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Pensions, Health and Long-term Care

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1 Executive Summary

In mid-2009 regular elections took place in Bulgaria, resulting in the formation of a new parliamentary majority. The new government took office in late July, announcing radical public-sector reforms aimed primarily at the rapid elimination of corruption at all levels of power and improving the efficiency of the public administration. A clear signal of strong political commitment to implementing the renewed Lisbon Strategy was given already in the first month of the new government after the Deputy Prime Minister and Minister of Finance Simeon Dyankov was appointed by the Council of Ministers as a National Coordinator for the Lisbon Strategy.

The analysis of the Bulgarian pension model shows that during the past years there were major deviations in its development, which lead to financial instability of the public insurance pillar. The need to continue the development of the Bulgarian pension model led to an exclusively large-scale public discussion, which has been taking place now for 10 months, with the participation of social partners, state institutions, academic and expert circles, the Economic and Social Council, pension funds, and the World Bank

A Consultation Council on the pension reform with the Minister for Labour and Social Policy was established in the autumn of 2009 with the aim of developing the framework of the continuing modernisation of the Bulgarian pension system, in order to overcome these challenges. The Consultation Council on the pension reform discusses a range of scenarios for measures, subordinated to the general objective of guaranteeing a long-term financial stability of the Bulgarian pension system, which would improve the adequacy of pensions.

Despite the Government's expectations of an imminent end to the severe economic and budget situation, recent expert research data shows that almost one third of the households in Bulgaria are directly hit by the economic crisis. Many of them are forced to restrict their expenditure on food, medical services, and education, which exposes them to additional risks in the future. The Government, social partners, and experts are continuing their efforts in 2010 to take appropriate economic and financial decisions to reduce the negative impact of the crisis. Having discussed hundreds of different proposals, the National Council for Tripartite Cooperation reached a consensus on 60 more or less concrete actions to be undertaken by the Government and Parliament in the months to come.

Based on MLSP data there is a positive trend concerning unemployment. The highest peak was in December last year, in January and in February, when it reached 10.26%. According to the Minister for Labour, the measures under the National Employment Plan and the new schemes under the human resources programme, as well as the reviving of tourism and services are already showing results.

Bulgaria is presently in an environment of global economic crisis and the issue about the place and role of health care is particularly important. Due to the crisis the Government had to adopt a programme for expenditure cuts in all sectors, whereas the planned cuts in the health care sector are 20% of the administrative expenditures. Meanwhile it became clear that NHIF[1] is not able to pay the full amount due for work done by medical doctors and health establishments. Many hospitals in the country received less clinical pathways for patient treatment. Restrictions were imposed with regard to the negotiations for drugs included in the positive drug list. The new team of the MH[2] is preparing a scheme for competence levels,

[1] National Health Insurance Fund.
[2] Ministry of Health.

which will be three, according to the Minister, and will be used to determine the diseases which the various HE[3] will be entitled to treat. Some new clinical pathways for post-operative and long-term treatment are being created, so that hospitals that are not entitled to treat acute diseases can restructure their activities.

2 Current Status, Reforms and Political and Scientific Discourse during the previous Year

2.1 Pensions

2.1.1 System's characteristics and reforms

Bulgaria launched a large-scale pension reform in 1999 and in practice profoundly changed the philosophy of the pension model. A transition from a one-pillar pension system to a three-pillar pension system was made, the latter combining: 1) mandatory state pension insurance, functioning under the pay-as-you-go principle (I pillar); 2) mandatory supplementary pension insurance in Universal pension funds for those people born after 31 December 1959 and in Occupational pension funds for those working under the first and second category of labour, functioning under a capital-funded principle (II pillar) and 3) supplementary voluntary pension insurance functioning under the capital-funded principle (III pillar).

The fundamental objective of the reform was to raise the overall level of pension protection with a view to ensuring better well-being of pensioners.

Almost 10 years after the start of the reform, the analysis shows that some of the objectives have been achieved fully or partially.

- Raising the overall level of the pension protection for pensioners. The objective was partially achieved, in so far as the net replacement coefficient[4] has risen from 48.3% in 2000 to 60.2% in 2009[5].

However, the problem of poverty among the older people still exists; as the Eurostat data show in 2008 the level of poverty among people aged 65 and above is 34%, and among those aged 75 and above 40%.

- Achieving fairer pension insurance. The objective was achieved; the more important steps undertaken since 2000 were:

The formula for calculating pensions was changed and the rate of the pensions depends on the overall insurance period.

More stringent requirements for pension entitlement were introduced, including longer insurance period and higher retirement age;

The insurance contribution rate was decreased; certain conditions were created for the contribution to be paid jointly by the employer and the insured person;

The range of incomes on which insurance contributions are paid was broadened – currently contributions are paid on all types of income from labour, not only on the salary.

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[3] Health establishments.

[4] The ratio between the average pension of one pensioner and the average insurance income (after taxation and deducting insurance contributions).

[5] In the third quarter of 2009.

- Concerning the financial stabilisation of the system in the medium term and long term there is no doubt that this objective has not been achieved. This circumstance, taken alone, creates the risk of discrediting the reform. Currently, the Bulgarian pension system is unstable in financial terms and strongly dependent on the state budget. Examples for this are the following facts:

Financial instability. In the current year the Law for the Budget of the State Social Security (SSS) 2010 provides for a transfer covering the shortage of resources from the state budget at the rate of BGN 2.06 billion. To compare, in 2000 the transfer for covering the shortage of resources was BGN 89.6 million. Therefore, over a period of 10 years the shortage of resources in the SSS has increased almost 23 times.

Dependence on the state budget. In 2009 the state became the “third insurer”, providing a transfer to the “Pensions” Fund at the rate of 12% of the insurance income of every insured person. In 2010 this transfer is BGN 2.3 billion or 34% of all the Fund’s expenditure for pensions. Therefore, in case the payment of the transfer is terminated, the pensions for 97% of pensioners must be decreased by more than 1/3. It is obvious that the revenue from contributions covers less than 2/3 of the expenditure for pensions. The Bulgarian pension insurance system is being transformed more and more into a system financed by taxes.

The reasons for the worsened financial situation of the first pillar of the pension system must be sought through the analysis of two groups of factors. One of them is related to the wrong decisions that led to drastic mismatching 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 the years ahead. The other group of factors is related to the influence of the global economic crisis, which led to the decrease of the insurance base – the number of insured people and the insurance income, two parameters that are fundamental for the insurance contributions revenue.

In 2009 the crisis continued having a significant impact on the operational results of the capital pension funds of the II and III pillars. Data of the Financial Supervision Commision show that there is no significant progress in the development of the voluntary pension funds based on occupational. There is still only one fund of this type. There is no growth of persons insured in voluntary funds for supplementary pension insurance (III pillar). Concurrently, the III pillar marks a significant decrease of the average montly revenues from contributions per insured – from BGN 67.65 in 2008, to BGN 45.02 in 2009.

There are also positive signals for the gradual overcoming of the hard situation. Most important are the positive changes in the yield of pension funds. Analyses of the universal pension funds (most financially powerfull funds, concetrating more than 70% of the entire financial resourse in the supplementary pension insurance) serve as a basis of a better development forecasts for 2010.

Table 1: Average monthly yield of universal pension funds

year	2005	2006	2007	2008	2009
% yield	8,16%	8,78%	17,19%	-21,14%	8,09%

Source: Financial Supervision Commission data

2.1.2 Debates/political discourse

The necessity to continue the development of the Bulgarian pension model led to a large-scale public discussion which has been conducted for 10 months now with the participation of the social partners, state institutions, academic and expert circles, the Economic and Social Council, the pension funds, and the World Bank.

The common position, shared by all participants in the discussion, is the increasing anxiety about the continuing financial instability of the solidarity pension fund. At the same time there are serious differences in the positions of the trade unions and the employers. On the one hand, the trade unions are against the raising of requirements for pension entitlement and on the other, the employers insist on continuing the policy for decreasing the insurance contributions.

The Government, despite some hesitations for the reforms schedule, declared its categorical position for stabilising the pension system.

A Consultation Council on the pension reform with the Minister for Labour and Social Policy was established in the autumn of 2009 with the aim to develop the framework of the continuing modernisation of the Bulgarian pension system for overcoming the above-mentioned short- and long-term challenges.

The Consultation Council on the pension reform is discussing a number of measures subordinated to the general objective of guaranteeing the long-term financial stability of the Bulgarian pension system for improving the adequacy of pensions. From today's point of view the most probable is the variant in which from 1 July 2011 pension entitlement shall be given to men after 40 years of insurance length of service (now 37 years) and to women after 37 years of insurance length of service (now 34 years), with minimum retirement age for men 63 and for women 60. This is the first scenario proposed by the Consultation Council on the pension reform, and in the opinion of the experts is more acceptable for the people, and is more achievable in the present conditions based on the health status of the population. This variant envisages that persons who have reached the age of 65, but do not have the necessary insurance length of service, will retire with a decreased pension if they have minimum 15 years of actual length of service. Persons who have reached the retirement age but still need three years of length of service will be entitled to a pension but at a decreased rate. A bonus is envisaged for the persons who meet the requirements for age and length of service and continue working without being granted a pension.

The Consultation Council proposes a number of measures for restricting early retirement:

- Raise the retirement age for persons who have worked under first category of labour by three years, i.e. the early retirement for them should be five years earlier, not eight, as it is now;
- Precisely determine the necessary rate of the contribution for workers under the first and second category of labour and for those entitled to early retirement under Art. 69 of the Social Security Code, having in mind the duration of participation in insurance and the period of getting a pension;
- Terminate the abuse of medical assessment of the capacity for work. Look for measures on how to restrict the disability pensions and improve control over the medical assessment of the capacity for work. Better administration of medical assessment bodies through the introduction of the principle "the one who pays, makes the assessment of the permanent incapacity for work".

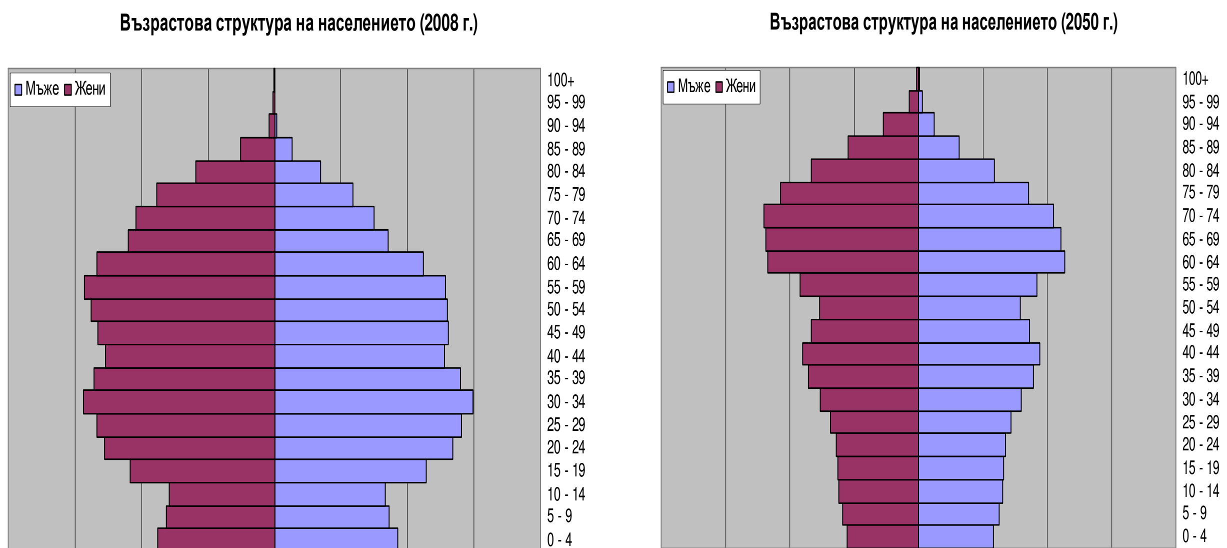
2.1.3 Impact assessment

There are serious demographic, economic, and social problems that influence the financial stability of the pension system:

- Decrease and ageing of population.

The demographic developments in Bulgaria during the coming years are characterised by a process of demographic ageing of the population. It will come in the worst possible development model – "upwards" and "downwards" ageing in the population pyramid, i.e. concurrent low birth rate and growing average life expectancy. The expectations are thay for a period of about 50 years, the share of population older than 65 will double from 17% in 2008 to 34% in 2050, while the number of people in active age will shrink almost twice – from 5.3 million to 2.7 million for the same period. This will be in parallel to a significant decrease of the total number of people:

Figure 1: Process of demographic ageing in Bulgaria



Age structure of the population (year 2008), blue – male, red - female

Age structure of the population (year 2050), blue – male, red - female

Source: National Statistical Institute

The National Statistical Institute data shows that the population will decrease by more than 1.6 million people up to 2050. This presupposes a decrease of the active population and an increase of the old-aged population. Presently, 100 people of active age must support 25 old-aged people; in 2050 this ratio will be 100 to 56;

- Low economic activity of the population and existence of the grey economy. Taken together, these circumstances restrict the potential revenue of the insurance system and negatively affect the tax revenue;

- Low rate and low adequacy of pensions. The low living standard of the pensioners will be related in future to serious public pressure towards policies for increasing the pensions rate, which will not be always possible in economic and fair balance terms.

2.1.4 Critical assessment of reforms, discussions and research carried out

The decisions that mostly affected the financial situation of the state pension system were the following:

- Pursuing simultaneously policies for restriction of revenue (decreasing contributions) and increase of expenditure (increasing the insurance benefits).

Table 2: Reduction of contributions to the Pension Fund (I Pillar)

Year	2001	2001	2004	2006	2007 (since 1.10.2007)	2009	2010
Decrease of contributions	3% points	2% points for the persons born after 31.12.1959	1% point for the persons born after 31.12.1959	6% points	1% point	4% points	2% points

Due to the increase of the number of people insured for pension (by 24% compared to 2000) and of the average insurance income (by 2.2 times in nominal terms compared to 2000), the revenue from insurance contributions to the Pensions Fund increased by 68.8% compared to 2000. The growth of pensions expenditure for the same period is 2.1 times. Consequently, the mismatch between the revenue and expenditure side of the pension system also deepened. It becomes increasingly difficult for the insurance contributions revenue to cover the pensions expenditure (from about 97% in 2000 the share of revenue from pension contributions to pension expenditure decreased to 63% in 2008). The major consequence is the increasing financial dependency of the state social security on the state budget and the opposite – the state budget increasingly has to comply with the needs of the pension system.

- Sub-optimal decisions and control over the certification of disability and disability pensions.

Due to the stricter requirements introduced for access to pension, the number of the new pensioners for insurance length of service started to gradually decrease. The objective was to establish conditions for decreasing the expenditure of the system and its long-term stabilisation. However, in practice the disability pensions increased and became some sort of an early retirement model and instrument for circumventing the new requirements for old age and period of service pension. A good example for this is the fact that in comparison with 2000, the number of pensioners is decreasing and in 2008 is 7.4% smaller, and the number of the newly granted pensions is decreasing by almost 27%. At the same time there is a doubling of pensions for disability due to general disease and a tripling of the social pensions for disability, the number of which increased from 145,600 pensions in 2000 to 484,300 pensions in 2008.

- Maintaining normative conditions in favour of certain groups of insured persons.

Certain groups of insured still exist that are in a more favourable position compared to the other insured persons. These are self-insured, including registered agricultural producers, who define themselves their contributory income.

- Maintaining regimes allowing for early retirement.

The review of the legislative decisions taken after the reform shows that the access to such regimes is made even easier and enlarged instead of the planned gradual restriction of early retirement. There are still groups of insured who can retire earlier than the standard pension age and along with this get a higher pension, which contradicts to the insurance principles. Such groups are the military service members, employees under the Ministry of Interior Law and the Law on Execution of Penalties, investigators, teachers, persons working under first and second category of labour.

- Maintaining structural discrepancies within the pension system which raise its dependency on the state budget.

Currently, there are elements of the pension system which have the character of social assistance or are not related to the insurance contributions (for example social pensions and others). Some of them are covered by the state budget, but others by the insurance funds.

Along with this, it is necessary to implement a flexible mechanism for updating pensions, keeping in mind inflation, the dynamics of the GDP, the contributory income and changes in life expectancy.

2.2 Health

2.2.1 Overview of the system

One of the main principles of the Bulgarian health care is the principle of equal access to medical care. The Government's commitment to guarantee this access is fulfilled by the provision of the necessary funds, legally guaranteed by:

- Health Law;
- Health Insurance Law;
- Law on the State Budget;
- Law on the Budget of the National Health Insurance Fund for 2008.

The state budgets' (SB) allocated funds for health care as share of the GDP for the period 1995-2008 have varied within the range 3.0% to 4.8%, as shown in the following table.

Table 3: Health care expenditures as % of GDP 2000 – 2003

Year	Health care expenditures as % of GDP
2000	3.7%
2001	4.0%
2002	4.5%
2003	4.8%
2004	4.0%
2005	4.2%
2006	4.4%
2007	4.3%
2008	4.2%
2009	4.4%

As an absolute amount these funds have been increasing, whereas in 2008 the Law on the SB approved BGN 2,223 million for health care.

-To compare, the average GDP share for health care of the other EU Member States is 8%. In Bulgaria, the health care expenditures per person amount to EUR 136 in 2009, this is by far less than the lowest level in the EU.

-The following factors influence the collection of health care contributions and the subsidies on national and local level:

- The revenues depend largely on the demographic profile of the country – a negative natural growth, new emigration wave. The ageing and emigration decrease the motivation of young generations to participate in the solidarity health insurance system;
- The coverage of insurees is incomplete due to informal employment, as part of the high share of the grey economy. Based on NSI and NHIF data, in 2008, more than 1 million Bulgarian citizens were not insured and therefore not eligible to use free medical care. In 2009 this figure is already 1.2 million.
- The country's economic profile – negative growth trend, bankruptcies in the real sector. At the end of 2008 and beginning of 2009, the number of companies who suspended their operations and made their staff redundant or sent on unpaid leave rose sharply. The official and unofficial employment in the construction sector dropped dramatically, due to the sector shrinking by more than 50%[6];
- Insufficient state budget financing, representing a major barrier that practically hinders the good access of everyone to the necessary medical care, as well as the response to the health needs of the population;
- Insufficient stimulus and rules for allocation of the financial resources for sickness prevention and health promotion;
- Insufficient effectiveness of the system for interaction among the main financing institutions – the Ministry of Health and the NHIF – and lack of comprehensive assessment of the needs and their financing;
- The communication and intersectoral cooperation are not sufficiently effective;

[6] Cf. http://www.nsi.bg/.

- The role of the voluntary health insurance in the financing of health care services is insignificant.

One of the main problems of our health care system during the past years is related to the unregulated payments, which increases the social burden of the population. Based on a survey made in 2007 by the University for National and World Economy (UNWE)[7], the personal health care expenditures, including direct payments, amount to some BGN 1,500 million, including the unregulated payments by the patients.[8] Therefore, a large portion of the financial resources targeted at health care cannot be covered by the official statistics, and, in turn, the actual health expenditures cannot be determined accurately.

In fact the regulations allow this. According to Ordinance No. 13 of the MH, the insured are entitled to choose their physician and surgery team. This facilitated the establishment of a popular practice in the hospitals to ask patients to pay great amounts, forced to make such a "choice", or make a "voluntary" donation. The fact that patients have been forced is difficult to prove. A large portion of these funds are not entering the hospital budget.[9]

2.2.2 Outpatient Health Care

Based on NSI[10] data in 2009 the GP[11] coverage per 10,000 persons was 6.3 on average for the country, remaining close to the average coverage levels of the new EU Member States. If reviewing the health insurance status of the population, though, in 2008 10,000 health-insured persons were serviced on average by 7.3 GPs[1]. As a comparison, this indicator was 8.1 in 2005. This is due to the fact that it is ever more unpopular for the GPs to work, so the medical doctors prefer to specialise and work in hospitals. Obviously there is a decline in the income of GPs, especially those working in remote and unattractive areas. Moreover the incentive system for those working in the latter conditions "froze" and is not adequate for the new circumstances – ageing and decline in rural population, as well as "medical" migration.

The trend of growth in the number and relative share of compulsory health-insured persons (CHI) registered with GPs remains the same as in the previous years – 6,660,335 or 87.6% of the population (for 2008 – 6,647,084 or 87.0%[12]). In 2009 health-insured are 6,270,000 persons.

A logical consequence of the outflow of medical doctors from primary care is the reduced POHC[13]. In 2009 NHIF[14] signed contracts with 4,238 practices (including 4,029 individual practices and 209 group practices) with 4,894 GPs, while in 2008 the average monthly functioning practices were 4,333 with 5,005 GPs. Approximately 1,029 practices remained unoccupied. Based on World Bank data, 17.8% of the places in regions with unfavourable conditions remained unoccupied. The decline is 2.2% for practices (entirely related to individual practices) and 2.3% for medical doctors.

7 Delcheva E., and panel, Market and non-market defects of the social and cultural environment, (panel treatise) University Publishing House "Economy", Sofia, 196 pages, 2007.
8 Delcheva E., and panel, Market transformation of the social and cultural spheres, University Publishing House "Economy", Sofia (forthcoming publishing), 2007.
9 Ordinance on the conditions for access to health establishments, promulgated SG issue 45 dated 2 June 2006.
10 Health establishments for inpatient and outpatient health care and health establishments in 2009. NSI, 2010.
11 General Practitioner.
12 Report on the health status of the population – a primary investment in the future of the nation 2006–2009, MH, 2009.
13 Primary Outpatient Health Care.
14 National Health Insurance Fund.

Unlike other European countries, in Bulgaria individual practices are more popular – 4,029 or 95.1%. Despite the proven advantages of group practices, their number in 2009 remained at 209 (4.9%), the same as in 2008. The highest number of group practices is in Sofia-City (41), while there are none registered in Vratsa, Smolyan and Silistra districts[15].

For 2009, the average monthly number of screenings carried out under the Children's Health Care remains at the level of 2008. The number of compulsory immunisations of CHI aged 0–18 years for 2009 increased by 8.1%.

The downward trend in the monthly average number of checks under Maternity Health Care continues: from 2,578 in 2008 to 2,243 in 2009, i.e. a decrease of 13.0%. This is due to the opportunity provided to pregnant and breastfeeding women to be monitored by obstetricians and gynaecologists in the SOHC[16].

In 2009 the average monthly number of *chronic outpatients* registered with GPs remained stable – 719,900 compared to 723,200 in 2008, i.e. 10.8 of every 100 CHI.

Even though still slow, there is an upward trend in *preventive checks per 100 CHI outpatients older than 18 years of age* – from 3.8 average monthly in 2008 to 4.1 in 2009.

As a monthly average, in 2009 one medical doctor from the SOHC made 111 examinations compared to 108 for 2008. Most busy are the doctors for endocrinology and metabolism disorders (194 examinations), followed by cardiologists (180) and ophthalmologists (161).

2.2.3 Inpatient health care

The increase in the number of health establishments for inpatient care observed in recent years continued in 2009. The growth is due to the opening of privately owned hospitals. For one year (2008–2009) the number of these hospitals increased from 85 to 103 (19.7% growth).

Based on NHIC[17] in 2000, there were 299 hospitals (including dispensaries and health establishments under other ministries), and in 2009 - 411 with 49,507 beds in total. Even though still weak, there is a trend of increase in the number of hospital beds for short-term treatment and monitoring in the outpatient care: 991 beds in 2009 compared to 961 for the prior year.

Hospices in 2009 increased by 10 compared to the prior year.

Within *the structure of specialised hospitals,* those for active treatment represent 42.9% of the total. The health system has 7 specialised hospitals for post-surgery and long-term treatment, 11 for long-term treatment, post-surgery treatment, and rehabilitation and 22 for rehabilitation. The number of these establishments has remained constant during the past several years and does not meet the demand for such health establishments.

Since 2000 *the length of hospital stay* has marked a stable trend of decline. In 2009 the average stay for all outpatient HE[18] was 6.2, whereas for multi-profile hospitals it decreased from 10.1 days in 2000 to 5.8 days for 2009 (6.4 in 2008), and for specialised hospitals for active treatment it decreased from 10.4 days to 6.1 days (6.5 days in 2008).

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[15] Annual report on the activities of the national health insurance fund for 2009.

[16] Specialised outpatient health care.

[17] Number of available beds and activities of the outpatient health establishments and dispensaries, NHIC, Sofia, 2009.

[18] Health establishments.

Mental health establishments retain the highest average stay: 60.1 days for hospitals (61.1 for 2008), 22.3 for psychiatric dispensaries (23.6 for 2008) and f 12.3 for pneumophtysiatric dispensaries (12.9 days in 2008). The extensive average stay in these establishments is due to the specific features of the diseases.

Based on NHIC data in the period 2000–2009 there was a trend of increase in the absolute number of all hospitalised cases in health establishments, not only those paid under the clinical pathways of NHIF. There are also major changes in the frequency of hospitalisation for some diseases. It is difficult to establish to what extent this is due to data distortion caused by the introduction of clinical pathways or whether other factors have influenced that.

The inpatient care problems of the transition had still not been overcome in 2009:

- The prices of CP[19] often are not in line with the actual costs – some are under-priced and others over-priced. The value of the CP is not linked to the severity of the disease, the accompanying diseases and the quality of care offered, which leads to an increase of hospitalisation under more "profitable" CPs and attempts to make a diagnosis which is included in a better-financed CP and to limited hospitalisation of old, polymorbid and risk patients;
- The approach for CP financing is related to the generated losses of the HE[20] which cure complicated cases;
- The risk of non-payment by NHIF relates to a major change of the diagnostic process – only diagnostic activities that are included in the CP algorithm are performed, including the final diagnosis; in some cases diagnostic and treatment activities necessary for the clarification of the status and complex treatment of the patient are omitted;
- The structure of the hospital beds by districts and specialties is still irrational;
- The number of profiled health establishments for patients with completed active treatment (for further treatment and rehabilitation, etc.) is insufficient.

2.2.4 Emergency health care

In 2009 there was a network of 28 independently functioning emergency health care centres (EHCC) and 195 affiliates of these. In 2008 the emergency sections of affiliates were closed and the emergency wards (EW) were transferred to the EHCC of MPHAT[21] in the district towns (with the exception of Sofia-City, where emergency entrances were established). The restructuring aimed at improving the interaction of emergency and hospital care, more efficient use of staff and material resources of hospitals and guaranteeing the continuity of the medical process.

The functioning of the EHC[22] in 2009 was hindered due to a number of structural, organisational, and technical reasons, the most significant of which are:

- Services at the EHCC and EW of a large number of persons with no emergency indications, who most often did not receive care by their family doctors or who are not health insured;

[19] Clinical pathways.
[20] Health establishments.
[21] Multi-profile hospitals for active treatment.
[22] Emergency health care.

- Unresolved issues with the financing of EW, which disturbed the budgets of the hospitals and led to a significant overspending;
- Lack of and high turnover of medical staff (mainly doctors) and hospital attendants in the EHCC, mainly due to the low pay, difficult working conditions and limited career opportunities;
- Omissions in the work of information and coordination operators, related to the acceptance of emergency calls and their distribution among the mobile teams;
- Insufficient and in some cases inconsistent information from different institutions about the activities of the EHC;
- Lack of air transport for patients in emergency conditions, as it is organised based on one-year contracts (after the end of 2008 no such contracts have been concluded).

2.2.5 Debates and political discourse

In a report for the analysis of the implementation of the National Health Strategy 2008–2013 and the related Action Plan, as well as compliance with the objectives, activities and indicators for implementation with the Programme of the Government for European Development, the Minister of Health draws the following conclusions:

- Implementation of the Strategy and the Action Plan is irregular and insufficiently organised.
- Compliance with the Strategy and the Action Plan is insufficient regarding the programme of the Government.
- Analyses and appraisals of the Strategy and the Action Plan are hampered due to the general nature of the set objectives, tasks, activities, and results.
- The analyses and the appraisals of the implementation of the Strategy are subjective due to the lack of objectively measurable indicators of appraisal.
- Implementation of the Strategy and the Action Plan is not tied to the required resources – financial, staffing, etc.
- Many of the set objectives, activities, and programmes exist on paper only; they have no real application.
- Many of the set objectives, activities and results correspond to the respective international documents and agreements)with WHO, EU and others) but are not implemented in the Strategy and the Action Plan as really assessable priorities and activities; they are only a desirable aims.
- The Strategy and the Action Plan are documents of general policy, but they lack focus related to the priorities of the country and of the citizens.
- It is necessary to re-evaluate carefully each of the strategic objectives, activities, tasks, and results by focusing on their connection with real life and the priorities of society. It is necessary to set clear, achievable, realistic, and appraisable objectives, activities, tasks, rather than the commonly valid values as in most of the cases in the Strategy and the Action Plan.

The information of the Ministry of Finance, mainly presented during press-conferences of the minister makes it possible to account for results achieved and relatively clearly define the

main problem areas in the health system at macro level regarding financing; the most specific of these are outlined below:

- Insufficient public financing, which is a major barrier and practically cannot provide good access for all to the necessary health care;
- There is a disproportion in the distribution of financial resources between outpatient and inpatient care, proportionally to the persons employed in outpatient care and the other budget-supported activities, as well as pro rata the level of wages of employees in the production sector of the economy;
- Lack of clearly defined methodology and information system for financing hospitals on a market-based principle;
- Lack of a model for a transparent and motivated method of financing of the urgent and emergency health care, including the intensive care and emergency wards of hospitals;
- Lack of a rigid system for adequate financing, both in volumes and in targets, of investment expenditures and the resulting delay in hospital network optimisation;
- Cyclical indebtedness of the hospital sector, accompanying the health system activities during the past several years;
- Insufficient incentives for distribution of financial resources for disease prevention and health promotion;
- There is no established integrated system for national health accounts;
- The role of voluntary health insurance in financing health services is insignificant.

Based on NHIF data for the second half of 2009 the revenues from health insurance contributions are BGN 240 million less, that is a 20% decline. In the first quarter of 2010, the decline is with about BGN 100 million, expected to exceed on an annual basis 27% of the total revenues.

2.2.6 Critical assessment

A nationally representative survey of the Agency for Social and Economic Analyses (ASA Ltd.) in partnership with the National Centre for Public Health Protection, carried out in 2009 among 1,025 persons, revealed the following important aspects of public opinion about health care in Bulgaria:

- Subjective health status;

For the first time, more than half of the population shares a positive self-perception of very good and good health – 56.1% (48.1% in 2004), while those with bad and very bad health decreased to 11.5% (19.8% in 2004). Still, there is a continuing differentiation of the subjective health status, and some groups (Roma, the elderly, and persons living in small remote areas) are vulnerable based on several aspects simultaneously. Self-established cases of acute diseases are found with 24.9% and chronic diseases with 33.1% of the persons interviewed.

- Common perception of health care:

In general the overall assessment remains negative – according to 42.0% of the interviewed health care became “a little worse” or “much worse” in the period 2006–2008

Nevertheless there is a decrease of the negative dynamics, which shows most clearly when the assessment is based on personal experience and concerns “services provided to me and my family”, as well as those of persons who have been treated in a hospital.

- Readiness for reforms:

Although opinions about the health system management remain conservative (40.4% of the interviewed still wish the return of the old system of budget financing), support for reforms of the system, mostly by introducing insurance funds (50.2%) has grown. The increase of the insurance contributions from 6% to 8% is relatively well accepted (61.1% vote “for”), but most of the interviewed were against the legalisation of the payment of “extras” to the health services (54.3%). There is very high support for the introduction of group GP practices (53.5%).

- Access:

Generally access to health care services in 2009 improved. Now 97.1% of the interviewed reply that they have a family doctor (95.3% in 2004). While in 2001 88.4% reported cases of refused health care services, in 2009 the figure was only 10.1%. Financial access to health care services has also increased. The most visible growth is in the number of people who have not refrained from buying medicines for financial reasons (an increase of some 10 percentage points). This is mainly due to the growth of the middle-class group. Besides the poor, in 2009 limited access to medicines for financial reasons applies to the less educated, those living in smaller towns/villages, the ethnic Turks and Roma, the elderly and women.

- Quality of health care services:

Satisfaction with the services of the GP (total for “satisfied” and “rather satisfied”) increased, reaching 74.2%, but this growth is smaller than in the period 2004–2006 (from 66% to 71.8%). This is also confirmed by the decrease in the ratio of persons who have changed their family doctor – from 19.9% in 2006 to 15.8% in 2009. On the other hand, there was an increase in the number of specific situations with insufficient quality of the services provided by the family doctor. This means that sensitivity towards the quality of GP services has begun to decline or at least remained at its previous level. Satisfaction with services provided by medical doctors in specialised primary care declined at the level of general perceptions from 39.6% for 2006 to 35.8% for 2009. Nevertheless, for the actually used services of a specialist doctor it increased to 41.2%. These services have been perceived as satisfactory also by persons who have been treated in a hospital: from 67.8% to 75.2%.

With regard to hospital services, the trend in the public perception level is unfavourable – from 15.2% satisfied or rather satisfied in 2004 it dropped to 14.5% in 2006, and in 2009 to 12.9%. Similarly to SOHC, this negativism seems grounded on the general negative attitude towards the health care sector in the country, because it contradicts the data from direct impressions for that level of the system. Thus, among the people who have undergone hospital treatment, the assessment is positive – 73.9% are satisfied or very satisfied with their actual stay in the hospital (73.3% in 2006). The cases of additional legal and illegal payments

for services, materials and medicines in the hospitals decreased, especially in the larger towns. However, the decline began from very high levels. Generally, 60.3% of patients would accept admission to the same hospital without hesitation, compared to 53% in 2006.

- Corruption:

The perception of corruption increases in all public sectors, including in health care, though the growth rate is not so high anymore. Perhaps the data from the summer of 2008 were the peak of the perception of corruption in Bulgaria.

The data about corruption among outpatient care doctors are at levels close to those in 2006 – for family doctors (8.4%) and for specialists (15.7%). These levels are some 3 times lower than the perception of corruption for inpatient care doctors. With regard to them, the general perception of the population for corruption reaches its peak. The highest rates are for surgery (45.9%) and for births (36.9%). At the situational practices level though, the frequency of "cash payment" as a corruption form among people treated in a hospital declined from 13.5% in 2006 to 8.3% in 2009.

The health status of a population is a complex value and is characterised by demographic indicators, morbidity indicators, indicators about physical development, exposure to risk factors and the self-evaluation of the population. The health status of the population of Bulgaria and the activities carried out for health protection, strengthening and recovery are negatively evaluated as a whole and characterised by the following general parameters (**+** = deemed positive; **-** = deemed negative; **±** = neutral):

1. *The birth rate* showed a slight tendency to increase, which makes it close to the EU average. The achieved highest level (after 1992) of the total ratio of fertility is also a positive fact **(+)**.
2. In 2008 the *mortality rate* showed a slight decrease. However, Bulgaria still has one of the highest indicators among the EU Member States. The leading reasons remain deaths connected with the blood circulation organs and new growths. The morbidity rate from the first is decreasing (the standardised indicator, however, remains higher than the EU one), while morbidity due to malign new growths is increasing **(-).**
3. *The average length of life* is increasing, but it remains lower than the EU average (±**).**
4. A positive fact is the reduction of the level of *child mortality* (with high level of perinatal and unfavourable data about the rate of stillbirth and of *early neonatal mortality*), which has reached its lowest value (+). Regardless of this, the child mortality rate is still higher than in other European countries **(-)**.
5. Morbidity among children aged from 0 to 3 is relatively low, while the data about the *physical development* of children above 3 show that it is within the norms for 90% of them, and for those aged between 7 and 18 there is a positive tendency in height and unfavourable changes regarding chest measurement. As a whole, however, a reduction of the energy level is observed (±).
6. The total number of the *labour accidents* and of lost calendar days has been reduced significantly. However the fact that the number of accidents with lethal outcome has increased, is disturbing **(±)**.
7. The mental health area lacks satisfactory categorisation and profiling of services, differentiated programmes of cares with indicated criteria for admittance and dismissal and with calculated capacity **(-)**.

8. *The real incomes* of the population are still low with an unfavourable structure. The main problems in *education are related to poverty and the social isolation* of certain risk groups **(-)**.
9. The population of the country has been "burdened" by a multitude of *risk factors* for health. The number of smokers, of alcohol abusers, of overweight people, of people of low motor activity, with high blood pressure, etc. is big. The factors are related also to the unhealthy way of life of the population, leading to chronic deceases which form the main burden of deaths for society **(-)**.
10. The public resources allocated for health care in 2008 were limited and were not used efficiently. A big part of it was earmarked for funding of hospital care, characterised by periodical indebtedness during recent years. The funds for maintenance of fixed assets in the health system are also restricted. The role of voluntary health insurance in funding health care services is insignificant. Quite a big part of the population still has health insurance. Health care is not able yet to meet the challenges of today **(-)**.
11. Despite the positive tendency to reduction of noxious emissions in the atmosphere and improvement in the quality of *air,* there are still regions of environmental problems **(±)**.
12. The protection of water sources against pollution and preparation of *water* for the centres of population are not in compliance with the contemporary standards about good manufacturing practice by water suppliers. However, there is no integrated European approach, requiring collaboration of different structures, to guarantee the right to permanent access to safe and clean potable water in all households **(±)**.
13. The *acoustic situation in cities* is deteriorating **(-)**.
14. Intersectoral collaboration in the field of food safety is not carried out efficiently, and this has a negative impact on the provision of *healthy foods* for the population. The basic responsibility lies with the producers **(-)**.
15. The results of the control activity on the provision of *health and safety at work* show partial or formal implementation of law both by employers and by the labour medicine services **(-)**.
16. In the field of *health promotion and prevention of diseases* at the Ministry of Health, a great number of programmes were financed: 24 programmes in 2008 **(+)**.
17. However, the funds under these programmes are provided mainly for programmes treatment nature and for contamination deceases, which could be called "preventive". Despite their large number, the results are unsatisfactory. Monitoring and evaluation mechanisms are not included in the development of most of the programmes. The participation of public structures at national and local level is also insufficient **(-)**.
18. Access to primary and specialised outpatient care is impeded. The practices of *outpatient care* are concentrated in bigger centres of population and municipal centres. Individual forms of outpatient practices are still dominant. The statutory framework regulating access to specialists has not been changed during recent years. There are no clear criteria for monitoring the quality of services in outpatient care **(-)**.
19. No evaluation and restructuring of the *hospital network* have been made yet. "Insufficiently funded" and "well funded" clinical paths still exist, and toolkits measuring the burden and the complexity of the hospital case are still missing **(-)**.
20. *The emergency care system* still has difficulties due to a number of reasons, the most important of which include: servicing a large number of people without any indications about emergency, most often the persons who have not received care from their general

practitioners or without health insurance; unsolved issues with funding, difficult conditions of work and the limited opportunities for professional development, etc. **(-)**.

21. There is no clear policy regarding the future development and use of *non-conventional methods* for impact on individual health **(-)**.
22. The *control* activity in the system has been carried out by the Ministry of Health both directly and through its bodies at regional level – the Regional Health Centres and the Regional Inspectorates for Protection and Control of Public Health and by NHIF as financing institution. In view of ensuring the quality of medical services, the Ministry of Health approves medical standards and carries out accreditation of health establishments. Despite the progress in this direction, there are no standards for a number of specialities and serious weaknesses in the process of accreditation are observed **(±)**.
23. Coordination between the individual levels of medical care is not good **(-)**.
24. There is no integrated information system, and in many cases management decisions are made on the basis of incomplete, and often untrue information **(-)**.
25. The existence of corruption practices remains a problem **(-)**.
26. With slight exceptions, intersectoral cooperation is not carried out yet on the necessary scale **(±)**.
27. There are still regional disproportions in the distribution of human resources; there is a low level of provision of nurses and an unfavourable ratio between nurses and doctors. There is a trend for the number of some specialists to fall, there are still difficulties in acquiring a speciality and continuing education, the payment of labour is inadequately low **(-)**.
28. There are positive changes in the perception of the population about health care regarding subjective health status and access to medical care. There is certain drop in the negative trend in the evaluation of the system by citizens **(+)**.
29. The evaluation made with the support of the European Commission remains negative and is even intensified. According to the calculated Health User Index, health care in Bulgaria is ranked last among 33 countries in Europe. Negatives are the appraisals for protection of the rights of the patient, direct access to specialists, non-formal payments for treatment, financial access to medicines, the possibilities for transfer of medical information between specialists, etc. **(-)**.
30. Bulgaria is among the countries in Europe where the personal costs borne by patients take the highest share in the total costs for medicines (56%). According to the opinion of citizens, the burden of expensive medicines is among the biggest problems of health care in Bulgaria **(-)**.

The easiest way to overcome restrictions in access to health care is through a significant increase of funding for health care compared to previous years both as a percentage of GDP and as an amount of health insurance, for whose increase, however, it should be taken into consideration what would be the total tax burden on wages caused by health insurance, pension security and unemployment insurance.

Even these measures would not lead to the desired effect if no changes were made in the sector, such as improvement of the management of the system, which would lead to efficient spending of funds. Besides this, it is necessary to strengthen the role of units at the community level, where the process of provision of health services itself is carried out and which are closest to users as their first contact with the system: the practices of general

practitioners or medical centres in smaller centres of population. The increase of their role requires provision of trained staff (doctors, nurses), medicines and transport.

2.3 Long-term care

The formal long-term care is mainly offered at specialised institutions, owned by the respective ministries (in the case of services for children at the age of 0 to 3 years of age) or the municipalities (in the case of care for elderly or disabled elderly people) and at community service places (day centres, protected homes, social rehabilitation centres). These establishments are financed with ear-marked subsidies form the state budget for municipalities and the service fees. Other institutions include physiotherapy facilities and such for recovery from chronic diseases.

The private long-term care establishments are few. The services provided by "social" and "personal" assistants are part of the formally offered service. Informal care is provided by the families to take care of the needs of elderly and disabled. There are neither surveys nor assessments of the extent of the informal care, but it is widely spread according to public media data.

The access to formal long-term care is still a problem. In the period 2006-2008, 30 new protected homes were established. By the end of 2008, the 21 existing establishments for elderly people were supplemented by 12 new day centres. The European Social Fund is a source of funds for the extension of the "social" and "personal" assistant services. After the successful pilot initiatives, the deinstitutionalisation programme developed at national level includes extended offering of community services (day centres, protected homes and social rehabilitation centres), which lead to a 9% decrease of the number of elderly in the institutions. These services also improve the general access, which is an important goal of the long-term care strategy. Despite this fact, publications about refused access or slow access can be observed on a daily basis.

Centralised control institutions perform quality control and issue recommendations to the entities providing long-term care. Local authorities though have the complete legal and financial power over their own establishments. They are also employers of the staff working at these establishments. The recommendations of controlling bodies regarding quality of care, including proposals closing specialised institutions or social services cannot be fulfilled without the decision of the municipal council. In the previous Joint Report Bulgaria was confronted with the great challenge to achieve a general improvement of community services and quality of institutional care.

Despite the aggravating crisis nobody commented formally any anticipated developments in the system. We may only judge on the actions of the Government and MH that the definition of clinical pathways for post-operative and long-term treatment will better regulate the long-term care activities. Some of the hostpials, not meeting the competence levels, are expected to restructure and specialise in post-operative and long-term treatment. The debates at political level concern the necessity to close more than 100 hospitals, the argument of the minister of health being that they should restructure into post-operative and long-term treatment establishments. There are no actions either of legal or of practical nature to that effect, or they are rather yet to be seen.

3 Impact of the Financial and Economic Crisis on Social Protection

The recent expert research data shows that almost one third of households in Bulgaria are directly hit by the economic crisis. Many of them are forced to restrict their expenditure on food, medical services and education, which is an additional risk for the future (by data of the nationally representative survey conducted jointly by the Open Society Institute – Sofia and the World Bank in February and March 2010). The survey clearly showed that the hardest shock on the labour market – the loss of a job – has affected 5% of the workers in the country. A further 30% of workers have been affected by the decrease of wages and working time, which are less severe negative effects. The greatest risk of losing a job and income is faced by the workers from the most vulnerable groups – those with primary or lower level of education as well as the representatives of the Roma community. 60% of the poorest households and those affected by the crisis attempted to find an additional job without any success.

The data show that as a result from the decrease of income households in general react to the crisis by restricting expenditure on their basic needs: 41% restrict the use of basic communal services; 29 % restrict the consumption of basic foods; 8 % miss some meals for the day. The households affected by the crisis will probably terminate the payment of social and health insurance contributions, thus becoming more vulnerable to additional risks (in case of illness or loss of a job).

The efforts of the Government, social partners and experts are continuing in 2010 in order to find appropriate economic and financial measures for reducing the negative effects of the crisis.

Hundreds of different proposals were discussed, after which the National Council for Tripartite Cooperation achieved a consensus on 60 more or less concrete actions to be undertaken by the Government and Parliament in the months to come. During the discussion no overall assessment was made on the effect of other 76 anti-crisis measures announced by the Government in the autumn of 2009. This leaves the impression of chaotic actions.

According to the analysts, the mechanism under which the package of measures was adopted is a very interesting one. For the first time for many years now the Government transferred the process of discussions to the Council for Tripartite Cooperation, the final draft of which was approved almost without amendments. There are two results: preliminary agreement for the adopted decisions and sharing of responsibility for the results with the employers and the trade unions.

The actions to be undertaken were represented as measures against the crisis but they are directed to stabilising the budget, aiming at a deficit under 3% of GDP by the end of 2010. The realistic projection of the deficit today is 3.9%.

More of the participants in the elaboration of measures are satisfied with the result achieved because the measures equally distribute the burden of the crisis between the workers, the employers, and the state.

A summary of the measures in the social sphere from the new anti-crisis package:

- Restrict by 10% the current expenditure of ministries and institutions
- Postpone the increase of supplementary payments to widow pensions and old age pensions (BGN 142 million)
- Introduce luxury tax on expensive houses, cars, yachts and planes (BGN 35 million)

- Efforts to temporarily restrict the increase of state-regulated prices of goods and services of public interest.
- The first three days of the sick leave of the workers paid by the employer
- Additional subsidy for the social ministry for social assistance activities
- Eliminate the unemployment benefit ceiling as of 1 July 2010 and determine the benefit rate as 60% of the insurance income
- Additional resources for subsidised employment to the National Employment Plan
- Restrict access to the labour market for workers from third countries

According to data of the Ministry of Labour and Social Policy there is a positive tendency concerning unemployment. The peak was in December last year, January and February when it reached 10.26%. However, for a second month now there is a slight decrease: in March the rate of registered unemployed persons was 10.14%, and as of 30 April 9.99%. According to the Minister for Labour, the measures under the National Employment Plan and the new schemes under the human resources programme as well as the trends in tourism and services are already having results.

Bulgaria is presently in an environment of global economic crisis, and the issue about the place and role of health care is particularly important. Despite this, the financial resources for health care should not be reduced. The sought opportunities for increased accountability and effectiveness of the available financial resources are an issue that is crucial for the implementation of health priorities. In this respect, efforts of all partners are oriented towards implementing a proactive approach to health care, aiming at:

- Development of anti-crisis programmes- restructuring of hospitals, reducing the number of referrals in order to restrict unnecessary consultations with specialists, etc.;
- Decisions to optimise financial resources by reducing capital and administrative expenditures- Government decision to cut administratie costs by 20%;
- Improving the effectiveness of the system by allocating resources for prevention activities
- Measures to improve budgetary discipline in the health sector- introducing DRGs[23] for reporting and financing of inpatient care;
- Ongoing dialogue with all partners from the social field and business to maintain social sustainability and cohesion;
- Facilitating the financial access of the population to medicines by providing more state subsidies for them, and exercising a maximum strict control by the state on their prices.

It is crucial to implement measures to strengthen and improve the functioning of the national health system to protect public health, especially for vulnerable persons (poor, elderly, sick). The efforts to seek and implement effective mechanisms for accessible individual and public services in health care focus mainly on effective intersectoral cooperation to develop policies to alleviate the negative impact of the economic crisis on public health.

[23] Diagnostically related groups.

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4 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

[R1; R2] CHYBALSKI, Filip, "Liberalisation of pension systems in Central and Eastern Europe", EVN Working Paper, July 2009. Retrieved from: (http://europeanvalues.net/docs/PP_Liberalization_of_pension_systems_in_Central_and_Eastern_Europe_09.pdf)

The aim of the paper is to describe the process of liberalisation of pension systems in Central and Eastern Europe in terms of basic structure and regulations applied in relation to pension funds. The following issues are addressed: the universality of participation in the various pillars of the pensions system, the amounts of pension contributions, public engagement in the area of pensions provision, investment limits for pension funds, systems of remuneration for pension fund management companies, and guaranteed rates of return for pension funds. The paper concludes on both positive and negative consequences of the liberalisation of pension provision, and attempts to outline the changes which ought to occur in further reforms.

[R1; R2] GOLINOWSKA, Stanislawa, KUROWSKI, Piotr, "Rational Pension Supervision - First Experiences of Central and Eastern European States in Comparison with Other Countries. CASE Network Reports, July 2009. Retrieved from: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1434819

The study undertakes the analysis of pension fund regulations in five countries of Central and Eastern Europe, ranked according to their degree of risk. The instruments for safeguarding this risk are then proposed by analysing the legal regulations, administrative standards, financial management standards, codes of ethics, the formula and competence of supervisory institutions, and the working of the market. The principles of balanced supervision over pension funds are defined as a trade-off between regulatory instruments and self-regulation. The practical experience of other countries is used to compare the selected countries with those with much more experience in this area.

[R2] DANEVA, Ivanka (2009), “Regulation of Pension Fund Investments in Bulgaria – Developments and Trends”, in: E-Journal Dialogue (1), available from: http://www.uni-svishtov.bg/dialog/2009/1.09.ID.pdf

Exchange of experience in relation to the pension reform in Bulgaria is very interesting because Bulgaria was one of the first countries in Eastern Europe to embark on pension reform in the early 1990s. The paper is divided into three sections: 1 - A brief overview on the Bulgarian Pension Reform – the stages of its implementation; the main features of the reform and development of pension funds in the country; 2 - Describing pension funds investements regulation almost 9 years after the beginning of the pension reform; amendments of pension legilsation related to investments of pension funds assets; 3 - The last part consists of the main forthcoming changes in regulation including some concluding comments.

[H] Health

[H3] RECHEL, B, BLACKBURN, C., SPENCER N., et al., Access to health care for Roma children in Central and Eastern Europe: findings from a qualitative study in Bulgaria, in: INTERNATIONAL JOURNAL FOR EQUITY IN HEALTH, Volume: 8, Article Number: 24, Published 30 June 2009, retrieved from: http://www.equityhealthj.com/content/8/1/24

The findings illustrate the complexity of the problems the Roma in Central and Eastern Europe face. Access to health care cannot be discussed in isolation from other problems this population group experiences. Unemployment and poverty are widespread and affect access to health care. The poor quality of education increases barriers to seeking and receiving information and impacts on health care seeking behaviour and communication with physicians. Access to proper housing and community infrastructures also have an impact on health and access to health services. Thus, strategies to improve access to health care for Roma children in Bulgaria and elsewhere need to adopt an integrated approach addressing the complexity of the needs of these children.

[H3] RECHEL, B. et al., Impact of health reforms on child health services in Europe: the case of Bulgaria, in: THE EUROPEAN JOURNAL OF PUBLIC HEALTH 19 (3), pp. 326-330, 2009.

In the last two decades, all countries in Europe have embarked on substantial health reforms, introducing new models of financing and provision of health services. Using Bulgaria as a case study, this article examines the impact of the reforms on child health services.

Primary health services for children are now provided by general practitioners. Children are exempted from health insurance contributions and user fees and are formally entitled to free health care. During the first years of the reform general practitioners still had insufficient training in child health. Restrictions on the number of referrals to paediatricians and discontinuation of community services at a time when general practice was not well established, undermined access to quality care.

While many of these issues have been subsequently addressed, the reform process was far from linear. Challenges remain in ensuring access to quality child health services to the rural population and marginalised groups, such as the Roma minority and children with disabilities. Throughout Europe, health reforms need to be based on solid evidence of what works best for improving quality of and access to child health services.

[H3] TODOROVA, I., BABAN, A., ALEXANDROVA-KARAMANOVA, A., et al., Inequalities in cervical cancer screening in Eastern Europe: perspectives from Bulgaria and Romania, in: INTERNATIONAL JOURNAL OF PUBLIC HEALTH, Volume: 54, Issue: 4, Pages: 222-232, Published: August 2009, retrieved from: http://www.isiwebofknowledge.com/

Multiple dimensions of inequalities in cervical cancer prevalence and prevention, including disparities in comparison to other countries, disparities due to socioeconomic status, education, residency and ethnicity, as well as differential barriers faced by women in access to screening and in relationships with providers. Mediators of the effects of socio-economic status on screening history.

The study concludes that the effect of SES on screening is mediated mainly by the structural barriers in accessing the health care system, as well as women's perceptions of the multiple costs of the smear. These conclusions are relevant to the development of national screening programmes and health promotion in the two countries.

[H3] VASEY, Victoria, Access to Health Care in Bulgaria: Marginalisation of Roma, in: ROMA RIGHTS JOURNAL 1 (2009), pp. 59-61.

There is sufficient evidence which shows that Roma communities do not live in healthy environments. This situation can in part be attributed to the failure of prevention policies by the State, for instance the lack of protective measures to guarantee clean water in Romani neighbourhoods, as well as the inadequacy of measures to ensure public health standards in housing in such neighbourhoods. Specific examples of discrimination presented to the Committee, including the refusal to send emergency aid ambulances to Romani districts, the segregation of Romani women in maternity wards or the use of racially offensive language by doctors.

[H4] DZHAMBAZOV, Yordan, Здравната система в България, 28 August 2009, retrieved from: http://ime.bg/bg/articles/zdrawnata-sistema-w-bylgariq/
"The Bulgarian health care system"

Most problems of our health care are similar to those in the Netherlands but unlike that country we have its example to follow in pursuing the health reform. As a start, the State may take several steps:

- *Eliminating the monopoly of the NHIF;*
- *Allowing access of private funds to the market, to ensure competition;*
- *Privatisation of hospitals;*
- *Restricting state subsidies;*
- *Supporting only those that are really in need;*
- *Improving the collection of contributions.*

Of course these are only a few of the necessary reforms, but a good start.

[H4] SLAVOVA, Zornitsa, С миши стъпки към здравна реформа, 20 November 2009, retrieved from: http://ime.bg/bg/articles/s-mishi-stypki-kym-zdrawna-reforma/
"Mouse steps towards the health reform"

The daring reform towards equal participation of the private sector and the opportunity for people to make a choice in the health care sector will have several effects:

- *Stronger competition*
- *Better service quality for citizens*
- *Lower prices*
- *More control over taxpayers' money*
- *More incentives for payment of contributions*

- *Improvement of health culture*
- *Higher payment for medical professionals*
- *Lower budget expenditures*
- *Reduced administrative expenditures*

Some of the positive effects of the health care reform will happen immediately, others will be delayed, but the decision for the daring change will not be postponed. There is no time to lose – there is a need to take a big step towards a modern, good-quality and cheap health care system, for which there are enough good models, like the Netherlands, Switzerland, Singapore.

[H5] GANOVA-IOLOVSKA, Milka and GERAEDTS, Max, Clinical pathways – the Bulgarian approach, in JOURNAL OF PUBLIC HEALTH 17 (3), pp. 225-230, 2009.

In Bulgaria, the requirements for understanding the procedures covered by CPs, for defining the rules of treatment, for monitoring deviations, for refining the rules and ultimately for modifying practice behaviour have not been complied with while developing the clinical pathways. Bulgaria uses CPs as an instrument for resource allocation to inpatient health-care providers rather than as a tool for improving health-care quality.

Conclusions: Despite the broad scope of discussion in Bulgaria and the experience and knowledge gained in the past 5 years, the utilisation of clinical pathways for improving the quality of medical care is still unsatisfactory. Bulgarian health decision-makers merely used the title of a tool with proven qualities in managed care and efficient resource utilisation without implementing it according to international standards.

5 List of Important Institutions

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.

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.

Министерство на здравеопазването – Ministry of Health

Address: 1000 Sofia, 5 Sv. Nedelya Sq.

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

The Ministry of Health is a legal entity financed by the state budget.
The Minister for Health is a central sole body of the executive power.
The Minister is, amongst others, in charge of:

- *Implementation of the state policy in health care;*
- *Developing and controlling the implementation of the national health strategy;*

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.*

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*

Комисия за финансов надзор – Financial Supervision Commission
Address: 1303 Sofia, 33 Shar Planina Str.
Webpage: http://www.fsc.bg/

The Financial Supervision Commission (FSC) was established on 1 March 2003 under the Financial Supervision Commission Act. It is an institution that is independent from the executive authority and reports its activity to the National Assembly of the Republic of Bulgaria. The Commission is a specialised government body for regulation and control over the financial system which unifies the regulatory functions that used to be carried out by the former State Securities Commission, the State Insurance Supervision Agency and the Insurance Supervision Agency. The primary function of the institution is to assist through legal, administrative and informational means in the maintenance of stability and transparency on the investment, insurance and social insurance markets.

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.

Български лекарски съюз – Bulgarian Medical Doctors' Union

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.*

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*

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".*

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 non-party 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.

Съюз на пациентите в България – Bulgarian Patients' Association

Address: 1606 Sofia, 29 Vladaiska Street, floor 1

Webpage: http://pacienti.hit.bg/

BPA is an independent, voluntary association, not-for-profit legal entity for public benefit, established on 20 February 2003, established to work on creating and ensuring conditions for civil society participation in all spheres of the health care system on a local, regional and national level, as well as to assist in establishing mechanisms and structures for civil

participation in the health care reform, with a view to protection of patients' rights and approximation to European norms and standards. Main goals:

- *Reassessment of the health care policy in the current economic environment and strengthening of the positions of health care.*
- *Encouragement of the citizens to act as agents of their health.*

Институт за пазарна икономика – Institute for Market Economics

Address: 1463 Sofia, 61 Patriarch Evtimii Blvd., floor 3

IME is the first and oldest independent economic policy think tank in Bulgaria. Its mission is to elaborate and advocate market-based solutions to challenges that citizens of Bulgaria and the region face in reforms. This mission has been pursued since early 1993 when the Institute was formally registered as a non-profit legal entity (Reg.: #831344929 – 15 March 1993, 729/XI/VI, p. 169.) IME objectives are to provide independent assessment and analysis of the Government's economic policies and to be a focal point for an exchange of views on market economics and relevant policy issues.

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.

Балкански институт по труда и социалната политика – Balkan Institute for Labour and Social Policy

Address: 1113 Sofia, Tzarigradsko Shosse Blvd., block 22, entr. 3

Webpage: http://www.bilsp.org

The Balkan Institute for Labour and Social Policy is a non-governmental, voluntary, independent and non-political not-for-profit association, established in September 2001. Its mission is to support the contribution of Bulgaria to the expansion of the European social space and to help integrate the Balkan and European social values. Its objectives are to build capacity for human development and social integration, form a Bulgarian social model based on European labour and social values, adapt the Balkan region countries to the standards and practices of the European Union, promote experience and practice related to labour and social sphere among the Balkan region countries, promote social dialogue and tripartite cooperation, develop national social models in the globalisation environment.

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

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en