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on the Socio-Economic Impact
of Social Protection Reforms

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Pensions, Health Care and Long-term Care

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Authors: Ivan Neykov (pensions) and Petko Salchev (health and long-term care)

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1 Executive Summary

The long-lasting debate on the second stage of the pension reform in Bulgaria is over. Several legislative amendments were adopted and will be gradually implemented between 2011 and 2016. The main purpose of these amendments is to reduce the deficit of the PAYG pillar and guarantee its financial sustainability.

One of the major shortcomings of these actions is the "turning back" to the pension adequacy issue. This issue was formally part of the debate's agenda but was not actually reflected in the adopted legislative measures.

There was practically no thorough discussion regarding the sense and meaning of the extension of working life. Instead of implementing effectively the existing regulations on early retirement options, the legislative amendments retained and extended these options.

The Government's assessment as to the successful implementation of the second stage of the pension reform contradicts with experts' analyses, which state that the actions are insufficient, and there is a great probability that the adopted measures will fail to achieve the expected outcomes.

The social and political changes that have taken place in Bulgaria since 1989 have had a great impact on the health system. The previous "Semashko" model was based on the principles of universal coverage and free access to health services[1].

Major reforms began in 1989 and by the mid-1990s they had transformed the centralised, tax-based system into a decentralised and pluralistic compulsory health insurance system, with employee contributions and contractual relationships between the National Health Insurance Fund (NHIF) as a purchaser of services and health care providers. The NHIF acts as a single agency providing most of the funding. Through its 28 regional bodies (the regional health insurance funds), it finances the entire health care network for outpatient care, and since July 2000, it also finances hospitals. Private insurers provide an alternative means of funding health care as well as for those drugs and treatments that are excluded from the basic health insurance package.

As gains in basic health care increase life expectancy, more people live past the age of 65, a time when the risk of dementia and other degenerative diseases is higher and people are more likely to require long-term care (LTC) services. Whether at home or in an institution, such care is an important way to protect the lives and dignity of a country's elderly citizens.

Bulgaria's LTC and social service system for the elderly has grown significantly in the past few years thanks to recent reforms aimed at deinstitutionalisation and providing more community and home-based services. Yet the country's National Report on Strategies for Social Protection and Social Inclusion 2008-2010[2] states that "there is no long-term approach for establishing an adequate system for LTC" to match demographic forecasts.

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[1] The system was centrally planned and run, financed from taxes and characterised by almost complete state ownership of treatment facilities. It is also notable that there was an absence of a private health care sector (as private medical practice was forbidden) and that all professionals in the health system had the status of salaried civil servants. The system was curative in orientation, reliyng on inpatient care with hospitals dominating the delivery system. Informal payments by patients for health care services and medicines were common, although not officially sanctioned by the authorities. All this led to mismanagement in health services delivery and therefore required radical reforms.

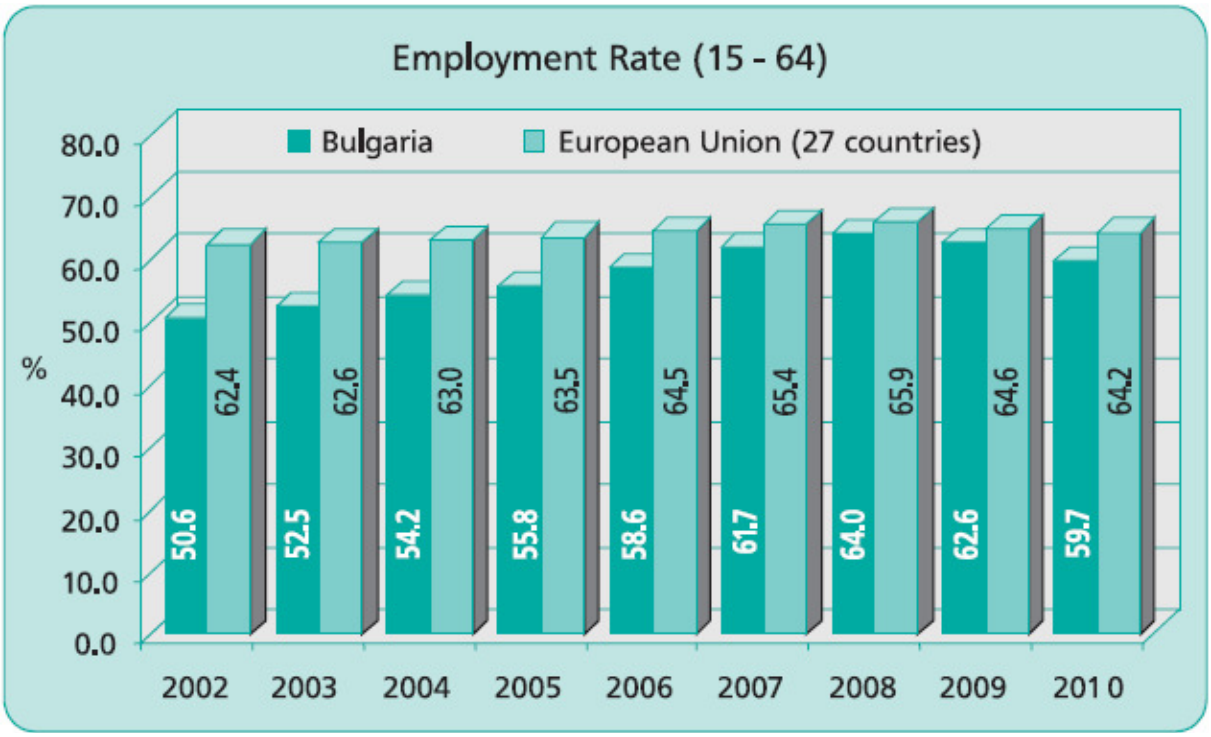
[2] Ministry of Labour and Social Policy. National Report on Strategies for Social Protection and Social Inclusion 2008-2010. Sofia, 2010. http://www.mlsp.government.bg/en/docs/index.htm.

2 Current Status, Reforms and the Political and Scientific Discourse during the previous Year (2010 until May 2011)

2.1 Overarching developments

The economic crisis in the country in 2010 made its logical impact on the labour market. The reported decline in employment of people of 15 and more years of age in 2010 is almost double compared to 2009. In the first quarter of 2010, the employment rate declined dramatically compared to the same period in 2009 (by 251,500). The following quarters of 2010 showed a gradual increase of employed, thus marking a decline in the fourth quarter of 2010 compared to the respective quarter of 2009 that is significantly lower (by 147,900 people). As a results of the economic crisis the number of employed declined and their average annual number dropped to and below the level of the year 2006, i.e. to 3,052,800 people, which is 200,800 people (6.2%) less than 2009. The employment rate dropped by 2.7 percentage points compared to the previous year to a level of 46.7%. In comparison to other European Union countries it would be worth noting the employment rate for the age group 15 to 64. In 2010, this level was 59.7% in Bulgaria, also declining by 2.9 percentage points on an annual basis. Based on latest Eurostat data for 2010, the employment rate among the population between 15 and 64 years of age in the EU27 is 64.2% (compared to 64.6% in 2009).

Figure 1: Employment rate in Bulgaria and the European Union



Source: http://www.az.government.bg/Analyses/Anapro/2010/year/Godishnik_2010_bul.pdf

2.2 Pensions

2.2.1 The system's characteristics and reforms

In 1999, Bulgaria started a large-scale pension reform, radically changing the philosophy of the pension model. It was transformed from a single pillar to a three pillar pension system, consisting of:

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[3], 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 main aim of the reform was to improve the overall level of pension protection in order to provide the pensioners with a better standard of living.

The reform aimed at achieving also the following objectives:

- Stabilise the finances of the system in the medium and long run;
- Achieve 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.

Nearly 10 years after the reform started, the analysis shows that most of the above objectives were fully or partially fulfilled.

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

Following a long-lasting debate that began in the autumn of 2009 and continued almost until the end of 2010, involving social partners and all stakeholders, and having made thorough financial and actuarial analyses, some tough decisions were taken with serious implications for the Bulgarian society 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 (promulgated SG, issue 100, dated 21 December 2010) established as of 1 January 2011 the legal framework for the enhancement of the pension model and introduced some short-term and long-term measures aiming at financial sustainability and improvement of the pension adequacy.

[3] 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.

2.2.2 Main amendments of the social insurance legislation introduced in 2011

The main amendments determining the new retirement conditions and stages for their implementation include the following elements:

- As of 1 January 2011, the requirements for pension entitlement were amended, abolishing the so-called "scoring system", which used to allow more flexibility for pension entitlements by combining age with contributory years. When the "scoring system" was in force, the insured were able to retire once they had collected a "score", comprising the contributory years plus the age (men needed a score of at least 100 points and women of at least 94 points). Thus, persons with more contributory years were able to retire earlier.
- As of 1 January 2011, the pension entitlement was changed. According to the amendment the entitlement for old-age pension is attained at 60 years of age for women and 63 years of age for men and after a length of service of 34 years for women and 37 years for men respectively;
- As of 1 January 2012, the required contributory years for workers of the third category will increase by four months each year until reaching 37 years for women and 40 years for men in 2020; the third category of work includes all works and activities that are not included in the first and second category as explained above. These involve normal tension and normal working conditions.
- As of 1 January 2021, the retirement age for women and men will start increasing by six months each year until reaching 63 years of age for women (2026) and 65 years of age for men (2024).
- If persons do not have the required contributory years they shall be entitled to a pension when reaching the age of 65 (both women and men) and no less than 15 effective contributory years. As of 21 January 2021, for such persons the pension entitlement age will start to increase on the first day of each calendar year by six months, until reaching 67 years of age;
- The early retirement period for workers of the first and second category will be extended to 31 December 2014;
- Retirement conditions for workers from the above categories will not change before 31 December 2014;
- As of 1 January 2015, early retirement pensions for first and second category workers will be paid only by occupational pension funds;

As of 1 January 2014, the ceiling of newly granted pensions will be removed and the ceiling for previously granted pensions will be raised. The currently effective ceiling is equal to approximately five times the minimum pension (BGN 136 BGN or approximately EUR 70). When the pension is determined at an amount higher than the ceiling, the excess amount is not paid to the pensioner;

- As of 1 January 2017, for the determination of the amount of pensions based on employment the weight of each contributory year will increase from 1.1% to 1.2% using a formula established in the law.
- As of 1 January 2017, the contribution payable by both the employer and the employee to universal pension funds will increase by two percentage points from 5% to 7%;

- As of 1 January 2011, the contribution payable to the pension fund (PAYG) by the employer and the employee (at a ratio of 60 by 40) has increased by 1.8%;
- As of 1 January 2011, the periods used for calculation for temporary disability, pregnancy and birth, and unemployment have changed as follows:
    - 18 months for pregnancy and birth benefits;
    - 18 months for unemployment benefits;
    - 12 months for general disease and job readjustment benefits.
- As of 1 January 2011, the conditions for purchasing contributory years required for pension entitlement have changed. The option for purchasing up to five lacking contributory years remains unchanged.
- As of 1 January 2012, the National Social Insurance Institute will cease paying the social old-age pensions and social disability pensions, since these benefits are not linked to social insurance contributions. These must be paid out of state budget funds by non-insurance institutions (e.g. the Social Assistance Agency).

Despite the two to three hardship years for the funded pension funds, data of the Financial Supervision Commission show that the trust of insured has been retained. In December 2009, the number of insured in voluntary pension funds was 598,336 persons and in December 2010 597,968 persons. Occupational pension funds in December 2009 accounted for 226,929 persons, and in December 2010 for 234,280 persons. As of December 2009, the social insurance contributions collected by universal pension funds amounted to some BGN 620 million, and a year later to more than BGN 639 million.

According to the Financial Supervision Commission 3,861,468 persons are insured with 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; that is a growth of 2.6% compared to 31 March 2010. The accumulated net assets within the supplementary pension insurance system as of 31 March 2011 amount to BGN 4.1bn, marking a growth of 24.52% compared to the first quarter of 2010.

Table 1: Factors and effects of the pension reform in Bulgaria

	1999	2010	2020
Pensioners	2.4m	2.1m	2.4m
Employed	2.6m	2.9m	2.8m
Revenues	BGN 1.8+0.2 billion	BGN 5+1.7 billion	-
Expenditures	BGN 2 billion	BGN 6.7 billion	-
Contributions	33%	16%	-
Replacement rate	30%	44%	-

Sources: NSSI annual budgets and BILSP forecasts.

2.2.3 Debates and political discourse

The second stage of the pension reform caused a broad national debate among the Government, the Parliament, social partners, representatives of academia, independent experts, media, and NGOs. Yet, there was no comprehensive discussion about the sense and meaning of the extended working life. Most of the people were left with the impression that the changes of the pension model are mainly due to the crisis. The real debate related to the

guaranteed minimum pension income was also postponed to the unforeseeable future. It was replaced by the notion of reduction and overcoming the deficit of the PAYG pillar.

The topic regarding the improvement of adequacy of pensions was formally included in the debate's agenda but was not actually reflected in the legislative measures.

According to the employers' organisations the mistakes are still being repeated. Some of the main risks according to the employers are the early retirement and the prevalence of PAYG over the funded pillar.

Some of the recommendations to overcome the shortages were spelled out by the employers long ago, but so far not supported by the state or the other social partners, i.e. trade unions. Among those recommendations are: the state should be treated equally with other employers; state employees should pay their own contributions; the ratio of contributions between the employer and the employee should be made equal, i.e. 50:50 instead of the currently applied 40:60 ratio.

2.2.4 Impact of EU social policies on the national level

Major deficits in various social spheres, as well as the subsequent effects of the crisis were practically not taken into account during the preliminary social and economic assessment of the situation. The second stage of the pension reform in Bulgaria implemented in 2009-2010 is practically based on the accumulated internal financial deformations of the system. The legislative measures are not based on the EU2020 strategy for smart, sustainable and inclusive growth and do not reflect the trends as specified in the Green Paper "Towards adequate, sustainable and safe European pension systems". The analyses show that the EU2020 strategy did not actually have an impact on the pension reform debates.

In view of the above, there are serious arguments to conclude that there is a significant risk that the implemented measures, changing only isolated elements of the PAYG insurance system, will have a short-term effect and fail to achieve the set medium and long-term objectives.

It is worth mentioning that a new conflict emerged because of the automatic accession of Bulgaria to the Euro-Plus Pact, announced by the Government. CITUB, the largest Bulgarian trade union, is of the opinion that such a move may lead to retaining the income levels as they are and to a breach of the agreed pension reform. According to the trade unions the Pact requires from those countries which want to join the Euro to restrict pension indexation as well as abdandon early retirement schemes after 2013. Another recommdenation of the Euro Pact Plus is to increase the retirement age in proportion with life expectancy. Meanwhile the Bulgarian trade unions and the Government agreed to start eliminating the early retirement schemes only after 2014.. The trade unions insist that the Government discuss with the social partners the effects of Bulgaria's participation in the new European scheme.

According to the Ministry of Finance, the improvement of the business environment and the efficiency of public expenditures by 2015 are the main economic priorities of Bulgaria, as stated in the NRP, and following the guidelines of EU2020. Further to that, the national goals include achieving a 76% employment rate by 2020 and investments in research and development of 1.5% of GDP. By 2020, the renewable energy sources as part of the gross end consumption of energy should reach 1.5% of GDP and energy efficiency should increase by 25%. During the next ten years the number of people living in poverty should decrease by 260,000 persons. The share of youths who drop out of school shall be limited to 11%, and the share of persons with university education in the age group 30-34 should reach 36% by 2020. Some of the other more important priorities are the investments in road and environmental

infrastructure, expected to result in accelerated economic growth in the mid term. The Bulgarian NRP reflects the recommendations of the Annual Growth Survey of the EC. It specifies as main priority of the economic policy the fiscal consolidation, as well as the labour market stimulation policy and prioritisation of the national reforms. The specific priorities for Bulgaria include a stable financial sector, improvement of the infrastructure, competitive youth, a better business environment, and increasing the trust in government institutions.[4]

2.2.5 Impact assessment

10 years after the pension reform started in 1999, the analysis shows that most of the objectives have been achieved fully or partially.

Unfortunately, one of the most important objectives – the financial stabilisation of the system in the mid and long term has not been achieved. This circumstance in itself is a risk of discrediting the reform. Considering the following facts, the Bulgarian pension system can be evaluated as being financially unstable and strongly depending on the state budget.

Financial instability. The State Social Security Budget Law 2010 provides for a transfer from the state budget in the amount of BGN 2.06 billion to cover the shortage of resources. In comparison to 2000, the transfer was at the amount of BGN 89.6 million. That is an increase by almost 23 times of the shortage in the state social security for a period of 10 years.

Dependency on the state budget. In 2009, the state was involved as "a third insurer", providing a transfer to pensions funds in the amount of 12% of the insurance income of every insured person. In 2010, this transfer was BGN 2.3 billion or 34% of all funds' expenditure for pensions. In case of canceling this transfer from the state budget the pensions would have to be decreased by more than 1/3 for 97% of the pensioners. It is obvious that the revenue from contributions cover less than 2/3 of the expenditure for pensions. The Bulgarian pension system is increasingly transforming from an insurance system into a system financed by taxes, a transformation that is not agreed by society.

The reasons for the worsened financial situation of the first pillar of the pension system have to be examined through the analysis of **two groups of factors**.

One of them relates to wrong decisions that have led to a drastic discrepancy between revenue and expenditure insurance parameters, with hard consequences for the budget of the state social security and the financial viability of the system for years ahead respectively. The decision with the most unfavorable effect on the financial condition of the state social security was the simultaneous implementation of policies restricting revenues (reduction of contributions) and raising expenditures (increase of insurance benefits). Due to the increased number of pension insurees (by 24% compared to 2000) and the increased average insurance income (by 2.2 times in nominal terms compared to 2000) revenues from insurance contributions to pension funds increased by 68.8% compared to 2000. The factor of growth of expenditure for pensions for the same period is 2.1. This deepened the discrepancy between revenues and expenditures of the pension system. The revenues from insurance contributions decreasingly cover the expenditure for pensions (of about 97% in 2000, the share of revenues from pension contributions compared to expenditure for pensions decreased to 63% in 2008). The main consequence is an increasing financial dependency of the state social security on the state budget; thus, the state budget needs proper adaptation to the pension system requirements.

[4] http://www.vesti.bg/index.phtml?tid=40&oid=3709371.

The other group of factors relates to the effects of the global economic crisis that led to the decrease of the insurance basis, i.e. the number of insured people and the insurance income - two parameters that are determining as regards revenues from insurance contributions. Adding to these factors there are also some objective demographic, economic and social problems which influence the financial stability of the pension system:

Decreasing and ageing of population. According to National Statistical Institute estimates until 2050 the population will decrease by more than 1.6 million people. That means a decrease of active-age people and an increase of older people. Presently, 100 people of active age maintain 25 older people; in 2050 this ratio will be 100 to 56;

Low level of economic activity and grey economy. Taken together these circumstances restrict the potential revenue of the insurance system and negatively influence tax revenues.

Still low rates and low adequacy of the pensions. The low living standard of the pensioners will lead to strong public pressure in the future to implement policies to raise pensions, which will not always be economically possible and fairly balanced.

After continued debates which started in autumn 2009 and went on almost to the end of 2010, serious discussions with the social partners and all the stakeholders, comprehensive financial and actuary analyses, the Bulgarian society took difficult decisions to guarantee the financial stability of the pension system and ensure higher pensions for the pensioners.

The amendments to the Social Security Code (State Gazette No.100 of 21 December 2010), enforced on 1 January 2011, provide for a legal framework for the improvement of the pension model and introduce short-term and long-term measures for financial stability and pensions adequacy improvement.

Following the adoption of the above amendments to the social insurance legislation, the debate was practically forced into a "standby mode". The Consultation Council on Pension Reform, established in 2009 to assist the Minister for Labour and Social Policy, was discharged as well. Despite the proposals made by experts to establish a permanent monitoring mechanism and early warning system for the pension reform, such was not created. And problems for sure exist. During this spring the tensions between the Ministry of Finance and the NRA on the one hand, and NSSI on the other hand increased, due to differences in opinion about the planned social insurance revenues and the collectability of social insurance contributions. This resulted in the resignation of the Governor of the National Social Security Institute.

Instead of following the clearly formulated conclusion by the European Commission about the need to reduce early retirement options, the amendments of the effective legislation not only retained but also extended this option. There is lack of targeted incentives for the employers to hire older workers and promote lifelong learning.

2.2.6 Critical assessment of reforms, discussions and research carried out

The changes of the social insurance system in late 2010 took place under the pressure of the financial crisis and the aggravating deficit of the PAYG pillar. Therefore, the claimed purpose of the change was to achieve financial stability of the pension system and improve the adequacy of pensions.

This is definitely insufficient and there is a big chance that the measures will not generate the expected results. We are already witnessing the first signs of that. The Statistical Bulletin of NSI on pensions for the end of 2010 proved the experts' expectations to be true – the number of persons who decided to retire because of the pension reform and the planned harder

retirement conditions increased. By the end of 2010, the number of newly granted old-age and contributory pensions were 11,734 more compared to 2009. Nearly 2,000 more are also the newly granted disability pensions, despite the implemented more stringent control – for 2010, they are 39,500 compared to 37,530 in 2009. The trend of a decreasing number of pensioners since the year 2000 due to the radical increase of requirements for contributory years at that time has stopped. By the end of 2010, there were 2,194,274 pensioners, while as of 31 December 2009 they were 2,189,131, that is more than 5,000 less.

The situation can be improved if Bulgaria applies more foresight to governance decisions, anticipating their repercussions a few decades ahead and, on this basis developes a comprehensive set of measures including not only improvement of the legal framework, but also of many other important social spheres.

Analyses are showing a lack of governance measures in the following areas:

- Labour market – the share of low-paid workers continues to expand. Meanwhile, the national minimum wage (currently BGN 240 or appr. EUR 123) has remained fixed for almost three years now at a level which can hardly be expected to guarantee the minimum standard of living.
- The price of labour – there is no adequate increase of wages, consistent with the economic and social development. At present, there is no reform of the wage payment system (and none is expected to be implemented in the near future) tightly linking the wage and productivity. Currently, the formation of salaries and wages is based on a minimum wage determined by the government, collective labour agreements, and the individual employment agreement between the employer and the employee.
- Demographic situation – the shrinking and ageing population of Bulgaria is the fundamental reason for the challenges faced by the labour market and social insurance system. In that regard, the Bulgarian Economic and Social Council (ESC) is extremely worried about the long-term impact of the demographic problems, which will result in additional fiscal burden. The ESC is convinced that the growth of the fiscal burden due to demographic changes will be much higher, even in mid-term, than the average EU level as specified by the EC. According to the ESC, so far there is no clear evaluation as to the expected load to the public financing resulting from the demographic developments, especially after 2020-2025.
- Societal life is changing and the social insurance system needs to take into account these changes and meet the social realities and needs. This requires an extension of the insured social risks. Such a social risk that remains uncovered by the Bulgarian social insurance system, while there is both logic and need for its coverage, is the **provision of long-term care.** This need stems from the unfavourable population structure with an ageing trend and extended life expectancy, which is accompanied with ill health or disability.

2.3 Health Care

2.3.1 The system's characteristics and reforms

The current organisational structure of the Bulgarian health 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*[5] 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 an annual basis; any providers who do not sign contracts can provide private services on a fee-for-service basis. *Inpatient care* is provided by general and specialised hospitals, dispensaries, nursing homes and hospices, and hospitals providing acute, chronic, long-term care and rehabilitation. Although the health care reforms of the 1990s saw a significant reduction in the number of beds, Bulgaria still has an extensive hospital network throughout the country that provides easy access to inpatient care. However, there is also an excessive and unnecessary use of beds.

The main sources of health system financing are compulsory health insurance (70% of total costs), state (24.7%) and municipality budgets for school health services, children's homes and homes for the elderly (4.1%). Voluntary health insurance (VHI) contributes with less than 1% to health system financing and household expenditure allocated to the system in the form of co-payments, fees for services or out of pocket payments, and external resources allocated from donor organisations and national and international non-governmental organisations (NGOs) amount to less than less than 1%. (MoF, Salchev, 2011; see Annex 4).

The main stakeholders in the Bulgarian health system are the Parliament, the Ministry of Health (MoH), the NHIF, and the Higher Medical Council. 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 practices have expanded significantly, now including dental practices, pharmacies, physician's practices, diagnostic laboratories and outpatient clinics.

In Bulgaria patients rights are defined by the 1998 Health Insurance Act, the 1999 Health Care Treatment Facilities Act, the National Framework Contract, and the 2004 Health Act. These normative documents regulate the rights of citizens within the general health care process, their autonomy, and the right to choose their physicians and health institution.

The new types of primary and outpatient health institutions that were established include the following: single and group practices for primary health care in accordance with the number specified in the National Health Map; single and group practices for specialised medical and dental care; independent medical diagnostic and consultative centres and medical technical laboratories. Every Bulgarian citizen should be covered by the compulsory health insurance scheme 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.

A constantly changing legislation

The leading aspects of Bulgarian health legislation are: 1) Protective: formulation of legal norms defining the rights and obligations of the state, the patients, physicians, treatment facilities, etc.; 2) Preventive: prevention of conflicts between persons and organisations in health care and 3) Organisational: establishment of clear and precise rules, objectives, rights and obligations, organisation of work, cooperation and responsibility of health care actors.

The legal framework 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 140, and the rest – ordinances, instructions, etc. of MoH and NHIF – are over 300.

[5] In accordance with the 1999 Health Care Establishments Act.

Throughout 2010, changes and additions were made in seven out of twelve main laws[6] concerning the national health system. Since 1998, health care had been "repaired" 230 times (or 18 times a year on average), while most of this happened in the last four years (2005-2010). The majority of those "repairs" are topical, i.e. adopted and implemented in one and the same year which raises suspicion of lobbying instead of focusing on strategic decisions.[7]

As a whole, the multiple legal changes, combined with the absence of a vision for reforming the health care sector (even after the adoption of the National health strategy in 2008), is one of the main reasons for the encountered difficulties in managing health care in Bulgaria (the main changes for 2010 are summarised briefly in Annex 3).

Funding

The total budget for health spending in 2010 is 2,947,685 (4.21% of GDP). The planned budget for 2011 is 3,250,896 (4.33% of GDP), 110% as compared to the previous year (Annex 4)

Funds from the Ministry of Health are distributed according to the principle of programme budgeting (Annex 5). The data presented (MoF, MoH, 2011) in the annexes illustrates that despite the economic downturn allocated funds remain in the same limits for MoH and the other spenders – NHIF and several ministries. In its budget the Ministry of Health plans to increase funding in several programmes: "Prevention and surveillance of communicable diseases" (more than twice as much); "Policy on diagnostics and treatment" (with more than 60 million); funding for Haemodialysis will almost double, whereas nor funds are allocated in 2011 for the Programme Policy on promotion, prevention and public health (70 million in 2010).

Government programme

The main goals in the government programme to ensure public health are:

- Provide freedom of choice of health services and their contractors
- Ensure availability of health interventions
- Make prevention a compulsory element in the health care system at all levels
- Development and construction of a modern system for child health
- Build and develop a system for continuous treatment and integrated care for older people with chronic diseases
- Strengthen control of medical services
- Strengthen the role of Bulgarian doctors and other health professionals

[6] The national health system has been constantly changing in the past 10 years and the health insurance system itself is a relatively new social system in Bulgarian public life. Annex 2 presents the most important laws influencing directly and indirectly the national health system, as well as the amendments they underwent over the years.

[7] In 2011, until end of April seven new ordinances related to structural changes, as well as 42 amendments and supplements to regulations, related mainly to medical standards, the basic package of medical services paid by NHIF, accreditation of treatment facilities, medical aid for uninsured foreign citizens, cosmetic products, etc. As many as 68 new ordinances on medical standards in separate medical specialties were adopted. In 2011, 16 new ordinances on requirements to hospital management, harmful emissions norms, treatment facilities accreditations, and on disinfection and deratisation, etc, were adopted. Issued and posted are 40 rules, instructions and orders principally related to structures, centres and agencies of MoH. In 2010, 19 new ordinances were adopted, predominantly on structural changes and activities of structures and agencies of MoH.

2.3.2 Debates and political discourse

Debates about legislation

The main tasks of the national health system are (a) policy and management; (b) raising of funds from mandatory health insurance and the budget; (c) funds management and spending; (d) population health protection. They are institutionally divided, and their implementation is regulated through dedicated legislation. The harmonisation of various acts and regulations is only one of the problems arising in this context. A specialised and independent analytic division is needed to aid the Government, MoH and NHIF in the formulation of strategic decisions.

Another prominent feature of the legal frame is its high dynamics, where frequent changes threaten the stability and sustainability of the health system. Risks stem from (a) the many changes which follow amendments or additions to the legal framework, (b) the need to master the changes in practical regulations and accumulate administrative experience, (c) the legal nihilism related to frequent legal changes. The legal instability leads to dissatisfaction among health care actors, breaks the management rhythm and leads to a direct loss of efficiency of the health care system (Bonev, 2010)[8]. Health care is subjected to constant extensive legal changes, meeting with strong dissatisfaction in particular on the part of trade unions and professional associations (Borissov 2010, Delcheva 2011, Popov 2011) [9] [10] [11].

Debates about insurance model

The main debate was on the insurance model:

- The solidarity model of health insurance: Some experts (Popov, 2011) estimate the cost of a health insurance model in comparison with state budget financing of health care as higher. Difficulties in maintaining this model are pronounced in particular by the MoH (Kostantinov, 2011)[12] in times of crisis.
- The role of NHIF as the single institution dispensing funds from compulsory health insurance.
- How to create favorable conditions for the development of voluntary health insurance when people are encouraged to use it as an alternative to direct payment for health services (MoH, 2011).

Financing

A heated debate during the year was the fate of the reserve of NHIF, accumulated mainly after the raising of the health insurance contribution from 6 to 8%. This contribution was initially raised in 2008 to finance the introduction of an additional insurance pillar, but the reform never started. The government transferred the accumulated over BGN 1.4 billion to the Republican budget, using part of it (0.3 billion) to increase the subsidy of MoH. The opposition and the Physicians Association reacted sharply, but the decision was justified by

[8] Bonev, Boiko, By whom and why was the National Frame Contract signed in 2011, 22.12.2010, http://www.zdrave.net/Portal/WeekTheme/Default.aspx?evntid=mINJwsbqC%2b4%3d.

[9] Borissov, V., Health reform - time for reassessment and revelation, http://zdraveonline.com/images/stories/pdf/otkrovenie.pdf.

[10] Delcheva, Unfair financial system will distort the DRG, 15.4.2011, zdrave.net, http://www.zdrave.net/Portal/WeekGuest/Default.aspx?evntid=vUNoSavpXqg%3d.

[11] Popov, Miroslav, Health care today is neither objective nor a roadmap, 15.04.2011, http://www.zdrave.net/Portal/Comments/Default.aspx?evntid=3UmlSLRVWWI%3d.

[12] Concept for better health, MoH, 2011, http://www.MoH.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=3103.

the Minister for Finance ont the grounds of the economic crisis and the lack of any reforms in health care.

President Mr Parvanov signed the decree to officially publish the 2011 State budget, but he voiced several strong remarks for the content and the policies included in the budget. One of them is the lack of planned reforms in the health care, higher education, social, and administrative sectors. Mr Parvanov said he was also alarmed by the fact that by the end of 2010 all resources of the National Health Insurance Fund (NZOK), currently deposited at the Central Bank, would be transferred to the central budget; thus, the health insurance moneys of the citizens in the so-called large NZOK reserve could now be used for other public expenses if needed - in violation of the health insurance principles of Bulgaria. The Bulgarian Industrial Association pointed out there is not a real health care reform with the government steering the funds away from the sector and using them for payments to the fiscal reserve.

Debates about health care – outpatient, hospital and emergency care

The main points of political debate on oupatient care have focused on: 1) How to ensure real 24-hour access for health insured to medical care and medical specialists[13]; 2) How to exempt the access to narrow specialists (administrative restrictions on access to narrow specialists on the basis of regulatory standards for GPs is a constant generator of dissatisfaction for patients and doctors)[14]; 3) A new policy about home health care (expanding the nursing home); 4) Reforms in the dispensary[15] (financing by NHIF) and 5) The introduction of financial incentives for GPs working in group practices..

The debate on hospital care has been associated with implementing the state policy on medical establishments for hospital care based on regional needs of the population. This includes the following main points: 1) Development of the concept of a compulsory health map[16], 2) Long-term policy to reduce the number of hospitals as a guideline for hospital reform; 3) Change in the form of registration of hospitals with dominant participation of the state from trade (for profit) to public companies (non-profit) and improving their management; 4) Introduction of mechanisms restricting the use and purchase of obsolete equipment; 5) Introduction of DRG as a method of funding the hospitals

Threats to the implementation: 1) Non-realistic expectations for quick hits for a short time (months to a year); 2) Lack of a consensus among different political parties on how to solve the problems; 3) Negative reactions of patients and health care workers towards a change in the status quo limiting their momentary advantages, and 4) Limited financial resources.

[13] 24 hour placement is not possible in practie, since the majority of practices are individual - 94.8% of their total number. Filtering role is also questionable to ever-increasing hospital admissions in emergency rooms of hospitals.

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

[15] Special health establishment with speciphic function for patient with chronic diseases – cancer, dermathology, pulmonology and mental disorders.

[16] The health map must describe the type, number, activity and distribution of hospitals in various levels of medical care in the regions, the minimum and maximum number of acute beds (therapeutic, surgical, pediatric, gynecological, and beds for intensive care) and beds for long-term treatment. It should also include centres for expensive and high-tech methods of diagnosis and treatment, which justifies their funding from public resources and medical establishments for hospital care, with which NHIF could conclude contracts on an annual basis under the Health Insurance Act.

Emergency medical care

MoH presented for public discussion and subsequent adoption by the Council of Ministers on 5 May 2011 the following *Concept for future sustainable development of the system for emergency medical care* that has two fundamental objectives: 1) Provision of equitable access to emergency care, covering up-to-date European practices and requirements for timeliness, sufficiency, quality, and safety, and 2) Improvement of the functioning of emergency care while guaranteeing its financial, staff, and material sustainability. Concrete measures of the concept are presented in Annex 15.

Debates about pharmaceutical policy

The following main issues were debated: 1) The transfer of certain drugs by the Ministry of Health to NHIF (post-transplant treatment, oncologycal treatment, etc.); 2) Establishment of a Directory of medical devices with the determination of price caps; 3) Establishment of the Fund for Rare Diseases in order to create a database for such patients to optimise and control their treatment, and 4) Regulating the entry of innovative products in medical practice to optimise public spending.

A sharp debate between the Ministry of Health and the professional organisation of pharmacists about the possibility of non-pharmacists to be employed for the sale of cosmetics and non-medical products and about the change of the authority for the registration of pharmacies and the exclusion of the professional organisation from this process is running at present.

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.

A review of the OPRD for Bulgaria demonstrated that the majority of the references to health are rather linked to health infrastructure development and medical equipment supply. Subsequently, the indirect health gains are predominantly considered through and in the realm of the relevant social, economic, environmental or generally sustainable development gains (Annex 17).

Between 2007-2013 was the first programming period for Bulgaria when seven operation programmes were developed. Health authorities were formally involved as members of the working groups established for that purpose and consulted in terms of the development of the programmes as described above. During the implementation of the OPRD, usually the cooperation between the institutions takes place on expert level.

The EC legislation, policy and guidance should give clear indications and guidance on issues which should be included in the operational programmes including the public health gains. It became evident that there is a need of a better understanding and a systematic approach to properly reflect on the public health impact on non-health-related investments.

2.3.4 Impact assessment

Demographic processes in the year 2010

The total population of Bulgaria is 7.35 million according to a recently completed count of population in 2011 (NSI, 2011)[17]. In 2010, the absolute number of births compared to 2009[18]

[17] National Statistic Institute, 2011.

decreased (see Annex 1 for more information).

In the general population, mortality in 2010 has increased compared to previous years. The ratio of total mortality (14.6%) increased by 0.4% compared to 2009. Mortality remains higher among men (15.8%) than women (13.5%) and in rural (20.7%) as compared with urban (12.2%) areas.

Indicators of premature mortality have decreased. In 2010, it was 23.4%. In previous years this indicator was higher (28.3% in 1995, 25.2% in 2001 and 24.4% in 2009). Premature mortality in Bulgaria is twice higher among men (30.9%) than females (15.2%). The total European Union (27) indicator of premature mortality is nearly 22% in 2008.

After 1997, there has been a stable trend of reduced child mortality. In 2010, 708 children aged one year died in the country. Compared to the previous year the number decreased by 21 children..

Life expectancy at birth in the period 2008-2010 was 73.6 years, which is 0.2 years higher than for the period 2007-2009. It is 70.0 years for men and 77.2 years for women.

The decrease in population, as measured by the coefficient of natural growth in 2010 was -4.6% which is an increase in absolute terms of 1.1% compared to the reduction observed in 2009 by -3.5%. The coefficient of population growth continues at very large negative values in the villages, -12.1%, while in cities it is -1.6%. This underlines that negative demographic trends are particularly accentuated in villages.

Overall, the analysis of the results regarding the development of demographic trends shows that more fundamental problems of demographic development of the country are a high level of mortality and relatively low life expectancy compared with other European countries as well as negative external migration balance.

In the structure of mortality by reasons of death, a traditional leader remains heart diseases and cancer; the highest share has stroke and ischaemic heart disease (31.4% and 20.2% respectively). In comparison with other European countries it can be seen that despite the decreased mortality from heart diseases, the standardised mortality ratios have remained significantly higher in Bulgaria, and with an increasing trend; the same goes for cancer.

Access to health care

By the end of 2010, the number of persons with suspended health insurance stood at more than 1,021,000, which represents 13.4% of the persons with a chosen GP (out of 7,597,000). By the end of 2008, this number was 965,000, or 12.7% of the total. The number of uninsured persons rises when unemployment increases[19]. According to data by the NSI, in 2010, the coefficient of unemployment was 10.2% (2009: 7.9%); in comparison with 2009 this is an increase by 2.3 percentage points. One influencing factor is the distribution of unemployment between the private and the public sector, as well as between small and large companies, which reflects on the insurance coverage and the size of the average monthlyinsured income.

[18] Registered births were 76,105, of which 75,513 (99.2%) were live births. The total birth rate in 2010 was 10.0%, while in the previous year and in 2008 it was 10.7% and 10.2% respectively. The number of live births among boys is greater than among girls, i.e. 1,000 males vis a vis 944 girls. Compared with the previous year, the number of live births decreased by 5,443 children, compared with 2008 by 2,199 children. Despite the decrease in comparison with the two previous years, the number of live births has remained at the same level since 2007 and is higher than for the period 1995-2007.

[19] There is a special scheme to cover health insurance to people who fall into unemployment. They have insurance coverage for a few months and then remain outside the scheme without any health insurance.

Another significant factor is external migration, as it affects the number of uninsured persons in the country.

Outpatient health care

Outpatient medical care concentrates on solving the health problems of patients applying horizontal and vertical relationships. Horizontal links are present at the pre-hospital care between GPs, specialists and medical laboratories (clinical and technical). Vertical links are the ones with other levels of care (highly specialised and hospital care, as well as with other systems, social, educational, legal, etc.). In total, the funds for primary health care have increased by about BGN 20 million in 2010 in comparison to 2007, whereas their share of total public spending for health care has grown from 4.8% to 5.1%. The average monthly transfer to a GP has grown from BGN 1,897 to BGN 2,344 for the same period. The sums reimbursed for primary care have increased for all age groups, but the largest increase falls in the group 18-65 years, which points to an increase in registered morbidity. The funds allocated for prophylactic examinations and immunisations within the scope of the "Children Health Care" programme have increased by almost BGN 1 million Annex 6 presents the distribution of transfers by directions in primary care. The comparative analyses of the existing individual GP practices applying the standard of the National Health Map show shortcomings in 1,157 GP practices. The difference between the registered GP practices and the standard is higher in the Sofia and Varna region. Only in the regions of Pernik and Burgas there are several GP practices above the standard. The correlation between GPs and specialists by region is presented in Annex 7. (NHIF, Salchev, 2011)[20].

Current situation of hospital care in Bulgaria[21]:

- Number of hospitals for active treatment per 100,000 population in Bulgaria is 4.7 in comparison to 2.7 (France), 2.6 (Germany), 1.1 (Slovenia), etc. (Regional Office of WHO Europe, 2007).[22]
- Number of hospital beds per 100,000 population in Bulgaria: 606.9, against 716.8 (France in 2006), 829.1 (Germany in 2006), 389.8 (United Kingdom in 2004), 564.8 (European Union in 2007) etc.[23].
- Progressively increasing hospitalisations over the years (from 1.2 million in 2001 to 1.85 million in 2008 and an estimated 2.08 million in 2010).
- Observed disturbing trends such as increasing numbers of hospitalisations and costs show growing inefficiency of the system.

The basic data for hospital care are presented in Annexes 8 and 9.

Emergency medical care

The system of emergency care in Bulgaria[24] includes 28 centres for emergency medical care (CEMC), corresponding to the administrative regions of the country, with subsidiaries (SEMC). The existing structures of emergency medical care, geographic features, road infrastructure, etc., predispose inequality in the access to emergency care. Qualification of

[20] NHIF, 2011, http://www.nhif.bg/web/guest/74.
[21] NHCI. 2010 http://www.nchi.government.bg/Eng/download/healthcare_10A.pdf.
[22] Eurostat.
[23] Eurostat.
[24] In its present state of organisation emergency care in Bulgaria functions since 1996.

personnel is a serious problem[25]. Annexes 10 to 14 present data on staff and activities of emergency care system.

The system of CEMC is funded directly through state subsidies. During the period 2006-2010 funds increased significantly (from BGN 52 million in 2006 to BGN 82.1 million in 2010), representing growth by around 57%. Annual spending in 2010 comprised 78.4% expenses for wages and insurances of personnel, upkeep 21.6%, but this figure includes also transportation for patients on dialysis, which since 2011 are transferred to hospitals. The annual spending for emergency care per one citizen in 2010 was BGN 10.86; the average cost of one call to CEMC in 2010 BGN 98.7.

Despite the increased budget, the system 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 to increase staff motivation.

Pharmaceuticals policy and pharmaceuticals provision

In 2010, the following main facts were observed on the pharmaceuticals market[26]:

In total, the pharmaceutical ATC[27] and the hospital market pharmaceuticals score a slight reduction of sales by packages (-2%) and a growth of 9% in value (Annex 11; see growth in comparison to 2009 in BGN and % in Annex 10).

In 2010, the factors with major influence on the pharmaceuticals market developments, (positive↑, negative↓), were:

(↑) Facilitated access to a Positive List and full deployment of the rights to utilise prescriptions for some therapies;

(↑) Rising parallel export of pharmaceuticals;

(↓) Reduced market cost under "Ordinance 34" of MoH;

(↓) Reduced direct purchases;

(↓) Slower payments in market chains – NHIF, pharmacy, distributor, producer, as well as hospital, distributor, producer;

(↓) Stagnating purchases from buyers/patients, as a result of economic insecurity in 2010;

(↓) Still insufficient public resources spent for health care;

Pharmacy market

Sales of original Rx medical products through the reimbursing list of NHIF and the extended rights for prescriptions of certain therapies by GPs, as well as some additional factors produced a growth of 12.5% on the pharmaceutical market. Mass OTC products also restored their growth and aided market developments (see Annex 12).

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[25] The physicians with specialty are 568, which represents 49.6% of working physicians, where 69 of them hold a specialty in "Emergency medicine". Without specialty are 50.4%. During the period 1999 – 2001 only a single systematic training of the medical personnel has been performed; financing came under the loan agreement with the World Bank. The number of trained personnel was 4,548, of which higher medical personnel 1,330, middle medical personnel 2,099, and drivers 1,085. After 2001, only sporadic trainings of personnel are undertaken and more as an exception than part of a systematic activity.

[26] Gergana Pavlova-Deputy Minister. Ministry of Health. http://www.MoH.government.bg/News.aspx?pageid=401&currentPage=16&newsid=3129.

[27] Anatomical Therapeutic Chemical (ATC) Classification System

In 2011, the role of the NHIF will grow and pharmaceuticals expenditure will increase by around BGN 40 million – up to BGN 400 million. The consumption of pharmaceuticals in hospitals will remain stagnant at BGN 280 million (Annex 13, 14).

The number of pharmacies in Bulgaria has been decreasing gradually, standing at 3,925 by the end of 2010. The average annual pharmaceuticals turnover of the "average" pharmacy reached BGN 408,000 in 2010. Naturally, there are pharmacies generating turnovers of several millions, and also such with an annual "business" of under 40,000 BGN. As a whole, the number of pharmacies is expected to continue decreasing, thus, in 2011 probably another 100 pharmacies will close down for economic reasons.

Unfortunately, nothing significant happened regarding the profitability of the work of distributors. The same overused surcharges and discounts in the trade chain, continued over-provision of pharmacies despite the shy attempts at optimisation, an enslaving lending to hospitals. An additional element of spending is added by the 100% reimbursement of pharmaceuticals by NHIF, i.e. another negative aspect.

2.3.5 Critical assessment of reforms, discussions and research carried out

Health care is a system that is considered to be too conservative, but rather dominated by outside influence. The position of the Ministry of Health about what is happening in the health care system was presented at the high level meeting that took place in Andorra [28]. The main points were: 1) Levers for responding to the financial crisis; 2) Success factors / government support, and 3) Challenges / Opponents to the change & points of negotiation

Discussion – what actually happened this year

- Bulgaria was spared by the financial crisis because of the Currency Board, but feels enormous pressure of the economic crisis gripping the world.
- The economic crisis led to a shortage of funds throughout the health system, but it is honest to say – an irrational spending of funds is also a factor.
- An attempt was made by the government to "nationalise" the National Health Insurance Fund (NHIF); continuous changes in the management of the Fund have been made.
- Continued scandals among the Bulgarian Medical Union and lack of a clear vision for future policy
- Hopes rest on the development of the insurance model, which has raised expectations among the public and participants in the market of insurance services – in reality there is the lack of a clear vision of the future of voluntary funds. A particular problem is the lack of vision regarding the harmonisation of legislation with the requirements of the EC in this area (Solvency II).
- Increasing mistrust of citizens towards the health system and increasing dissatisfaction among certain groups of patients, e.g. cancer patients, patients with rare diseases, etc.
- Lack of real mechanisms for system management, management contracts, financial instruments, etc.

[28] Dessislava Dimitrova – Deputy Minister for Health. Andora High Level Meeting, 2011. http://www.MoH.government.bg/News.aspx?pageid=401&currentPage=6&newsid=3208.

- Continuous changes in the political leadership of the national health system (three ministers, eight deputies and two NHIF direcors within one year) and lack of a clear vision for future development.
- The lack of any activity for the allocation of funds from EU programmes.
- The lack of real research in the field of public health, health population needs etc. The Government and the Ministry of Health do not allocate any money for studies in this area.
- There is a lack of both the desire and opportunities to work with NGOs and medical universities and research institutes in the field of health.
- Lack of vision for the development of medical education, postgraduate education and continuing training - completely failed model of continuing medical education;
- Constantly decreasing number of medical professionals - doctors, nurses and other professionals;
- The Government adopted the decision to take BGN 1.5 billion (equal to 1,000,000 Euro) from the NHIF reserve - contributions provided by all insured persons in Bulgaria - which were transferred to the fiscal reserve of the country;
- Further clinical pathways for long-term treatment were developed, but remained only wishfull thinking without adequate financing.
- Changes in drug policy:
    - Changes in the Ordinance on prices: If there is no production price in any of the countries in the first group, the price cannot exceed the lowest price for the same product, paid by public funds in Belgium, France, Poland, Latvia and Slovakia.
    - The second significant change was the transfer to NHIF or specialised hospitals of financing of medications from the reimbursement list, previously paid by MoH (cancer, haemodyalisis, rare diseases, tuberculosis, etc.). This also leads to the abolishment of centralised pharmaceuticals tenders, called by MoH.
- Significant problems in the system of emergency care:
    - lack of a clear and official definition of emergency care as a medical service, leading to burdening the system with non-specific functions, both on the side of the patients and the health system itself;
    - growing disproportions and inequality in access to timely and qualitative emergency aid for the population,
    - absence of clear criteria regulating the structure of the emergency care system and the number and composition of medical teams;
    - deteriorating personnel provision, insufficient qualification and disincentive of personnel;
    - hard to overcome traditions and behaviour of patients to seek infinite and free access to emergency care often in order to solve non-urgent medical problems;
    - increased demand for emergency care as a result of the troubled access to outpatient and hospital care;
    - overloading the system with extrinsic functions and activities, outside the main domain of work.

- In recent years a trend has been observed of movement of qualified staff (mainly doctors and nurses) to other countries. This affects the functioning of the various medical establishments reducing the possibilities to provide effective medical care. This is particularly relevant for smaller cities where the pull-out of one specialist leads to a suspension of operation of the whole unit.

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

- Retrenchment of the free cash resources of both the state and private households to meet basic medical and health needs of the population.
- Restricted access to highly specialised medical and health services.
- Increased morbidity of the population for many reasons both medical and under the influence of economic, social and psychological factors, especialy diseases of modern life, associated with poverty, malnutrition, stress, unemployment, irrational nutrition, etc.
- Economic pressure on hospitals may lead to contraction of their activities and reduction of staff respectively, and to shrinking incomes.
- Movement of the greater part of medical professionals and pressure on the labour market.
- Demotivation of health workers, leading to increased errors and reduced quality and safety.
- Collapse of the pharmaceutical market and focus on cheaper drugs by both hospitals and patients, bankruptcies of distributors, pharmacies etc.
- Increased pressure on the National Health Insurance Fund by hospitals, doctors and by patients, rising discontent and protests.
- Increased expectations of the population will exert continuous pressure on the Ministry of Health, which will be a constant target of discontent.
- Increased usage of the system, in particular emergency medical care will face increased tension in their work, hence increased errors and, in turn, dissatisfaction of the population.
- Cost reduction in the system leads to a reduction of social protection of citizens and increasing informal payments.

2.4 Long-term Care

2.4.1 The system's characteristics and reforms

Long-term care and other social services for elderly are provided through two distinct systems in Bulgaria. 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" [29] are regulated by the Social Assistance Act (SAA) and Rules for the Implementation of the 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 Bulgarian legislation at this time, nor an official classification of who qualifies for it.

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

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

As is the case in many countries, the social service sector and the health care sector do not have an official mechanism for the coordination of 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[30]. This includes concrete steps such as including rooms for health counselling in homes for the elderly and disabled.

In 2010, the national strategy "Vision for de-institutionalisation of elderly people with psychic disorders, mental retardation, and dementia"[31] under the motto "Nothing for the persons with impairments without the persons with impairments" has been published. The key objectives of the strategy are:

- to put the foundations of a long-term policy on social services for people with psychic disorders, mental retardation, and dementia, based on human rights.
- to establish a new type of social work, including social protection, real integration, rehabilitation, consultancy, mediation, vocation and provision of occupation in order to reach the final target: full inclusion in community life of people with psychic disorders, mental retardation and dementia.
- to harmonise the requirements of social economics with conditions and standards in the provision of social services, as well as to create a suitable atmosphere in their realisation.

Organisation of Services

Traditionally, long-term care and other social services for the elderly are categorised as formal and informal, institutional and non-institutional. Every country has a different "menu" of services depending on cultural preferences, state capacity and funding. In Bulgaria, informal services such as home care by a family member most likely make up the bulk of LTC; however, there are no available data on this (Salchev&Chobanova 2004)[32]. What the data do show is that until recently most formal LTC and social services for the elderly were provided by institutions (nursing homes, hospices etc.). After Bulgaria revamped its social service system in 2003, the share of formal services provided grew steadily from 17% to 81% in 2008.

In terms of service delivery, more than 90% of services are public, provided by either the state or municipal governments. While institutional care is almost entirely public, NGOs and charities are increasingly involved in providing services at 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 service.

To access social services, beneficiaries must submit a written request to the accordant municipal or national authority for public services or to a private service provider. Based on

[30] Concept for a Better Health, MoH, 2011, http://www.MoH.government.bg/Articles.aspx?lang=bg-BG&pageid=472&home=true&categoryid=3103.

[31] National Strategy: http://www.asp.government.bg/ASP_Files/SISURT/VISIA_ZA_DEINSTITUCIALIZACIA__POSLEDEN_2222_11.doc.

[32] Салчев П., Розалина Чобанова, Права и процедури при неработоспособност, инвалидност, професионално заболяване, трудова медицина, ИК "Топ Мениджмънт Адвайзорс", 2004, София.

the request, the relevant authorities conduct a social evaluation and make a recommendation for the placement of the beneficiary. Access to health services is based on the insurance status of the beneficiary, however, every Bulgarian woman over the age of 60 and every Bulgarian man over the age of 65 has full health insurance coverage paid by the state.

Non-institutional Care: Community & Home-Based Services

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 directly paid by the Social Assistance Agency under a special programme (after applying to it on specific criteria) established by the Agency to provide basic cooking, cleaning, personal hygiene, and shopping or errand help for people who do not require institutionalisation but cannot meet these basic needs of their own. This system was originally established to provide relatives of elderly and disabled residents who need constant care with a salary and insurance coverage but it is open to third parties as well.

In addition to personal assistants and other home helpers, municipalities provide daycare centres for elderly people, for adults with disabilities, centres for social rehabilitation and integration, protected homes, and care services at home. Annex 18 provides more details on each of these services.

Of all community-based social services, the newer services by personal assistants, social assistants and home helpers have proven particularly effective and popular. They see to the basic needs of the elderly and disabled while keeping them in their home environment and out of institutions. Communities also often "employ" (part time per hour) a family member who otherwise cannot work because of their fulltime care responsibilities. And in the case of outside social assistants and home helpers, they provide a previously unemployed person trained in the special programme[33] and an official employment contract.

Institutional Care

While the bulk of long-term care services are now provided by community and home-based service providers, institutional services remain a critical part of a comprehensive LTC system (Social Assistant Agency, Annex 21). In Bulgaria, institutional services consist mainly of homes for adults with disabilities, homes for elderly people, specialised hospitals for continuing treatment and rehabilitation, and hospices (Annex 19). Beneficiaries of these services are beyond the scope of community-based services.

In terms of the geographic distribution of institutional services, not all types of institutions are available in every district. Only five of 28 districts have all types and in some cases the institutions are outside towns, which further isolates residents. While geographic coverage is uneven, it corresponds, in general, to the population distribution within the country[34].

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 contributions through fees are minimal. In general, LTC and other social services for the elderly in Bulgaria are financed in the following ways:

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

[33] Operational Programme Human Resources - BG051PO001-5.2.07 "Care in a family environment for independence and dignity of persons with various disabilities and people living alone - work social assistance anddomestic worker", Social Assistance Agency 2010.

[34] Report of the Social Assistance Agency 2010. http://www.asp.government.bg/ASP_Files/APP/Otchet-ASP-obobshten-2010.htm.

- State delegated services: Financed from the state budget based on established standards, funds are transferred to municipalities which then fund 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 a municipality or the state, depending on the service. All but one service (personal assistants) are subject to fees based on the particular service and the recipient's income.
- Private services: Financed by private organisations (NGOs, foundations, firms) that are registered with the Social Assistance Agency.

In terms of expenditures[35], the bulk of services are state-delegated, i.e. they are funded by the state but managed by the municipalities. While this ensures at least a minimum amount of funding available to meet local needs, it does not ensure high quality, universal coverage. Municipalities must manage services within strict budgetary limits that are based solely on the number of beds or units of service rather than the quality of a service (Annex 20). In addition, the state provides an equal amount of funding for state-delegated services for each municipality, regardless of the population size or level of demand.

Funding Sources and Flows

Funding for state-delegated services comes from national target programmes (for example, "Assistance for Persons with Disabilities")[36], social assistance funds, and grant schemes for social services (for example, OP "Human Resource Management", EC structural funds with national cofinancing). Until 2003, social services were funded by municipal governments whose budgets included general transfers from the state. Unfortunately, municipalities were unable to provide sufficient, high quality social services based on the funds provided by the state and more and more residents went without the services they needed.

Thus, in 2003, the Government took up to provide targeted funds to municipalities for specific social services to ensure both quality and universal coverage. These "state delegated services" now represent a majority of LTC and other social services for the elderly. This change in funding mechanism (or fiscal decentralisation) has been crucial in fixing the previous imbalance between the central government's limits on funding and the local government's responsibility for service provision.

For state-delegated services, the central government determines the rate at which each service will be subsidised. Municipalities are expected to provide high quality services within the targeted subsidy, however, they are welcome to co-finance state-delegated services from their own revenues. This is particularly important because the state provides an equal amount of funding for social services to each municipality, regardless of its size or the conditions under which it provides services. This has resulted in a significant increase in the amount of co-financing provided by municipalities.

As from 2008, the state has not only been determining the rate for each social service but also instituted uniform standards for salaries and maintenance of facilities. This aims to eliminate inequalities among institutions and service providers in different municipalities. The state also determines a national ceiling on the funds available for a particular type of service which

[35] For 2010, the budget of SAA was BGN 828,291,482**.** http://www.asp.government.bg/ASP_Files/APP/Otchet-ASP-obobshten-2010.htm.

[36] http://www.asp.government.bg/ASP_Files/AHU_2011%20z-d%20397%20ot%2019.05.2011.pdf.

means there is a limit on the amount of funding each municipality can receive. This has implications for municipalities meeting the needs of their residents as the demand varies across municipalities.

The use of predetermined rates for each service works relatively well for institutional care because calculating a figure based on the number of beds is straightforward. However, as the proportion of community-based services grows, it becomes more difficult to determine a fair rate.

The cost of labour becomes more important rather than the number of "places", and the services can vary depending on the unique needs of each beneficiary.

Fees for state services are determined by the Council of Ministers and are "low, differentiated, socially affordable and not burdensome" (MLSP, 2010)[37]. Fees are generally determined by the cost of the service and the financial position of the recipient. For example, users of institutional centres must pay 70-80% of their income while users of day care centres must pay 30-50%. For beneficiaries with no income, there is no fee. The fees for state-delegated services are allocated in part to the state budget and in part to the Social Assistance Fund which is an important source of funding for social services in general.

When the state began funding social services in 2003, they also asked municipalities to remit any fees collected back to the state treasury. This broke the direct link between service provision and the collection of fees, resulting in a decrease in overall fee collection. Once collected fees had to be remitted to the state, local employees were less motivated to collect them in the first place and to adapt their rate based on changes in the recipient's income. This also broke the link between the quality of service and fee payment. Municipalities receive the same fee regardless of the quality of service, and recipients pay the same fee regardless of the quality of service (SAA, 2010, Annual Report)[38].

Fees for long-term health services are directly related to the recipient's health insurance status and their package with the National Health Insurance Office. For elderly, there is no risk of an interruption in their health insurance status due to unpaid contributions, because their contributions are paid by the state starting at the age of 60 for women and 65 for men.

The Government is clear that the current system of funding for LTC and other social services is unsustainable given the demographic projections. The heavy reliance on state-delegated services will need to change and local municipalities will need to find other sources of funding.[39]

2.4.2 Debates and political discourse

From the perspective of the Ministry of Health (MoH), long-term care (LTC) is a social service with some minor medical components. The MoH is responsible for long-term treatment after certain diseases, rehabilitation and hospice care ("*dolekuvane*"). These services are regulated by the Law on Health Insurance (ZZO) as well as Ordinance 34 by the MoH. In the latest amendment of the ZZO from 8 June 2010, the service "hospice care" was included in the scope of services to be financed by the National Health Insurance Fund (NHIF), even though hospice care is not financed by health insurance in other European countries.

[37] MLCP 2010. http://www.mlsp.government.bg/bg/docs/indexbudjet.htm.
[38] http://www.asp.government.bg/ASP_Files/APP/Otchet-ASP-obobshten-2010.htm.
[39] Club "Economika 2000". Cost Study of Long-term care Services in Bulgaria (June, 2009).

In the political debate representative organisations of persons with disabilities were not sufficiently involved, which shows a lack of experience in working with NGOs. The President of the Union of Disabled K. Kotsev wrote an open letter to the MLSP and NII protesting against deliberate creation of negative social attitudes against disabled people and forfeiture of their rights in the discussion on the pension reform[40].

2.4.3 Impact of EU social policies on the national level

In 2010, contracts under two procedures for the selection of projects under the domain of intervention 5.2 "Social services for prevention of social exclusion and overcoming of its consequences" have been concluded[41].

Established in 2010, the programmes elaborate and build upon national measures and initiatives in the sphere of the provision of social services: "Personal assistant", "Social assistant" and "Home helper". These programmes are coming in response to the necessity to target social services in a suitable form to the real needs of persons with impairments and lonely living people, guaranteeing their independence and inclusion in public life.[42]

Measures under the scheme "Care in family environment for independence and dignified life of persons with various types of impairments and lonely living people: 'Social assistant' and 'Home helper'", "Elaboration and improvement of the service 'Personal assistant' for persons with impairments and lonely living people", and "Alternatives" are a contribution to overcomig the key challenges, identified in the National Strategy Report on social protection and social inclusion of the Republic of Bulgaria for the period 2008-2010. They correspond to the priorities of Bulgaria in the domain of social services as part of a wider policy to develop long-term care.

2.4.4 Impact assessment

In Bulgaria, the geographic coverage of LTC and other social services is uneven across districts. For the most part, more institutions with larger capacities are located in administrative centres where the population is higher. But while all types of social services have expanded in the past few years, there remains unmet need. In 2008, the number of registered beneficiaries awaiting services equaled approximately one third of existing capacities (Shopov 2009)[43].

Accessibility of long-term care services is more even across the country although there has been less growth in these services compared to social services (Shopov 2010)[44]. There has been a small increase in the number of hospices though, which provide critical services to Bulgaria's elderly who cannot receive care at home. Unfortunately, the growth in services has not been matched by increases in personnel or improvements in the patient to personnel ratio, which raises important questions about the quality of services (Shopov 2009, National Statistics Institute).

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40 http://www.disability-bg.org/upload_files/bulet-8-2010.pdf.

41 Agency for Social Assistance http://www.asp.government.bg/ASP_Client/ClientServlet?cmd=add_content&lng=1&sectid=19&s1=41&s2=113&selid=113.

42 Ministry of Labour and Social Policy, http://www.mlsp.government.bg/bg/projects/index.htm.

43 Shopov, G., Long-term care for Elderly People in Bulgaria, background paper prepared for the World Bank (April, 2009).

44 Shopov, G., World Bank Report Long-Term Care Policies for Older Populations in new EU Member States and Croatia: Challenges and Opportunities, the Bulgarian case, November 2010, pp 51-67, Washington.

Undertaken steps and changes in the organisation and provision of long-term care (LTC) in 2010

As of 31 December 2010, 161 specialised institutions were operating in Bulgaria, of which 76 for elderly people and 85 for elderly people with impairments with a total capacity of 11,751 places (Annex 20)[45].

In 2010, during the implementation of the process of de-institutionalisation and improvement of the quality of life in specialised institutions, a home for elderly persons with physical impairments with a capacity of 40 places was closed and the capacities of eleven specialised institutions for elderly persons and elderly persons with impairments have been diminished.

The capacities of three specialised institutions (HEP) have been increased by 78 places in total; 33 new social services of the residential type opened**.**

In 2010, the capacity of three social services of the residential type – protected homes for elderly persons with mental retardation and psychic disorders was increased overall by ten places.

20 new social services in the communities were opened: Seven day centres for elderly persons with impairments (DCEPI) (capacity of 241 places); four centres for social rehabilitation and integration (CSRI) (capacity of 90 places); nine day centres for elderly persons (DCEP) (capacity of 270 places). In 2010, the capacity for social services for the elderly in the community was increased in two day centres for social rehabilitation and integration of elderly persons with impairments.

Annex 22 presents the existing institutions delivering long-term care and social services, as of 31 December 2010:

Implementing the concept for deinstitutionalisation and prevention for social inclusion of persons living in specialised institutions, the Agency of Social Assistance developed a plan for reforming the 14 specialised institutions for elderly persons with impairments (comprising six HEPMR, four HEPPD, and four HEPPI) in the period 2010-2011. Seven of these institutions are to close down stepwise, and another seven are to reduce their capacities.

With the purpose of humanising the conditions of life in specialised institutions for elderly persons with dementia the reform plans for the specialised institutions for elderly people with dementia includes a reduction of capacities of the 13 respective homes..

National programme "Assistance for persons with impairments"

The national programme "Assistance for persons with impairments" offer employment opportunities to jobless persons, who provide quality care in a family environment to persons with impairments and gravely ill persons living alone. The programme's objective is to achieve social adaptability within the context of an existing disability. Activities along the programme are of significant importance to small residential areas in which perspectives and opportunities for reintegration for persons with impairments are lacking. The programme also influences significantly the reduction of the number of persons with impairments accommodated in specialised institutions through their relocation in their family environment.

In 2010**,** for the implementation of the national programme "Assistance for persons with impairments" funds amounting to BGN 8,806,387 were allocated for hiring 4,000 personal

[45] Agency for Social Assistance. Report of the Social Assistance Agency for 2010. http://www.asp.government.bg/ASP_Client/ClientServlet?cmd=add_content&lng=1&sectid=12&s1=207&selid=207.

assistants based on a 6-hour working day[46]. The activities are realised on the territory of the whole country by territorial units of the Agency for Social Assistance – Directorate "Social Assistance".

In 2010, no funding for social assistance activities was provided. This service is provided according to projects funded by grants under the Operational Programme "Development of human resources".

2.4.5 Critical assessment of reforms, discussions and research carried out

The main findings are:

- Insufficient number of services, which do not meet the complex needs of target goups; uneven distribution on the territory of the country;
- Lack of comprehensive rehabilitation of persons with impairments, which is a crucial condition for their full inclusion in society life. The rehabilitation of persons with impairments is a complex process which requires the establishment of programmes and structures to ensure consistent implementation of all steps in medical, professional and social rehabilitation;
- Lack of adequate schemes for financing of activities, unrelated to active treatment of the group in question, on behalf of NHIF;
- Social stigmatisation of persons from the target groups and lack of understanding for their problems and needs;
- Insufficient financial resources for construction and renovation of buildings for social services;
- Disengagement on part of the municipalities and civil society in the development of services for people of the target groups;
- Insufficient number of alternatives to institutional care and community-based social services;
- Lack of social services for the target groups in the municipal and regional startegies and of annual development plans;
- Lack of an inter-departmental commission on regional level to guide and follow up the process of deinstitutionalisation;
- A large number of elderly people wishes to be accommodated in specialised institutions;
- Insufficient horizontal interaction between Regional Health Inspections, Regional Directions for Social Assistance, and municipal administrations in solving concrete problems of the target groups;
- Lack of relations between services in the community and in specialised institutions;
- Lack of experience in the involvement of NGOs in setting policies and making decisions.

[46] Agency for Social Assistance, http://www.asp.government.bg/ASP_Client/ClientServlet?cmd=add_content&lng=1&sectid=19&s1=41&s2=117&s3=586&ss=255&st=441&selid=441.

One of the main problems of the MoH 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 by opening hospices for them, creation of clinical pathways to be financed by NHIF, etc. The lack of joint action and collaboration between the MoH, MLSP, ASA, and NHIF makes it impossible to solve this socially important problem. The lack of adequate understanding of LTC as a process related to the continuity and collaboration between multi-professional and multi-institutional teams in providing this service is the major obstacle to the establishment of a common national programme.

The following guiding principles might be helpful for any future policy reforms of the Bulgarian LTC sector: (i) LTC has to be provided in a multi-disciplinary setting that encompasses health as well as social care services; (ii) home-based, ambulatory, and community-based day care services lead to better outcomes, are more cost efficient, and are overwhelmingly preferred by patients; (iii) LTC has to put the patient in the centre, guarantee a continuum of care across needs and care settings, and has to ensure that the money follows the patient.

The main conclusions can be summarised as follows:

The strong growth in home and community-based services has helped to cope with the growing number of elderly who need assistance with the activities of daily life. These services tend to be more financially efficient and more highly rated by recipients.

The fragmentation of services between the health and social service sectors can be seen in types of benefits, eligibility criteria, and provision of benefits. While it is difficult to quantify the efficiency impacts of such fragmentation and duplication, available global evidence shows that fragmentation and duplication generate inefficiencies and with it additional costs for the LTC system.

There is a systematic lack of reliable data on LTC expenditures mostly due to the fragmentation of services between the health and social service sectors.

The generally low levels of financing for LTC will have spill-over effects on the sustainability of health financing**.**

There is a lack of a coherent strategy and vision for LTC services. The reform of the LTC sector in Bulgaria is taking place without a coherent and long-term vision on the financing and provision of LTC services based on global good practices and lessons learned.

References

AGENCY FOR SOCIAL ASSISTANCE. http://www.asp.government.bg.

BULGARIAN INDUSTRIAL ASSOCIATION, "Pension Insurance in Republic of Bulgaria – Issues and Necessary Changes", http://www.bia-bg.com/ , retrieved on 10.05.2011.

CLUB "ECONOMIKA 2000". *Cost Study of Long-term care Services in Bulgaria* (June, 2009).

CONFEDERATION OF INDEPENDENT TRADE UNIONS IN BULGARIA (CITUB), "Position on the Euro-Plus Pact", http://www.knsb-bg.org/index.php?option=com_content&view=article&id=1649:2011-04-12-17-14-11&catid=63:--&Itemid=171, retrieved on 10.05.2011.

ECONOMIC AND SOCIAL COUNCIL OF REPUBLIC OF BULGARIA, "Analysis of the taxation and social insurance conditions in Republic of Bulgaria", December 2010, http://www.esc.bg/bg/activities/analysis/item/1471, retrieved on 02.05.2011.

ECONOMIC AND SOCIAL COUNCIL OF REPUBLIC OF BULGARIA, "Opinion on Social Security and Social Protection", ESC/2/016/2010, http://esc.bg/bg/documents/category/4?download=46, retrieved on 02.05.2011.

ECONOMIC AND SOCIAL COUNCIL OF REPUBLIC OF BULGARIA, "Opinion on the Strategic priorities of the Bulgarian economy in the context of EU2020 Strategy" http://www.esc.bg/bg/activities/opinions/item/506, retrieved on 03.05.2011.

ECONOMIC AND SOCIAL COUNCIL OF REPUBLIC OF BULGARIA, "Resolution on projects of the National Reform Program of Bulgaria" - http://www.esc.bg/bg/activities/resolutions/item/1484, retrieved on 10.05.2011.

ENP NEWSWIRE, Bulgaria Faces Increasing Demand for Long-Term Care Services for a Fast Ageing Population, December 10, 2010, http://www.allbusiness.com/population-demographics/demographic-trends-aging/15352516-1.html

EUROSTAT. http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home.

FINANCIAL SUPERVISION COMMISSION, "Social Insurance Market", http://www.fsc.bg/go.idecs?i=4156, retrieved on 13.05.2011.

INTERNATIONAL LABOUR OFFICE, "Global Jobs Pact Country Scan Bulgaria", http://ilo.org/public/english/region/eurpro/budapest/download/news/bulgaria_scan_bu.pdf, retrieved on 10.04.2011.

MINISTRY OF HEALTH (MOH), Concept for better health 2010-2015. http://www.MoH.government.bg/.

MINISTRY OF LABOUR AND SOCIAL POLICY. National Report on Strategies for Social Protection and Social Inclusion 2008-2010. Sofia, 2010. http://www.mlsp.government.bg/en/docs/index.htm.

MINISTRY OF LABOUR AND SOCIAL POLICY, "Plan for 2010 for the implementation of the National Strategy for Demographic Development of Republic of Bulgaria", http://www.mlsp.government.bg/bg/docs/indexplan.htm retrieved on 10.05.2011.

MINISTRY OF LABOUR AND SOCIAL POLICY. http://www.mlsp.government.bg/bg/projects/index.htm.

NATIONAL HEALTH INSURANCE FUND, 2011. http://www.en.nhif.bg

NATIONAL SOCIAL SECURITY INSTITUTE, Bulletin 2009-2011 http://www.nssi.bg/content/publikacii/Buletini/09/Br_6_09.pdf, retrieved on 13.05.2011.

NATIONAL STATISTICAL INSTITUTE OF BULGARIA, 2011. http://www.nsi.bg/index_en.htm.

NATIONAL STATISTICAL INSTITUTE, "Social Activities", http://www.nsi.bg/otrasal.php?otr=27, retrieved on 13.05.2011.

NHCI. 2010 http://www.nchi.government.bg/Eng/download/healthcare_10A.pdf.

PAMPOROV Aleksei, Цената на благоденствието, Foreign Policy, 28.01.2011, http://www.foreignpolicy.bg/print.php?storyid=1033446.

PHARMA AND HEALTH CARE INSIDE. Market intelligence, trend analysis and forecasts for the Pharma and Health care industries across the regions. http://www.pharmaceuticalsinsight.com/file/9124/home.html.

PHYSORG.COM. 23 Aug 2010. Romania, Bulgaria have EU's sickest health systems. http://www.physorg.com/news201776479.html.

SALCHEV P., Bulgarian Health Care Facing Certain Risks. Presentation in Confecernce „Risk Management". Sofia, Boiana, 16,10,2010, http://www.freewebs.com/salchev/ in Bulgarian.

SALCHEV P., Health Care system in time of economic crisis, 2010, http://www.freewebs.com/salchev/apps/blog/, in Bulgarian.

SALCHEV P., In the vicious circle of drugs (Paragraph 22), August 25, 2010, http://www.freewebs.com/salchev/apps/blog/, in Bulgarian.

SALCHEV P., Provoked words about new ideas for health insurance system in Bulgaria, November 6, 2009, http://www.freewebs.com/salchev/apps/blog/, in Bulgarian.

SALCHEV P., Розалина Чобанова, *Права и процедури при неработоспособност, инвалидност, професионално заболяване, трудова медицина*, ИК "Топ Мениджмънт Адвайзорс", 2004, София.

SHOPOV, G. *Long-term care for Elderly People in Bulgaria.* Background Paper prepared for the World Bank (April, 2009).

SHOPOV, G. World Bank Report Long-Term Care Policies for Older Populations in new EU Member States and Croatia:Challenges and Opportunities. Bulgaria case. November, 2010. pp 51-67. Washington.

THE ECONOMIST INTELLIGENCE UNIT LIMITED, 2011. The future of health care in Europe. A report from the Economist Intelligence Unit. Sponsored by Janssen. Retrieved at: http://www.eufutureofhealthcare.com/sites/default/files/EIU-Janssen%20Healthcare_Web%20version.pdf.

THE MEDICAL DEVICE MARKET: Bulgaria. Opportunities and Challenges. February 10th 2011, http://www.espicom.com/prodcat2.nsf/Product_ID_Lookup/00000536?OpenDocument.

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

WWW.STRATEGY.BG, Internet portal maintained by the administration of the Council of Ministers, containing 163 of the strategic documents on national level, systematised in 22 categories by topics, retrieved on 02.05.2011.

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

[R1] CONFERENCE: Ten years pension reform in Bulgaria: achievements and challenges, 16.03.2010, Sofia, organised by the Centre for Economic Development and Balkan Institute for Labour and Social Policy,
http://www.econ.bg/news/article174608/ideologiyata_na_pensionnata_reforma_e_pravilna_no_sa_narusheni_nyakoi_ot_principite_y

The ideology of the pension reform that was introduced in 2000 was correct, but during the past 10 years some of its principles were violated. The system is built up on the grounds of balance and solidarity, but the balance was disrupted by several factors – the one-sided stimuli provided to the business by reductions of social insurance rates, updating of old and new pensions, using the social insurance system as all-purpose remedy. The pension system suffers both by the ageing population and the political threats for adoption of popular measures which have a positive short-term effect on the voters but in the long run are negative. A very important principle, which will be one of the main elements for the further development of the Bulgarian pension model, is the flexible voluntary retirement.

[R1] FICHTL, Florian, Conference: Ten years pension reform in Bulgaria: achievements and challenges, March 2010,
http://www.worldbank.bg/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/BULGARIAINBULGARIANEXTN/0,,contentMDK:22502796~menuPK:399229~pagePK:141137~piPK:141127~theSitePK:399204,00.html

The economic crisis puts its pressure and limitations on the system, but in addition to that and with longer-term effect is the impact of the demographic developments. These do not fade away and we have to find solutions to handle them.

The decrease and ageing of Bulgarian population does not allow postponement of the discussions on the achievement of long-term stability of the pension system. Bulgaria is facing maybe the most dramatic decrease of its population compared to other new EU Member States. By 2025, almost a fifth of the Bulgarian population will be 65 years of age and older, representing the highest share of ageing population among the new EU Member States. In practice that means: There will be less contributors to the Bulgarian pension system, a smaller share of working population in active age, and more beneficiaries.

[R2] HRISTOSKOV, Yordan, Yearbook containing the overall professional knowledge on social insurance in 2009. http://www.book.store.bg/p30420/socialno-osiguriavane-2009-godina-jordan-hristoskov.html

- State public insurance
- Supplementary pension insurance
- Letters and instructions issued by NSSI, NRA and FSC on the application of the Social Insurance Code and the Tax and Insurance Procedures Code
- Detailed commentaries on the amendments of the social insurance legislation
- Information on practical application

[R2] NINOV, Dimitar, The pension system in Republic of Bulgaria today and tomorrow – achievements and challenges, 2010, www.union-econ.com/includes/download.php?id=158

Which of these objectives were fulfilled in 2009-2010 and which were not? Achievements, failures and challenges, the pension "reform" 2010, the need of changes, the most important measures and changes in the Social Insurance Code regarding pension insurance, actuarial estimates and results, The biggest omission in the analyses and forecasts from 2010, our notions and their theoretical financial and social consequences.

[H] Health

[H2] ALEKOVA, S., V. Slavova, M. Platikanova, B. Parashkevova. Socially significant diseases and their frequency in general medicine. Trakia Journal of Sciences, Vol. 8, Suppl. 2, pp 369-373, 2010, Available online at: http://www.uni-sz.bg

Arterial hypertension, diabetes, chronic obstructive pulmonary disease and neoplastic processes are most important national priorities, which the Bulgarian health care must cope. A decisive role in the prevention, diagnosis, treatment and monitoring of socially significant diseases have family doctors and their activities in a general medical practice. A sociological study was conducted among the general medicine practitioners from the region of Stara Zagora on the frequency of some diseases with socially significant character. A standard questionnaire was used, which was aimed at the socio-demographic profile of the family doctors, including a specification of their practices, as well as questions concerning the average number and age of the registered patients with the respective disease in general medicine, the monthly number of new cases, average number of individuals with complications, frequency and type of the complication. After processing, the results found a high incidence of arterial hypertension and diabetes among patients in active age and retirement age who are registered in dispensaries for general medical practice, and increased

incidence of neoplasms among them. This is a prerequisite for enhancing active promotional and preventive activities in the general medical practice.

[H1] ALIN, Opreana, Mihaiu Diana Marieta. Correlation Analysis between the Health System and Human Development Level within the European Union. International Journal of Trade, Economics and Finance, Vol. 2, No. 2, April 2011 http://www.ijtef.org/papers/85-F00033.pdf

This study aims to test the correlation between the effects, effort and efficiency of health expenditure in the European Union and Human Development Index (HDI). Although we observe a correlation between HDI, effects and effort in the health system, HDI is not correlated with the health system efficiency calculated as the ratio between effect and effort.

[H4] BALKANSKA, P., N. Georgiev, K. Popova. Modeling of the core management competencies in the process of training and development of health managers. Trakia Journal of Sciences, Vol. 8, Suppl. 2, pp 424-428, 2010. Available online at: http://www.uni-sz.bg

The success of any organisation depends on effective management, but health systems face a lack of competent management at all levels. During the past decade, there has been a growing interest in competency-based performance systems for enhancing both individual and organisational performance in health professions. This article reviews the processes and outcomes associated with the training and development of health managers. The study attempted to draw up guidelines for basic modeling of key management skills necessary to optimise the training of health managers. To achieve this, the following methods of research were used: critical analysis and synthesis of scientific literature on the research problem; documentary method - national and European documents were examined, inquiry method - direct inquiry. Results: A noticeable deficiency in knowledge and application of appropriate motivational approaches to communicating with staff. The most desired areas of excellence to which it is necessary to focus future training topics relate to: motivation skills, conflict resolution and team cohesion, communication skills, persuasion and influencing / leadership skills.

[H3] BJORNGREN, Cuadra Carin, Policies on Health Care for Undocumented Migrants in EU27. Country Report Bulgaria. Malmo Univesity. April 2010.
http://files.nowhereland.info/651.pdf

Undocumented migrants have gained increasing attention in the EU as a vulnerable group which is exposed to high health risks and which poses a challenge to public health. In general, undocumented migrants face considerable barriers in accessing services. The health of undocumented migrants is at great risk due to difficult living and working conditions, often characterised by uncertainty, exploitation and dependency. National regulations often severely restrict access to health care for undocumented migrants. At the same time, the right to health care has been recognised as a human right by various international instruments ratified by various European Countries (PICUM 2007; Pace 2007). This presents a paradox for health care providers; if they provide care, they may act against legal and financial regulations; if they don't provide care, they violate human rights and exclude the most vulnerable persons.

[H3] BOIKA, Rechel, Nick Spencer, Clare Blackburn, Bernd Rechel. Policy challenges to the quality of child health services in Bulgaria. The International Journal of Health Planning and Management. Volume 25, Issue 4, pages 350–367, October/December 2010. http://onlinelibrary.wiley.com/doi/10.1002/hpm.1030/

The study aimed to explore policy challenges to the quality of child health services in Bulgaria. The study was based on qualitative in-depth interviews, analysis of regulatory documents, and review of the literature. Respondents included policy-makers, providers and users of health services, from both rural and urban areas. Problems identified included insufficient training of general practitioners, medical errors, delays in response to emergencies, inadequate information provided to patients, and underdeveloped child public health. A common view was that paediatricians provide better quality care than general practitioners. Respondents described a lack of clinical guidelines for rational use of pharmaceuticals, overprescribing of antibiotics, reliance on pharmaceutical companies for information, and unrestricted sales of drugs over-the-counter. 'Clinical pathways', introduced as a payment mechanism in hospitals, were perceived as lacking transparency, complicating clinical practice, and forcing doctors to record wrong diagnoses and conduct unnecessary investigations.

[H6] ESPICOM BUSINESS INTELLIGENCE. Bulgaria. World Pharmaceutical Market. Q1, 2011, ISSN 0957 8072.
http://www.espicom.com/web3.nsf/structure/TocsWPM01/$File/Bulgaria.pdf

In per capita terms, the Bulgarian pharmaceutical market is one of the smallest in Central & Eastern Europe, similar in value to Romania. The market is predicted to increase at a moderate CAGR over the next few years. The growth rate has been affected by the economic crisis, with GDP contracting in 2009 and 2010. However, the economy is expected to recover in 2011. Health expenditure is expected to grow steadily over the next few years. In per capita terms, Bulgaria has the third lowest level of spending in the region. Public health expenditure accounts over half of total spending in 2011. All Bulgarian pharmaceutical companies produce generics as they cannot afford to develop innovative drugs. Generics account for a large proportion of the pharmaceutical market in volume terms, with two thirds of this supplied by domestic manufacturers; Actavis (formerly Balkanpharma) and Sopharma are among the leading producers. With regard to patent laws, counterfeiting was rife in Communist times, leading to the presence of many copied versions of leading drugs on the Bulgarian pharmaceutical market. This practice has become less common, however, as Bulgaria has moved its regulations in line with international norms.

[H4] KUNURJIEV, T. and Salchev, P., Technical eficiency of hospital psychiatric care in Bulgaria – assessment using Data Envelopment Analysis. 15. February 2011, MPRA Paper No. 28953, Online at http://mpra.ub.uni-muenchen.de/28953/

The present article deals with the theme of efficiency in health care and especially technical efficiency in psychiatric hospital care. The used method was the data envelopment analysis (DEA), which finds increasing application in many spheres of public life, including health care. The constant increase of spending in national health care systems and the problems stemming from financial deficits, raise the need for efficiency analyses in these systems. Effective spending of financial resources is related to a certain degree to the technical efficiency of treatment facilities. This study was focused our attention on technical efficiency in psychiatric hospital care in Bulgaria. This sector is primarily funded by state and municipal

budgets. Psychiatric care in Bulgaria is organised at two levels – prehospital care by psychiatrists and hospital care in specialised hospitals psychiatric wards in multiprofile hospitals. For the purposes of efficiency assessment the authors used the method of arranging and analyzing hospitals according to the relation between their product and used resources. This approach provides an opportunity for making optimal decisions in hospital management.

[H2] SALCHEV; P., Hristov; N., Georgieva; L., Evidence based policy – practical approaches. The Bulgarian National Health Strategy 2007-2012, A Handbook for Teachers, Researchers and Health Professionals, 2009, http://biecoll.ub.uni-bielefeld.de/volltexte/2009/2120/pdf/Dokument2_10.pdf

In recent years we have seen the successful implementation of new methods in formulating health policy, based on sound research data – the so called evidence based policy. This new approach to health policy helps experts formulate decisions on the basis of good information concerning programmes and projects, through presenting supporting evidence from research, which in turn becomes the core for political development and implementation. We decided to analyse the project for a National health strategy 2007-2012 of Bulgaria and see how well it corresponds to the principles of evidence based policy. Critical evaluation of the last draft of the National health strategy 2007-2012 reveals a number of weaknesses due to the documents' inconformity with the basic principles of evidence based policy making. We conclude with a discussion on possible implications for Bulgaria's health policy.

[H5] SALCHEV, P. and Hristov, N., Stress test of hospitals in Bulgaria - proposed methodology. 06. December 2010, MPRA Paper No. 27284, Online at http://mpra.ub.uni-muenchen.de/27284/

Stress tests of financial institutions are becoming more common in the midst of a global recession and unpredictable future economic growth. We believe that apart from banks, stress tests can be conducted on hospitals as well and will have their merit. The proposed methodology for risk assessment in hospitals is only one of many possible solutions and has already been tested on the field. We demonstrate the results from such testing. Consequently, we propose the introduction of routine stress testing in the hospital care sector.

[H5] SALCHEV, P., Integral Hospital Benchmark Index. Methodology and Practical Implementation. September 21, 2010 Second Edition, ISBN 978-1-4461-9905-3, Pages 389, Language Bulgarian, http://www.lulu.com/product/ebook/integral-hospital-benchmark-index-methodology-and-practical-implementatioin/12790220

Creating a single integral benchmark index holds a formidable challenge to any researcher. This assessment tool and analysis may provoke reactions ranging from enthusiastic acceptance to complete negation, but it could be argued with confidence, that it represents a powerful weapon for the elimination of subjectivism in the assessments, raising public and decision makers' awareness, increasing the transparency in activities of such a complex organisation such as the hospital.

[H5] SALCHEV, Petko; Hristov, Nikolai and Georgieva, Lidia, Possible approaches to benchmarking voluntary health insurance funds in Bulgaria. MPRA Paper No. 23065, June 2010 , Online at http://mpra.ub.uni-muenchen.de/23065/

Following the adoption of the Health Insurance Law in Bulgaria (1999), which provided the legal framework for the development of the voluntary health insurance, several health insurance funds had been established. Bulgaria had two licensed voluntary health insurance funds in 2001; in 2003 their number grew to six; and in 2009 this number stands over twenty. Despite the increased number of funds in recent years, their share of health care spending stayed at 1-1.5%, which is below European average. To this date, there are no serious and profound studies in the field among the scientific community in Bulgaria. The economic data published by the Commission of Financial Surveillance (CFS), conforms to EC regulations, but do not allow non-specialists to assess realistically voluntary health insurance funds (VHIF). This article introduces a methodology for comparing VHIF and establishment of a complex index (Benchmark Index - BI) based on 5 groups of indicators, related to several available variables. This index is intended as a tool for analyzing the voluntary health insurance sector and managing resources through a set of analytic indicators and variables. It can be used to create a certain type of ranking of VHIF.

[L] Long-term care

[L] SHOPOV, G., In Long-Term Care Policies for Older Populations in new EU Member States and Croatia: Challenges and Opportunities. World Bank Report, NOVEMBER , 2010, EUROPE AND CENTRAL ASIA REGION HUMAN DEVELOPMENT DEPARTMENT, pp. 51-67, Bulgaria,
http://siteresources.worldbank.org/BULGARIAEXTN/Resources/305438-1224088560466/5477317-1291895575007/ECCU5_LTC_AAA_Case_Studies_November_30_2010_FINAL_EN_1.pdf

The objective of this Summary Report is to highlight the main lessons learned from OECD countries with advanced LTC policies and the implications for LTC policymaking in new EU member states and Croatia. The first section examines the main findings from the Framework Report on the financing, provision and regulation of LTC services. The next section presents comparative findings from the four case study countries, including the demographic context for LTC services, the main features of the financing, provision and regulation of LTC services and the strengths and weaknesses of current LTC systems there. The last section identifies policy directions for the four case study countries.

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 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;*

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.

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.*

Катедра по социална медицина и здравен мениджмънт – Department of Social Medicine and Health Care Management

Address: Sofia 1524, 8 Bialo more str.
Webpage: www.ksmzm.medfac-sofia.eu

University department – under and postrgraduate teeching and researches in the fields of social medicine, public health, health policy and economics, health informatics and biostatistics, medical ethics and law, epidemiology, disaster medicine, management etc.

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.MoH.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;
In exercising their powers the Minister is responsible for their actions before the Council of Ministers and the Parliament; participates in the work of the Council of Ministers; makes contacts and interacts with local and foreign state bodies and NGOs, as well as with international organisations and institutions.

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.

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.

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".*

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.

5 Annexes

Annex 1: 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 2: Legal Framework of Health Care – Changes in applicable lagal frame by year[1]

Applicable laws	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Laws regulating the national health system													
Act on Health Insurance	2	6	1	1	7	4	6	7	8	8	2	6	12
Act on Health								6	9	6	2	7	8
Act on Treatment Facilities		3	3	1	2	3	1	5	4	2	1	2	4
Act on Medicinal Products in Human Medicine (*prev. Act on medicines and pharmacies in human* - 1995)	1	1	4	1	1	4	2	6	5		2	5	3
Act on Medical Devices										1			
Act on Narcotic Substances and Pre-cursors			1		3	1		3	3	2	3	4	5
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
Act on Blood, Blood Donation and Blood Transfusion							1		2	1			2
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
Codex on Labour	8	3		1	2	4	1	5	8	6	3	3	7
Act on Foods	1					1	1	2	7	2	2	5	5

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

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
Tax-Insurance Procedural Codex									11	6	3	4	5
Act on the Protection of Personal Data					1		2	2	2	1		1	2
Act on the Access to Public Information					2			1	3	2	1		1
Act on Public Contracts							1	3	4	1	3	2	5

Source: Salchev, 2011.

Annex 3: The main changes in health legislation in 2010

Act	Changes
ACT ON HEALTH INSURANCE	Changes in the **structure of management of NHIF**: director, supervisory body Changes in the **election of a director**: now selected by the Parliament The **forecasting of prices and volumes** by a specialised body of MF. The volumes, prices and methods for pricing and reimbursement of medical services are adopted annually by the Council of Ministers under a proposition by the Minister of finance. Changes in the **reimbursement** of diagnostic and treatment activities related to cancer and kidney insufficiency in need of dialysis, including the procurement of medications and medical devices: transferred from MoH to NHIF Setting of the ratio **health insurance contribution** distribution between employer and employee to 60:40 Enhancing the scope of medical aid under the mandatory health insurance to long-term care and rehabilitation Changes in the **contracting** and reimbursement between NHIF and pharmacies and health services providers The establishment of an **executive agency "Medical audit"** under MoH
ACT ON HEALTH	Merger of the Regional Health Centres and the Regional Inspections on Protection and Control of Public Health in Regional Health Inspections (RHI). **Increasing the responsibilities** of the Chief state health inspector regarding the **state sanitary control**. Changes in the activities of optical shops. **Increased responsibility of the Minister of health on the provision of healthy living environment**. Changes in legislation aimed at limiting of smoking, e.g. smoking in public places is allowed only in designated rooms. **Changes in the surveillance of communicable diseases –** the prevention and control of nosocomial infections are established with an ordinance of the Minister of health. Changes in the arrangement of isolation for infectious patients. The establishment of a sequence in the performance of autopsies.

	Changes in the **requirements to medical expertise**: the type and degree of disability are expressed as a percentage in relation to the capacity of a healthy individual. Changes in the **medical provision during disasters, related to the management of processes by RHI. Changes in** the activities of health offices and the qualification of staff. **Changes related to** mental health regarding the place of treatment, types of medical activities, emergency psychiatric care, mandatory care, the restructuring of psychiatric dispanseries into centres for mental health. **Changes in the requirements to medical studies: responsibility for incurred damages to participants, insurance for participants**
ACT ON TREATMENT FACILITIES	Reformation of **dispanseries** Changes in the organisation and financing of **emergency hospital care** Changes related to the **National health map** a) Planning based on population needs and on territorial principle and b) Regional maps and the National map define the minimum and maximum number of beds for active treatment and the structure of hospitals – levels of competence according to standards. Changes in the requirements for **accreditation** of hospitals
ACT ON THE MEDICAL PRODUCTS IN HUMAN MEDICINE	Changes in the issuing of working permits. Clinical trials **–** can be conducted in treatment facilities with a positive accreditation rating. Requirements to the positive medications list – it should include now AIDS and infectious diseases medications. Introduction of a **state control on medicinal products**
ACT ON THE TRANSPLANTATION OF ORGANS, TISSUES AND CELLS	Changes regarding the **collection, expertise, processing, labeling, keeping, provision and grafting of tissues and cells**, which can also be done by treatment facilities for pre-hospital care, only in the case when such activities are indicated in their certificate of. Expenses of treatment facilities are paid by MoH. The reimbursement of necessary medications for post-transplantation conditions is done by NHIF. Establishment of the opportunity for NHIF and voluntary health insurance funds to finance such activities under contracts with treatment facilities.
ACT ON THE CONTROL OVER NARCOTIC SUBSTANCES AND PRE-CURSORS	Medicinal products, containing narcotic substances, can be exempt from some measures for control, under the following conditions: 1) The product should pose no risk for abuse or the risk should be negligible; 2) The narcotic substance can not be extracted in quantities that could lead to abuse. Changes in control: Control on the prevention of drug abuse is performed by the Minister of education, youth and science and the Minister of health care. The Minister of health care and the Minister of labour and social policy exercise control over the psycho-social rehabilitation of persons, addicted to narcotic substances. Control over the treatment of addicted persons is exercised by physicians from the RHI Changes in the licensing of wholesalers and retailers – import permits, storage and prescription requirements. Changes in the requirements for documentation, reporting, marking and advertising. Changes in the functions of the National focus centre.

	Provision of access of all addicted persons to programmes for treatment, psycho-social rehabilitation and the reduction of harms. NGOs and treatment facilities can also participate in the implementation of programmes. The establishment of an expert council on addictions.
ACT ON BLOOD, BLOOD DONATION AND BLOOD TRANSFUSION	The centres for transfusion haematology provide to hospitals and cancer centres diagnosed and processed blood and blood products gratuitously within the quantities, approved by the Minster of health care. The organisation of supply is changed. Commissions on the control of quality are established in treatment facilities.

Source: Salchev, 2011.

Annex 4: Financing of the health care system (in BNG)

	Consolidated state budget	2008	2009	2010	2011	2011 in comparison to 2010	
						Growth in %	Growth in absolute amount
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*
	% 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**	**110%**	**303,210.9**
		,	,	,	,	,	,
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**	**112%**	**254,297.7**
		,	,	,	,	,	,
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**	**112%**	**254,297.7**
1.1.1.	Wages and stipends	20,636.0	21,806.0	21,665.4	21,665.4	100%	0.0
1.1.2.	Insurance contributions	4,280.4	4,061.9	3,998.9	4,322.9	108%	324.0
1.1.3.	Upkeep	12,201.6	13,779.8	21,687.3	22,863.3	105%	1,176.0
1.1.4.	**Health insurance payments**	**1,705,686.3**	**1,708,615.7**	**1,986,990.3**	**2,234,788.0**	**112%**	**247,797.7**
1.1.4.1.	*Hospital*	1,006,798.9	977,587.0	1,143,990.0	1,218,288.0	106%	74,298.0
1.1.4.2.	*Outpatient*	401,935.8	391,227.3	463,000.3	505,500.0	109%	42,499.7
1.1.4.3.	*Pharmaceuticals*	295,480.8	325,598.0	347,000.0	391,000.0	113%	44,000.0
1.1.4.4.	*Other health insurance payments*	1,470.8	14,203.4	33,000.0	120,000.0	364%	87,000.0
1.1.5.	Capital expenditure	3,160.3	1,991.6	2,000.0	7,000.0	350%	5,000.0
		,	,	,	,	,	,
2.	**MINISTRIES AND DEPARTMENTS**	**867,414.9**	**648,554.0**	**648,601.0**	**803,262.3**	**124%**	**154,661.3**
2.1.	MINISTRY OF HEALTH	698,942.4	524,724.2	563,727.4	705,632.8	125%	141,905.4
2.2.	OTHER MINISTRIES AND DEPARTMENTS	168,472.5	123,829.8	84,873.6	97,629.5	115%	12,755.9
3.	**MUNICIPALITIES**	**207,641.6**	**219,198.1**	**216,318.9**	**133,777.8**	**62%**	**-82,541.1**
	Subsidies for hospital care	80,731.7	95,572.3	85,360.8	,	0%	-85,360.8
4.	**CENTRAL REPUBLICAN BUDGET**	**4,023.0**	**4,259.7**	**43,305.9**	**17,913.1**	**41%**	**-25,392.8**
		,	,	,	,	,	,
5.	**OTHERS**	**5,767.5**	**12,100.4**	**3,118.2**	**5,304.0**	**170%**	**2,185.8**

Source: MoF, Salchev, 2011.

Annex 5: Programme budgeting from Ministry of health (in BNG)

Programme	2010	2011	Difference 2011-2010
Health control	19,779,307	19,890,187	110,880
Prevention of non-communicable diseases	11,511,180	11,102,869	-408,311
Prevention and surveillance of communicable diseases	32,390,049	80,005,055	47,615,006
Secondary prevention of diseases	5,158,736	4,812,388	-346,348
Reduction in drugs demand	1,600,302	1,896,008	295,706
Policy on diagnostics and treatment	342,289,829	408,728,594	66,438,765
Outpatient care	5,625,554	6,593,355	967,801
Hospital care	129,893,988	163,018,879	33,124,891
Dispanseries	4,292,000	0	-4,292,000
Emergency care - phone 150	76,958,042	71,804,476	-5,153,566
Transplantation of tissues, organs and cells	2,499,781	2,499,781	0
Provision of blood and blood components	10,714,191	11,014,191	300,000
Medico-social care for disadvantaged children	31,765,085	32,265,085	500,000
Expertise on degree of impairment and permanent disability	6,249,546	6,649,546	400,000
Haemodialysis	38,733,281	69,883,281	31,150,000
Other medical services	398,361		-398,361
Intensive treatment	35,160,000	45,000,000	9,840,000
Policy on medical products and medical devices	143,831,990	161,633,280	17,801,290
Accessible and high quality medical products and devices	143,831,990	161,633,280	17,801,290
Administration	13,533,248	23,931,619	10,398,371
Policy on promotion, prevention and public health control	70,439,574		-70,439,574
Total:	570,094,641	712,000,000	141,905,359

Source: MoH, Salchev.

Annex 6: Allocation of financial resources in health

	Hospital for acute care	Hospital for long-term care	Outpatient services	Drugs
Bulgaria	51%	3%	18%	28%
Europe (average)	29%	12%	31%	28%

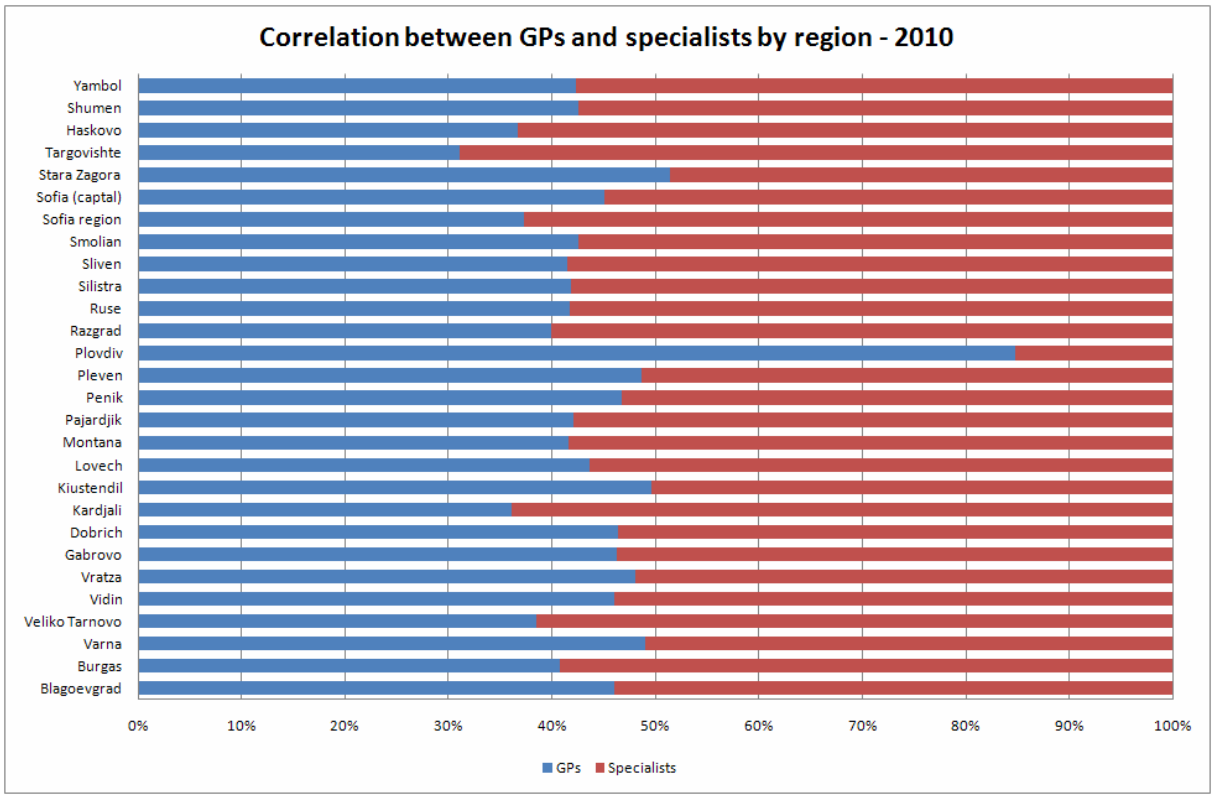
Source: NCHI, 2011.

Annex 7: Distribution of funds by directions

Directions	2007	2008	2010
Prophylactic examinations	19.15%	20.02%	21.29%
Prophylactic examinations for children 0-1 years of age	11.03%	11.78%	12.72%
Prophylactic examinations for children 1-2 years of age	3.69%	3.92%	4.24%
Prophylactic examinations for children 2-7 years of age	8.71%	9.07%	9.72%
Prophylactic examinations for children 7-18 years of age	18.39%	17.92%	18.33%
Prophylactic examinations for persons over 18 years of age	51.30%	58.44%	54.99%
Immunisations for persons aged 1-18	1.53%	1.51%	1.68%
Programme maternal health care	0.03%	0.03%	0.04%
Programme children health care	10.13%	9.96%	10.12%
Per capita payment	57.02%	55.55%	63.11%
Per capita payment for persons under 18	21.65%	21.01%	20.82%
Per capita payment for persons aged 18-65	47.74%	49.70%	55.07%
Per capita payment for persons over 65	24.12%	23.95%	24.11%
Cost of occasional visits	0.12%	0.12%	0.13%
Unfavourable conditions	1.77%	2.84%	2.91%
Costs of examinations by GP of insured persons	10.25%	9.98%	10.84%
Total	100	100	100%

Source: NHIF, Salchev, 2011.

Annex 8: Correlation betweens GPs and specialist by region (2010)



Source: NHIF, Salchev, 2011.

Annex 9: Hospital Beds in 2010

Types of health establishments	***Number***	***Beds***
Health establishments for hospital care – total	**306**	**45,906**
Multiprofile hospitals	**122**	**27,779**
Multiprofile hospital for active treatment	122	27,779
Specialised hospitals	**69**	**8,105**
Specialised hospital for active treatment	29	3,616
Specialised hospital for continuing and long term treatment	6	356
Specialised hospital for continuing, long term treatment and rehabilitation	12	840
Specialised hospital for rehabilitation	22	3,293
Psychiatric hospitals	**12**	**2,685**
Private facilities for hospital care	**93**	**5,291**

Source: NHCHI, 2011.

Annex 10: Activities of the Inpatient Wards of the Hospital Health Care Facilities

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	**11,287,817**	**267**	**43**	**6.2**	**1.3**
Multiprofile hospitals Multiprofile hospital for active treatment	**7,508,305**	**277**	**47**	**5.9**	**1.7**
Specialised hospitals	**2,080,978**	**269**	**35**	**7.7**	**0.5**
Specialised hospital for active treatment	958,571	276	46	6.0	0.7
Specialised hospital for continuing and long term treatment	127,498	317	33	9.5	0.1
Specialised hospital for continuing, long term treatment and rehabilitation	216,035	271	25	10.8	0.7
Specialised hospital for rehabilitation	778,874	255	26	9.8	0.0
Psychiatric hospitals	**771,326**	**287**	**5**	**60.9**	**0.9**
Private facilities for hospital care	**927,208**	**191**	**53**	**3.6**	**0.3**
Prophylactic centres (dispanseries)	**1,211,667**	**294**	**32**	**9.1**	**0.6**
For pulmonary diseases	180,374	239	22	11.0	1.0
For dermato-venerological diseases	53,200	244	28	8.8	0.0
For oncological diseases	528,885	327	57	5.8	0.7
For psychiatric diseases	449,208	294	13	22.9	0.2

Source: NHCHI, 2011.

Annex 11: Overview of pharmaceutical market

Market share	Sales by packages 2010	Growth against 2009 in packages%	Sales in BGN 2010	Growth against 2009 in BGN%
ALL Monitored Markets (ATC + OTC + Nutritional)	269,062,157	-2%	2,019,434,850	9%
Prescription Bound	165,455,406	-2%	1,554,260,085	10%
OTC - Registered	77,662,727	-3%	322,285,509	4%
OTC - Non Registered	24,166,220	4%	132,482,353	4%
Other Therapeutic Products	1,777,804	-8%	10,406,903	-4%

** Total market - pharmaceutical, hospital, OTC, nutritional supplements and specialised foods.*

Sources: http://www.ceepharma.com/c_136/Bulgaria.shtml.
The Pharmaceutical Market: Bulgaria Opportunities and Challenges, 2011,
http://www.espicom.com/Prodcat2.nsf/Product_ID_Lookup/00000331?OpenDocument.

Annex 12: Market by channel of realisation

Channel of realisation	Sales by packages 2010	Growth against 2009 in packages%	Sales in BGN 2010	Growth against 2009 in BGN%
Total Market	243,118,133	-2.3%	1,876,545,594	9.0%
Pharmacy market	200,373,716	-1.0%	1,601,125,079	12.5%
Hospital market	42,744,417	-7.9%	275,420,515	-7.5%

** Total market – pharmaceutical ATC and hospital market.*

Sources: http://www.ceepharma.com/c_136/Bulgaria.shtml.
The Pharmaceutical Market: Bulgaria Opportunities and Challenges, 2011,
http://www.espicom.com/Prodcat2.nsf/Product_ID_Lookup/00000331?OpenDocument.

Annex 13: Pharmacy market

	Sales by packages 2010	Growth against 2009 in packages%	Market share in packages2010	Sales in BGN 2010	Growth against 2009 in BGN%	Market share in BGN,% 2010	Average price 2010
PHARMACY MARKET	198,373,426	0.4%	100%	1,581,400,190	14.0%	100%	7.97
Rx	125,222,197	-0.1%	-37%	1,288,770,140	14.3%	81%	10.29
OTC	73,151,229	1.4%	-42%	292,630,051	12.5%	19%	4.00

Sources: http://www.ceepharma.com/c_136/Bulgaria.shtml.
The Pharmaceutical Market: Bulgaria Opportunities and Challenges, 2011,
http://www.espicom.com/Prodcat2.nsf/Product_ID_Lookup/00000331?OpenDocument.

Annex 14: State funded market by segments for 2010 and against 2009

	Values – million BGN	
	2010 (BGN), million	2011 (BGN), million, prognosis
State funded market	642	↑ 680
NHIF – reimbursing list	367	↑ 400
Hospital – tenders of MoH	137	= 140
Hospital – tenders of hospitals	138	= 140

Sources: http://www.ceepharma.com/c_136/Bulgaria.shtml.
The Pharmaceutical Market: Bulgaria Opportunities and Challenges, 2011,
http://www.espicom.com/Prodcat2.nsf/Product_ID_Lookup/00000331?OpenDocument.

Annex 15: Concept for future sustainable development of the system for emergency medical care

Action	Steps
1. Clear defining of the role of emergency care	focusing the personnel, technical and financial resource on emergency aid
2. Shortening access time to emergency aid	the setting of a clear time frame in which a set percentage of calls will be processed at national level. In view of present data – initially the realistic aim should be 90% of life-threatening conditions tackled under 20 minutes
3. Improvement of the structure of emergency care system	a. Adoption of standards for territorial distribution (map) of emergency care structures b. Optimisation of the number, type and distribution of emergency aid teams
4. Better quipping of the system with communication systems, sanitary vehicles, and medical equipment	
5. Raising the quality of emergency medical aid a. ***Sustainable development of human resources***	training of paramedics should start in accredited structures with duration of 1 (lower) and 2 (higher) levels, meaning that the first to graduate will join the system no earlier than in 3 years. This is a new form of servicing for Bulgaria, so some changes will be needed in view of acknowledging this profession, the adaptation of staff, the perception to this practice among the population, etc.
b. ***Improvement in the provision of emergency medical aid***	i. Improvement in the admission of calls and triage of patients in dispatching centres i. Improvement of the organisation of reacting to calls, the triage of patients on the spot and their transportation i. Integration of the system for emergency aid in the National system for urgent calls
6. Relations with other sectors	Improvement of the relations and distribution of responsibilities among the system for emergency medical aid and the systems for primary care and specialised outpatient medical care Improvement of the coordination and relations between the system for emergency aid and the system for hospital care
7. Development of the financing of the system for emergency medical aid	According to MoH calculations the necessary annual funds for the functioning of the emergency aid system amount to a minimum of 150 million BGN i.e., for the next year 75 million BGN will be needed additionally, of which 60 million for wages and insurance contributions of the personnel, 10 million for gradual replacement of ambulances, 1 million for maintenance of the information and communication system, 1 million for training of personnel, 3 million for maintenance of equipment and new equipment. In the situation of economic crisis this goal seems unattainable.
8. Time schedule for realisation of the concept	MoH envisages the realisation of the proposed measures within 3 to 5 years, including: Public discussion and adoption of the concept – 3-6 months Changes in legislation – 6-9 months Preparation for a start in the training of paramedics and training itself – 2 years for first level, 3 years for second level – according to experts – unrealistically short period Changes in financing – taking over of some activities by NHIF and other funds – 12 months (2012) – according to experts the redistribution of financing is unclear and terms are too short.

Annex 16: Access time to emergency medical care

	less than 20 min	between 20 and 30 min	over 30 min
settlements	58%	27%	15%

Annex 17: Peronnel and teams – emergency medical care system (2010)

Team type	N
reanimation teams	87
first aid teams	267
incl.:	
with physicians	141
with physicians assistants and nurses	126
transport teams	35
stationery teams	167

Staff	N
physicians	1,146
physicians assistants	1,508
other medical specialists (nurses, midwives, etc	1,103
	3,757
unfilled positions	5.3%

Annex 18: Working experience of the staff of emergency medical care system

Working experience	%
with less than a year working experience	11%
with experience of 1 to 5 years	23%
with experience of 5 to 10 years	14%
with experience of over 10 years	52%

Annex 19: Emergency medical care system activities (2010)

Processed calls	831,968
delayed calls	4%
emergency aid calls	76%
specialised medical transportation	15%
non-urgent calls.	9%
average workload per team	3.2 calls

Processed persons	793,734
over 18	706,527
hospitalised	25%
children under 18	87,207
hospitalised	38%
ambulatory examinations	62,9336

Annex 20: Bulgaria: the six convergence regions at-a-glance

Figures from 2007	Severozapaden	Severen tsventralen	Severoiztochen	Yugoiztochen	Yuzhen tsentralen	Yugozapaden
Population (inh.)	0.93 m	0.93 m	0.99 m	1.13 m	1.55 m	2.12 m
Surface area (km^2)	19,070	14,974	14,487	19,799	22,365	20,306
GDP per capita in EUR (PPS)	6,700	7,100	8,600	8,200	7,200	16,600
GDP per capita as% of EU 27 (PPS)	27%	28%	34%	33%	29%	67%
Cohesion Policy status	Convergence	Convergence	Convergence	Convergence	Convergence	Convergence
Life expectancy at birth, male	68.6	69.5	69.2	68.9	70	70
Life expectancy at birth, female	76.1	76.3	76.3	75.8	77.2	77.3

Sources: Eurostat and Fifth report on economic, social and territorial cohesion.

Annex 21: Non-institutional LTC and Social Services

Type of Service	Services Provided	Service Delivery/Management
Personal assistant	Take permanent care of a child or adult with disability or serious illness	Financed and managed by the state through the "Assistants for persons with disabilities" programme. Small contribution from the municipalities that apply for this service. This is the only service that is completely free of charge for the users.
Social assistant	Provide a range of services to elderly or disabled person, including food delivery, shopping, personal hygiene, cleaning, errands, etc. Social assistants play an important role in avoiding institutionalisation for clients.	Financed and managed by the State In the framework of the National programme "Assistants for persons with disabilities." Users pay small fees for a set number of hours per week. Fees for additional hours are higher. Municipalities – provide some financial and managerial support. Social assistants are normally a trained unemployed person hired by the national programme.
Home helper	Provide services at home, house cleaning, cooking, shopping, errands, etc. Number of hours per week varies with individual needs.	This service (from 2009) is a component of the National Programme "Social services at home", financed by the state budget. User fees based on income.
Daycare centre	Provide comprehensive services for the elderly including food, health, education, rehabilitation, and general social contact.	Funded by the state, managed by the municipality. Can be contracted out to a private organisation. Clients pay 30 percent of their income.
Centre for social rehabilitation and integration	Provide a range of social services by a team of specialists (psychologist, physical therapist, counselors, etc.) to prepare clients for integration into society and eventual independent living.	Funded by the state, managed by the municipality. Small user fees based on a set schedule. Management can be contracted to a private organisation.

Care services at Home	Social services provided at home such as food delivery, cleaning, help with personal hygiene.	Initially financed through municipal budgets but recently added to the national programme: "Services in Family Conditions" which provides additional state funding to expand services. User fees apply, based on the Local Taxes & Fees Act.

Source: Social Assistance Agency at the Ministry of Labour and Social Policy, Shopov 2009.

Annex 22: Institutional LTC and Social Services

Type of Service	Services Provided	Service Delivery/Management
Home for adults with disabilities	Range of social services related to activities of daily living (ADL).	Financed and managed by the state the through the "Assistants for persons with disabilities" programme. Some user fees apply.
Homes for elderly people	Specialised institution, providing a range of social services to people entitled to a pension. Requires certification by an expert	Financed and managed by the state the through the "Assistants for persons with disabilities" programme. User fees based on income and assets.
Specialised hospitals for further and continuing treatment and rehabilitation	Comprehensive medical care for people with chronic diseases or conditions that require continuing care and physical rehabilitation.	Managed by commercial entities registered under the Commercial Act and based on standards laid out in the Medical Treatment Facilities Act. Funded by the state and user fees.
Hospices	Long-term medical observation and treatment based on personalised plans.	Managed by commercial entities registered under the Commercial Act and based on standards laid out in the Medical Treatment Facilities Act. Funded by the state and user fees.

Source: Social Assistance Agency at the Ministry of Labour and Social Policy, Shopov 2009.

Annex 23: Specialised institutions

Type of institution	Number	Capacity (places)
Homes for elderly persons with mental retardation (HEPMR)	28	2,349
Homes for elderly persons with psychic disorders (HEPPD)	15	1,202
Homes for elderly persons with physical impairments (HEPPI)	25	1,495
Homes for elderly persons with sensory disorders (HEPSD)	4	148
Homes for elderly persons with dementia (HEPD)	13	843
Homes for elderly persons (HEP)	76	5,534

Source: Salchev, Social Assistance Agency.

Annex 24: New social services of the residential type open in 2010

Type of Institution	Number	Capacity (places)
Protected homes (PH) for persons with mental retardation	3	3(
Protected homes (PH) for persons with psychic disorders	7	6
Protected homes (PH) for persons with physical impairments	2	1
Family type centres for accommodation (FTCA) for persons with physical impairments	4	5(

Family type centres for accommodation (FTCA) for persons with mental retardation	4	28
Family type centres for accommodation (FTCA) for elderly persons	2	30
Family type centres for accommodation (FTCA) for persons with psychic disorders	1	15
Transitional homes (TH)	5	46
Monitored homes (MoH)	4	34
Crisis centre (CC)	1	18

Source: Salchev, Social Assistance Agency

Annex 25: Institutions, delivering long-term care and social services: 31.12.2010

Type of institution	Number	Capacity
CENTRES FOR SOCIAL REHABILITATION AND INTEGRATION FOR ADULTS	49	1,757
CENTRES FOR SOCIAL REHABILITATION AND INTEGRATION FOR CHILDREN	18	713
DAY CENTRES FOR CHILDREN WITH IMPAIRMENTS	66	1,776
DAY CENTRES FOR CHILDREN AN ADULTS WITH IMPAIRMENTS	7	378
DAY CENTRES FOR THE ELDERLY	49	1,449
DAY CENTRES FOR ELDERLY PERSONS WITH IMPAIRMENTS	53	1,495
TRANSITIONAL HOMES FOR CHILDREN	15	126
TRANSITIONAL HOMES FOR ADULTS	9	81
MONITORED HOMES	16	100
PROTECTED HOMES	105	927
FAMILY TYPE CENTRES FOR ACCOMMODATION OF CHILDREN	68	793
FAMILY TYPE CENTRES FOR ACCOMMODATION OF ADULTS	19	230
CENTRES FOR PUBLIC SUPPORT	68	3,156
Total	542	12,981

Source: Agency for Social Assistance.

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(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;

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