bulgarian Pharmaceutical Days".

Международен институт по здравеопазване и здравно осигуряване – International Health Care and Health Insurance Institute

Address: Sofia, 57 Tsar Simeon Street
Webpage: http://www.zdrave.net/

IHHII is a non-governmental not-for-profit organisation established in 2002, which studies the processes in health care, organises and provides the largest health portal in Bulgaria, presents and comments on novelties in health care, supports NGOs and patients in their contacts with the health system, provides training to medical specialists on issues related to management, health care policies and organisation of health care, implements international projects and plays the role of a corrective of the state institutions.

Министерство на здравеопазването – Ministry of Health

Address: 1000 Sofia, 5 Sv. Nedelya Sq.

Webpage: http://www.mh.government.bg/Default.aspx?lang=bg-BG

The Ministry of Health is a legal entity financed by the state budget. The Minister for Health is a central sole body of the executive power. The Minister is, amongst others, in charge of:
Implementation of the state policy in health care;
Developing and controlling the implementation of the national health strategy;

Министерство на труда и социалната политика – Ministry of Labour and Social Policy

Address: 1051 Sofia, 2 Triaditza Str.

Webpage: http://www.mlsp.government.bg/en/index.htm

The Ministry of Labour and Social Policy (MLSP) is a body including a Council of Ministers for the development, coordination and implementation, as well as the supervision of state policy in the following fields: labour market and vocational training, income and living standard, industrial relations, health and safety at work, social insurance, social assistance. MLSP implements the state policy through its specialised units, namely the Employment Agency, General Labour Inspectorate, Social Assistance Agency and their regional structures, and the Agency for Foreign Aid.

Народно събрание – National Assembly

Address: 1169 Sofia, 2 Narodno sabranie Sq.

Webpage: http://www.parliament.bg

The ideas of a Constitution and Parliament, of electivity and representation emerged even before the restoration of the Bulgarian State in 1878 under the influence of European thinking and practices. The Political Programme of BCPS (former BRCC), which was worked out for the Bulgarian People's Assembly at the end of 1876 and sent to the Istanbul Ambassadors' Conference, emphasised that Bulgarian statehood had to be restored and explicitly stated that: "The Bulgarian State will be governed independently in accordance with a Constitution elaborated by a legislature elected by the people". It further read in the following two articles that "All branches of government will have special laws in the spirit of the Statute and in accordance with the people's needs" and "All foreign nationalities intermingled with the Bulgarian people will enjoy the same political and civil justice". This is not only the historical tradition but also the democratic principle underlying political life in post-Liberation Bulgaria.

Национален център по обществено здраве и анализи - National Center of Public Health and Analyses

Addreess: Sofia, 15 Acad. Ivan Geshov Blvd

email: office@ncpha.government.bg

The National Center of Public Health and Analyses is a structure of the national system of health and exercise activities: public health, health promotion and disease prevention, information security, management of health.
In line with its core activities the prevention and promotion of health, the Center examines health status and its relationship with environmental factors and living conditions; conduct

epidemiological studies and evaluation of risk factors for chronic non-communicable diseases, participating in the development, coordination and implementation of national programmes and action plans, as well as in international research programmes aimed at strengthening the public health / mental health, including, reproductive and sexual /; conduct intervention activities, training seminars and publishes information and methodical materials; assess exposure and public health risk from exposure to biological, chemical and physical hazards in the environment and working environment and in foods such as make appropriate recommendations; monitored diet and nutritional status of the population and develop guidelines for the feeding of certain population groups.
The centre manage, supervise, monitor and coordinate the information activities in health, develops and unify medical statistical records of the health status of population and resources and activities of hospitals, developing mathematical models and forecasts of demographic and health status, and provides operational years of medical statistics and economic information, carries out development of a unified health information system and e-health, develop and implement a system for classification of patients and technology for reporting and payment; maintain classifications, nomenclatures, standards and methodologies, participate in the implementation of statistical activities of the state in collaboration with the National Statistical Institute; maintain, update and publish health information standards, organise, coordinate and monitor development activities e-Health, develops methods and models for planning and resource management for hospitals, develops, implements and maintain national standards for coding in hospitals and monitor the process of coding.
The mission of the National Centre of Public Health and Analysis is to combine these various activities in the interest of better health. All efforts of the Centre professors and associate professors, experts and technical staff are directed towards the application of modern technologies in the field of public health and occupying the leading place in the National Health System.

Национална здравноосигурителна каса – National Health Insurance Fund

Address: 1407 Sofia, 1 Krichim Str.
Webpage: http://www.nhif.bg/eng/default.phtml

The National Health Insurance Fund (NHIF) was founded in March 1999 as an independent public institution separated from the social health care system.
Major principles:

- *Obligatory participation in raising the contributions*
- *Participation of the state, the insured and the employers in the NHIF management*
- *Solidarity of the insured in using the funds raised*
- *Responsibility of the insured for their own health*
- *Equality in the use of medical care*
- *Equality of the medical care providers*
- *Self-government of NHIF*
- *Negotiation between the NHIF and the health care providers*

The insured are free to choose health care providers who have signed a contract with the NHIF
Publicity of the NHIF activities

Национален осигурителен институт – National Social Security Institute

Address: 1303 Sofia, 62-64 Alexander Stamboliiski Blvd.
Webpage: http://www.nssi.bg/en/index.html

The National Social Security Institute (NSSI) is a public institution which guarantees the pension and benefit rights of the citizens, provides quality services and manages efficiently

and transparently the state public social security funds, by the virtue of its obligations, stipulated in law. NSSI plays the role of an active intermediary between the insured, the insurers/employers and the state. It is a carrier of the public relations in the PAYG first pillar and supporter of the functioning of the second pillar of the social security system, ensuring the principle of reliability of the social security through variety. The main NSSI publications are the Year-Book of Social Security in Bulgaria and the NSSI Bulletin.

Сдружение за развитие на българското здравеопазване - Society for Growth of the Bulgarian Health Protection

Addreess: Sofia, j.k. „Suhata reka“, bl. 11, entr. V, fl. 1
email srbz@abv.bg

Objectives: Establishment of public support for development and improvement of the Bulgarian health care, creation of public support for health reform and the creation of public support for development and improvement of health care.

ANNEXES

Annex 1: Legal framework of health care – changes in applicable legal frame by year[43]

Applicable laws	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Laws regulating the national health system														
Act on Health Insurance	2	6	1	1	7	4	6	7	8	8	2	6	12	4
Act on Health								6	9	6	2	7	8	4
Act on Treatment Facilities		3	3	1	2	3	1	5	4	2	1	2	4	2
Act on Medicinal Products in Human Medicine (*prev. – Act on medicines and pharmacies in human* - 1995)				1	1	4	2	6	5		2	5	3	4
Act on Medical Devices										1				2
Act on Narcotic Substances and Pre-cursors			1		3	1		3	3	2	3	4	5	4
Act on the Professional Associations of Physicians and Dentists (prev. – Act on the professional associations of physicians and stomatologists - 1998)							1	2	4		2			
Act on the Professional Association of Master Pharmacists									1	1	2			
Act on the Professional Association of Medical Nurses, Midwives and Associated Medical Specialists								1	3	1	1			
Act on the Transplantation of Organs, Tissues and Cells								1	1			2	1	1
Act on Blood, Blood Donation and Blood Transfusion							1		2	1			2	1
Act on the Budget of NHIF	Adopted annually													
Laws regulating the social system (influencing health care indirectly)														
Codex on Social Insurance		1	3	3	5	6	8	5	12	7	9	8	10	8
Codex on Labour	8	3		1	2	4	1	5	8	6	3	3	7	4
Act on Foods	1					1	1	2	7	2	2	5	5	1
Act on Higher Education		2	3	1	2		2	2	4	2	3	2	6	
Commercial Law	4	6	2		3		3	5	5	4	5	5	2	3
Tax-Insurance Procedural Codex									11	6	3	4	5	2
Act on the Protection of Personal Data					1		2	2	2	1		1	2	3
Act on the Access to Public Information					2			1	3	2	1		1	1
Act on Public Contracts							1	3	4	1	3	2	5	2

Source: Salchev, 2011

[43] http://lex.bg/bg/laws/tree/laws

Annex 2: Financing of the health care system

	Consolidated state budget	2008	2009	2010	2011
1	*2*	*3*	*4*	*5*	*6*
	% of GDP	*4,09%*	*3,84%*	*4,21%*	*4,33%*
	TOTAL SPENDING FUNCTION "HEALTH CARE" (including reserve)	**2 830 811,6**	**2 634 367,2**	**2 947 685,9**	**3 250 896,8**
1.	**NATIONAL HEALTH INSURANCE FUND (including reserve and transfers)**	**1 745 964,6**	**1 750 255,0**	**2 036 341,9**	**2 290 639,6**
1.1.	**NATIONAL HEALTH INSURANCE FUND (not including reserve)**	**1 745 964,6**	**1 750 255,0**	**2 036 341,9**	**2 290 639,6**
1.1.1.	Wages and stipends	20 636,0	21 806,0	21 665,4	21 665,4
1.1.2.	Insurance contributions	4 280,4	4 061,9	3 998,9	4 322,9
1.1.3.	Upkeep	12 201,6	13 779,8	21 687,3	22 863,3
1.1.4.	**Health insurance payments**	**1 705 686,3**	**1 708 615,7**	**1 986 990,3**	**2 234 788,0**
1.1.4.1.	*Hospital*	1 006 798,9	977 587,0	1 143 990,0	1 218 288,0
1.1.4.2.	*Outpatient*	401 935,8	391 227,3	463 000,3	505 500,0
1.1.4.3.	*Pharmaceuticals*	295 480,8	325 598,0	347 000,0	391 000,0
1.1.4.4.	*Other health insurance payments*	1 470,8	14 203,4	33 000,0	120 000,0
1.1.5.	Capital expenditure	3 160,3	1 991,6	2 000,0	7 000,0
2.	**MINISTRIES AND DEPARTMENTS**	**867 414,9**	**648 554,0**	**648 601,0**	**803 262,3**
2.1.	MINISTRY OF HEALTH CARE	698 942,4	524 724,2	563 727,4	705 632,8
2.2.	OTHER MINISTRIES AND DEPARTMENTS	168 472,5	123 829,8	84 873,6	97 629,5
3.	**MUNICIPALITIES**	**207 641,6**	**219 198,1**	**216 318,9**	**133 777,8**
	Subsidies for hospital care	80 731,7	95 572,3	85 360,8	
4.	**CENTRAL REPUBLICAN BUDGET**	**4 023,0**	**4 259,7**	**43 305,9**	**17 913,1**
5.	**OTHERS**	**5 767,5**	**12 100,4**	**3 118,2**	**5 304,0**

Source: MoF, Salchev, 2012

Annex 3: Programme budgeting from Ministry of health

Programme	2010	2011	Difference 2011/2010	2012	Difference 2012/2011
"Health control"	19 779 307	19 890 200	101%	20 922 800	105%
"Prevention of non-communicable diseases"	11 511 180	11 102 900	96%	11 195 800	101%
"Prevention and surveillance of communicable diseases"	32 390 049	80 005 000	247%	59 220 400	74%
"Secondary prevention of diseases"	5 158 736	4 812 400	93%	0	0%
"Reduction in drugs demand"	1 600 302	1 896 000	118%	3 077 200	162%
"Policy on diagnostics and treatment"	342 289 829	0	0%	0	0%
"Outpatient care"	5 625 554	6 593 300	117%	6 508 600	99%
"Hospital care"	129 893 988	163 018 900	126%	183 995 500	113%
"Dispanseries"	4 292 000	0	0%	0	0%
"Emergency care - phone 150"	76 958 042	71 804 500	93%	87 400 000	122%
"Transplantation of tissues, organs and cells"	2 499 781	2 499 800	100%	4 539 800	182%
"Provision of blood and blood components "	10 714 191	11 014 200	103%	13 450 000	122%
"Medico-social care for disadvantaged children "	31 765 085	32 265 100	102%	31 494 000	98%
"Expertise on degree of impairment and permanent disability "	6 249 546	6 649 500	106%	7 454 000	112%
"Haemodialysis"	38 733 281	69 883 300	180%	0	0%
Other medical services	398 361	0	0%	0	0%
"Intensive treatment"	35 160 000	45 000 000	128%	0	0%
Policy on medical products and medical devices	143 831 990	0	0%	0	0%
"Accessible and high quality medical products and devices "	143 831 990	161 633 300	112%	16 126 600	10%
"Administration"	13 533 248	23 931 600	177%	22 800 300	95%
Policy on promotion, prevention and public health control	70 439 574	0	0%	0	0%
Total:	570 094 641	712 000 000	125%	468 185 000	66%

Source: MoH, Salchev

Annex 4: Crude birth rate and natural population growth

Year	Birth rate (per 1,000 people)	Natural increase (per 1,000 people)	The total fertility rate
1990	12.1	-0.4	1.81
1995	8.6	-5.0	1.23
2001	8.6	-5.6	1.24
2005	9.2	-5.4	1.31
2006	9.6	-5.1	1.38
2007	9.8	-5.0	1.42
2008	10.2	-4.3	1.48
2009	10.7	-3.5	1.57
2010	10.0	-4.6	1.49

Source: National Statistical Institute, 2011

Annex 5: Beds in medical establishments for hospital care - 2011. types of beds

	2005	2006	2007	2008	2009	2010
Bulgaria	**49626**	**47719**	**48749**	**49507**	**50041**	**45 906**
Beds for active and intensive care	38024	36539	37480	38016	38506	36 686
Mental beds	5245	5150	5138	5120	5179	2 685
Beds for long term care	1372	1093	991	988	871	1196
Other beds	4985	4937	5140	5383	5485	5339

1 In accordance with that used by Eurostat statistical group

Source: NSI, NCHI, 2011

Annex 6: Activities of the Inpatient Wards of the Hospital Health Care Facilities (2010)

Types of establishments	***Bed days***	***Utilisation of beds*** *(days)*	***Turnover of beds***	***Average length of stay*** *(days)*	***Hospital mortality*** *(%)*
health care establishments for hospital care – total	**11287817**	**267**	**43**	**6.2**	**1.3**
Multiprofile hospitals Multiprofile hospital for active treatment	**7508305**	**277**	**47**	**5.9**	**1.7**
Specialised hospitals	**2080978**	**269**	**35**	**7.7**	**0.5**
Specialised hospital for active treatment	958571	276	46	6.0	0.7
Specialised hospital for continuing and long term treatment	127498	317	33	9.5	0.1
Specialised hospital for continuing, long term treatment and rehabilitation	216035	271	25	10.8	0.7
Specialised hospital for rehabilitation	778874	255	26	9.8	0.0
Psychiatric hospitals	**771326**	**287**	**5**	**60.9**	**0.9**
Private facilities for hospital care	**927208**	**191**	**53**	**3.6**	**0.3**
Prophylactic centers (dispanseries)	**1211667**	**294**	**32**	**9.1**	**0.6**
For pulmonary diseases	180374	239	22	11.0	1.0
For dermato-venerological diseases	53200	244	28	8.8	0.0
For oncological diseases	528885	327	57	5.8	0.7
For psychiatric diseases	449208	294	13	22.9	0.2

Source: NHCHI, 2011

Annex 7: Projects in ministry of health funded by EU

Project Number	Description	Resorces
BG051PO001-5.2.10-0001	DIRECTION: family" procedure for the direct provision of grants BG051PO001-5.2.10 "Chance of a happy future," Component 1: "Preparation for restructuring Children homes" is implemented under the Operational Programme "Human Resources Development 2007-2013", Priority axis 5 "Social inclusion and promotion of social economy" area of intervention 5.2 "Social services for the prevention of social exclusion and overcoming its consequences –	1 972 503.62 BGN and financed by the European Social Fund (ESF) of the European Union
BG051RO001-2.6.08	'BASIC – base for health information system" - financed by the Operational Programme" Human Resources Development 2007-2013 ", Priority Axis 6" Increasing the effectiveness of the institutions of the labour market, social and health services" area of intervention 6.2 "Strengthening the capacity of institutions for social inclusion and provision of health services." The project duration is 27 months and is expected to be completed by October 2013.	The total budget is 9 729 833, 85 BGN
BG051RO001 -6.2.04	"FLY" (Continuing education of physicians through effective technology) is funded under the Operational Programme "Human Resources Development 2007-2013", Priority Axis 6 "Increasing the effectiveness of the institutions of the labor market, social and health services" area of intervention 6.2 "Strengthening the capacity of institutions for social inclusion and provision of health services". The project duration is 40 months and launched in August 2011.	The total budget is 9 999 977, 13 BGN
BG051RO001-3.5.02-001-S0001	"Stop and go through" (National Campaign for early diagnosis of cancer) is within the Operational Programme "Human Resources Development 2007-2014". The project duration is 53 months and was launched on May 21, 2009. It is planned to end on October 21, 2013.	The total budget is 19 558 281.73 BGN
BG051PO001-6.2.03	"Accreditation of hospitals and the continued training of medical staff" is financed by the Operational Programme "Human Resources Development 2007-2013", Priority Axis 6 "Increasing the effectiveness of the institutions of the labor market, social and health services" , area of intervention 6.2 "Strengthening the capacity of institutions for social inclusion and provision of health services." The project duration is 53 months and was launched on July 10, 2009. Anticipated to be completed by 10 December, 2013.	The total budget for 3 312 536.26 BGN
BG051PO001-5.3.01	"Informed and healthy" is implemented under the Operational Programme "Human Resources Development 2007-2013", Priority Axis 5 "Social inclusion and promotion of social economy" area of intervention 5.3. "Employability through better health."	The total project cost is 4 692 754.30 BGN
BG051RO001 6:02:02	PULSS (Practical introduction to the treatment of emergency conditions) is within the Operational Programme "Human Resources Development 2007-2014." The project started on July 10, 2009 and lasts 53 months	The total project cost is 6 258 653. 64 BGN
BG161PO001/4.1-05/2010	"Support for reconstruction / renovation and equipment of municipal hospitals in municipalities outside the urban agglomerations." - 13 hospitals, 8 Children homes equipment for laboratories, provision of defibrillators, ultrasonic equipmen	148 000 000 BGN

Source: MoH, Salchev, 2012

Annex 8: Projects in area of long term care funded by EU

Project Name	Description	Resorces
Project "New opportunities	Priority 5, area of intervention 5.1. "Support for social economics" . the project is aimed at supporting municipalities in providing occupation and activity for persons from groups at risk.	Total value of the project 30 000 000 BGN
Project "Chance for all"	Priority 5, area of intervention 5.1. "Support for social economics". Social inclusion for persons with impairments – through offering of training and acquiring professional qualification for persons with impairments.	Financing – 20 000 000 BGN
Project "Life in the community".	Priority 5, area of intervention 5.2. "Social services for the prevention of social inclusion and overcoming its consequences". It is directed towards children, accommodated in homes for children without parental care, children in homes for children with physical impairments, and persons who do not have the alternative to stay in home environment or use municipal services.	Financing – 29 275 075 BGN
Project "Empathy".	Priority 5, area of intervention 5.3. "Ability to work through better health". To establish preconditions for active social inclusion of persons with impairments as one of the most socially vulnerable groups in society through raising their awareness and change in public attitudes.	Financing – 10 000 000 BGN.
Project "Chance for a happy future".	Priority 5, area of intervention 5.2. "Social services for the prevention of social exclusion and overcoming its consequences". Component 1. Restructuring of homes for medico-social care – deinstitutionalisation of children aged 0-3.	Financing 500 000 BGN.
Project "Accept me".	Priority 5, area of intervention 5.2. "Social services for the prevention of social exclusion and overcoming its consequences". Realisation of a model for sustainable replacement family environment for children accommodated into specialised institutions	Project "New opportunities"..

Source: Ministry of Labor and Social Policy, Salchev, 2012

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(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
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