Country Document 2013

Pensions, health and long-term care

Bulgaria

November 2013

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

Disclaimer: This report reflects the views of its authors and these are not necessarily those of either the European Commission or the Member States.

On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.

Table of Contents

1 Executive Summary

The implementation of legislated pension reform started in the beginning of 2012 and included an increase in the retirement age for women and men and the contributory period needed for pension entitlement. These changes were mainly influenced by a rising deficit in solidarity insurance system, and the strong recommendation from the Council of the EU to accelerate the second stage of the pension reform.

However, after early parliamentary election in May 2013, Bulgaria is witnessing further pension policy changes. Only in the period June - October 2013 six bills were submitted to Parliament by the new Government and Members of Parliament from the ruling majority, relating to the conditions for pension entitlement, as well as with the 2013 budget of the National Social Security Institute (NSSI). Some of them have already been adopted and others are pending adoption in the coming weeks.

The main feature of these legislative initiatives is the intention of the ruling coalition dominated by the left party, to suspend the subsequent stages of the pension reform, in particular the gradual increase of the pension age and the contributory period. Along with that, some proposed amendments to the Social Security Code create more opportunities for early retirement.

It is estimated that in 2014 there will be a further increase of the NSSI budget deficit. Generally, at present most of the proposals made are related to facilitating access to the state pension system, which leads to increased scarcity of resources and the deterioration of its financial situation.

The amendments to the Health Insurance Act (2012) have dramatically changed the insurance model, where the supplementary voluntary health insurance that existed in the previous version of the law was changed and focused on insurance principles (Solvency 2 Requirements). No measures were planned and undertaken to solve this problem, which led to full monopsony of the National Health Insurance Fund (NHIF) in the disbursements for healthcare services and a marginalization of the second pillar of insurance. This in turn results in complete concentration of payments in a single payer and continuous desire for state intervention in health funding (for instance, the Ministry of Finance unreasonably takes NHIF's reserves) and the infringement of the principle of increased financial autonomy of the health sector. The healthcare system is now in a "stabilized crisis and systemic chaos".
Resources directed to prevention and health promotion policy are insufficient and constantly decreasing. State withdraws from its main function in ensuring the implementation of this policy. Allocated money and resources under that policy are used inefficiently, without setting clear priorities, target horizon, risk determinants and groups assessment and without required monitoring.

Bulgaria still has untapped potential to achieve better health of the population and prevent most of the diseases and premature mortality, respectively. This potential is in the scope of health promotion and disease prevention, particularly social and health policies at national and regional level

Even though the system for long-term care and social services in Bulgaria is in recent years considerably expanding as a result of actions aimed at deinstitutionalization and providing more community-based and family-friendly services, there are serious challenges in this area, resulting in insufficiently extensive network of community services and suppliers across the country, which for the majority of Bulgarian citizens impedes access to quality care.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

In 1999 Bulgaria carried out a large-scale pension reform and introduced a three pillar pension system, consisting of a

1. Mandatory state pension insurance, functioning on the basis of the pay-as-you-go principle (I pillar);
2. Mandatory supplementary pension insurance with universal pension funds for those born after 31 December 1959 and with occupational pension funds for persons working in the first and second category of work[1], functioning on the basis of the funded principle (II pillar);
3. Supplementary voluntary pension insurance, functioning on the basis of the funded principle (III pillar);

This pension reform has included the separation of the state public insurance budget from the state budget, the establishment of specialized funds by social risks and the introduction of tripartite management of the state insurance system.

The main aim of the reform was to improve the overall level of income protection in order to provide the pensioners with a better standard of living.

More than 12 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 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.

2.1.2 System characteristics

The pension reform introduced a new formula for calculating pensions. The amount of the pension benefit depends on the insurance period, an individual pension coefficient and the average monthly insurance income in the country. The size of the individual coefficient depends on the insurance income for the period after 1996.

The insurance basis on which the insurance contributions are calculated was also enlarged including the income under employment as well as civil contracts. After 2000 a national maximum threshold and minimum branch thresholds of insurance income as well as registration of employment contracts were introduced. The possibility for early retirement was

[1] According to the ordinance for the categorisation of work for pension calculation all works and activities are divided into three categories, depending on their nature and difficulty and based on the working conditions where they are performed by the insured person. The first category includes those employed in the hardest and most hazardous production and activity conditions. Such are for example: underground and underwater works. The second category of work includes work of those employed in hard and hazardous production and activity conditions. Such are for example: 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.

sharply restricted. In 2000 by the re-categorisation of labour the number of those who belong to I and II category of labour and are entitled to early retirement was reduced from 700,000 to 150,000-160,000.

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

The pay-as-you-go first pillar and the funded components of the pension model (II and III pillar) are financed by contributions by employees and employers.[2]

There is a contribution ceiling at BGN 2,200 (2013) which will be raised to 2,400 in 2014. The effect of this increase on contribution revenue is expected to be about BGN 36.9 million.

The principle of pension indexation was renewed recently. It will be implemented as of 1 July of the respective year by a percentage equal to 50 per cent of the consumer prices index and 50 per cent of the increase of the average insurance income in 2013.

2.1.3 Details on recent reforms

After a long political and societal debate which started in autumn 2009 and continued almost till the end of 2010 and an extensive financial and actuarial analysis, political decisions were taken to guarantee the financial stability of the pension system and ensure higher replacement rates.

The amendments to the Social Security Code in 2011 introduced short-term and long-term measures for financial stability and pensions' adequacy improvement. The implementation started in the beginning of 2012, based on which retirement age for women and men was increased - with 4 months each year until the age of 63 years for women in 2020 and 65 years for men in 2017. Along with this measure, the contributory period needed for pension entitlement was increased by 4 months of each calendar year, whereas for workers in the most popular third category of work this process will continue until reaching 37 years of service for women and 40 years for men in 2020.

However, the 2013 elections changed the situation considerably. The coalition that took over the government after the elections in May 2013, irrespective of the consensus that had been achieved, has frozen the most important measures which had been decided earlier.

The following conclusions are particularly alarming: „The Bulgarian pension system is facing an unprecedented situation and it is close to a financial collapse. It is financially unstable and at the same time ensures low rate and inadequate pensions. The revenue from insurance contributions covers not more than 50 per cent of expenditure on pensions whereas the rest of expenditure is covered by the state budget subsidies. A shortage of resources is generated

[2] The social insurance contributions for Pension Fund for 2013 are:
For persons born before 1 January 1960: 17.8% for workers in III category of labour; 20.8% for workers in I or II category of labour.
For persons born after 31 December 1959: - 12.8% for workers in III category of labour; - 15.8% for workers in I or II category of labour.
The distribution of contributions to the Pension Fund for 2013 is, as follows:
For persons born before 1 January 1960: - 7.9% to be paid by the insured; - 9.9% to the paid by the employer for workers in III category of labour, and 12.9% to the paid by the employer for workers in I or II category of labour.
For persons born after 31 December 1959: - 5.7% to be paid by the insured; - 7.1% to the paid by the employer for workers in III category of labour, and 10.1% to the paid by the employer for workers in I or II category of labour.

every year at the rate of 2-3 per cent of the GDP. The pension system may face the challenge to guarantee the payment of pensions in the future if no measures are undertaken including measures for raising the trust in it and also enhancing the motivation for social insurance."

These conclusions and prognoses are contained in a Draft Law submitted by MPs from the left (which has been adopted at first reading). At the same time (in full contradiction to the conclusions above) the Draft Law "freezes" the pension reform and thousands of people have the opportunity to retire up to two years earlier than the required age and insurance period.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

According to Eurostat figures, poverty and material deprivation among pensioners in Bulgaria is widespread. Most vulnerable are elderly living alone, in particular women. Pensioners from ethnic minorities and people with disabilities can also be attributed to groups with serious risk of poverty and social exclusion. Low qualification combined with major gaps of the social security contributions result in lower levels of income replacement.

According to latest EU SILC indicators, the at risk-of poverty rate of older people in Bulgaria stood at 28.2% (2012). Although this represents a decrease compared to the previous year (31.2%), it is well above the EU average of around 14%. The at risk of poverty rate of elderly women (34.3%) is considerably higher than the one of men (19.3%). The aggregate replacement rate according to EU SILC is 42% (EU average 56%).[3] The material deprivation rate for people 65 and over in Bulgaria has been 72.9% in 2012, the highest rate in the EU (average 17.5%).

The Aging Report projects an increase of replacement rates in the future, e.g. for an average earner from 62.3% in 2010 to 67.5% in 2050 (theoretical replacement rates). The projected increase in replacement rates is largely due to a substantial increase in income from the mandatory second pillar.

2.2.2 Sustainability

In 2012/2013, the 2011 pension reform already showed some positive trends, i.e. a substantial decrease in the number of newly granted old-age pensions by 22,6% and an increase in the effective retirement age from 61.3 (2011) years to 61.4 years in 2012.

With the new Government, the proposals made so far are related to the short and long term improvement of pensions' adequacy as well as to facilitating the access to the state pension system, but they lack funding and will further threaten the financial sustainability of the system.

The overall financial effect on the budget of the state social security only for 2014 that will result from the implementation of the proposed amendments to the Social Security Code equals to about BGN 145 million additional expenditure. However, it should be taken into consideration that expenditure in 2014 will be raised by more than BGN 300 million compared to 2013. In this relation, even without the implementation of new measures and policies towards the expenditure part of the state social security budget in 2014, the additional transfers from the state budget to the budget of the state social security in 2014 should raise by about 13% compared to 2013. It means that, for the first time, the additional transfer from the state budget to the NSSI budget will exceed BGN 2 billion.

[3] http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database

Currently, the mandatory PAYG system (I pillar) is strongly dependent on the state budget. Due to the reduction of the contribution rate during previous years already more than 60 per cent of expenditure in 2013 is financed by transfers and subsidies from the state budget. The increase of state subsidies, mostly by tax revenues, in funding pensions questions its financial stability now and for the future. The substantial share of state subsidies in the social insurance funds strongly demotivates workers and their employers to pay contributions.

2.3 Private pensions

The obvious unwillingness of the governing majority to continue the development of the pension reform is reflected by a number of problems left unresolved in the second and third pillar. The most urgent of them are the following:

1. **The payment of pensions from the Occupational Pension Funds/OPF/**

This issue is not fully covered by the Social Security Code thus creating grounds for potential problems. The multitude of attempts to solve this issue in the course of years has led only to its postponement and complication. Under the circumstance that the OPF are envisaged, as of 2015, to start payment of pensions, it is necessary to find adequate legislative solutions consistent with the accumulation of resources of insured persons in the occupational funds, the term and the regularity of transferred insurance contributions.

2. **Problems related to the collection and distribution of insurance contributions in the supplementary obligatory pension funds.**

To solve these problems, packages of measures are necessary relating to:

- Improved control over the collection of insurance contributions;
- Raising the active participation of state and competent authorities in the process of forced collection of insurance liabilities;
- Timely distribution of collected contributions in the supplementary obligatory pension insurance funds.

3. **Legislative framework of pension payments from the Universal Pension Funds /UPF/.**

This pressing issue has been postponed in the course of time with the argument that the first supplementary pensions from these funds will be paid in 2018 at the earliest whereas the biggest part of them will be paid out only in 2023. As this affects a considerable public group, this issue cannot be postponed any more.

The Social Security Code has to provide in detail rules and procedures for pensions from the UPF, to regulate reserves of these funds as well as investments. The law amendments also have to solve the issue of survivors' rights and survivors' pensions.

2.4 Summary

The biggest problem of the Bulgarian pension system today is the inability of the public insurance (I pillar) to ensure sufficient resources for the insured after retirement. An aging population and an aggravating system dependency ratio represent serious challenges for the financial sustainability of the public system.

The expert assessments of these actions as well as the envisaged indexation of all pensions in the next year show that in 2014 there will be a new increase of the NSSI budget deficit. In

general, the proposals that are made relate to facilitating access to the state social security will increase the shortage of resources and worsen its financial situation.

The proposals under discussion are not in conformity with the major recommendations of the European Commission and other international institutions concerning the pension systems, namely, to restrict and not admit new forms of early retirement in the Bulgarian pension system, to raise the effective retirement age, to equalize the retirement age for men and women, etc.

Even though these conclusions are shared by virtually all expert circles, they do not lead to a changed position of the Government. The U-turn of the ruling coalition with regard to the pension reform is practically supported by the social partners as well.

2.5 Reform debates

After the long debate that started in the autumn of 2009 and continued almost till the end of 2010, for almost three years now there is no serious broad discussion in the society on further development of the pension model. The actions undertaken by the government after the elections in May 2013 are characterized by considerable populism and unwillingness to take into consideration the position of experts.

Those actions of the governing coalition receive direct support by trade unions and implicit consent on behalf of the major employers' organizations.

In practice the only two key debates between social partners concerning pension reforms are:

- The renewed proposal by trade unions to incriminate the non-payment of insurance contributions on behalf of the employer which was categorically rejected by the employers' organizations, and
- The insistence of the trade unions to raise contributions for the solidarity pillar by one percentage point with the aim to ensure higher revenue which, according to the employers, would led to an increase of unemployment rates and grey economy.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

The significant reforms, which started in 1989, had no considerable impact on healthcare by the end of the 90s of the twentieth century. The real change in the healthcare system began in 1999 with the adoption of the main laws governing its nature and organizational structure. The major laws regulating the healthcare system development were associated with the introduction of the health insurance model, the stipulation of the status of medical facilities as well as the place and role of professional organizations. There was further development of legislation in healthcare in the period 2003 – 2005 when the Health Act, the Transplantation

of Organs, Tissues and Cells Act and the Blood, Blood Donation and Blood Transfusion Act were adopted.[4]

In the field of social health insurance have been introduced new legally binding principles; solidarity; risk sharing; payments based on income; public nature of the insurer controlled by the insured, the employers and the state; sharing contributions between employees and employers and co-participation of state.

The development of healthcare legislation over the past 23 years can be classified into four periods:

- The first period (1991 – 1999) – a constitutional setting and amendments to delegated secondary legislation characterized by a number of repealed ordinances and guidelines and adoption of a new Drugs Act;
- The second period (1999 – 2000) – adoption of the major health insurance acts and the operation of the insurance model;
- The third period (2003 – 2005) – adoption of the common Health Act and several specialized acts;
- The fourth period – legal amendments and adoption of the required secondary legislation and its implementation into practice..

3.1.2 System characteristics

The new health model assumes a decentralized and pluralistic system of compulsory health insurance with health insurance contributions from employees and contractual relationship between the National Health Insurance Fund (NHIF) as purchaser of services and healthcare providers. NHIF acts as a single agency providing basic financial flows for health services funding to the insured persons. The National Health Insurance Fund was established in 1999 as a public institution, which conducts the mandatory health insurance for the Bulgarian citizens. NHIF was established as an independent public institution, being separated from the structure of the public healthcare system and having its own governing bodies. The key goal of the NHIF is to provide and ensure free and equal access for the insured persons to medical care by a specific type, scope and package of health services and the free choice of a provider who has contracted an agreement with the Regional Health Insurance Fund (RHIF). Through its 28 regional authorities (regional health insurance funds) it carries out the financing of the entire healthcare network of outpatient care and hospitals. Private insurers provide alternative manners of healthcare funding as well as the funding regarding those medications and treatments that have been excluded from the basic health insurance package.

The organizational structure of the Bulgarian healthcare system is determined by the interaction of public and private entities and a mixture of centralized and decentralized structures. The organization is based on primary care viewed as a primary unit (entrance) to

[4] The endorsement of the new Constitution of the Republic of Bulgaria (1991) forms the legal framework of health legislation. Article 52 of the Constitution stipulates the new relationships, on which contemporary Bulgarian health legislation should be built. It also defines some fundamental rights for the citizens of the country, namely: 1.) the right to health insurance; 2.) the right to affordable medical care; 3.) the right to free medical services under the terms and conditions laid down by law; 4.) state protection of citizens; 5.) physical development promotion; 6.) protection from compulsory treatment; 7.) the right to health measures; 8.) the right to protection and control of the production of pharmaceuticals, biologics and medical devices, and 9.) the procedure and manner of healthcare system funding.

the system and place for a patient's first contact. The hierarchy of the system and the relationships in it are based on the so called "referral system".

Healthcare facilities are relatively autonomous. Outpatient care is provided by a single or group practices, medical and dental centers and independent medical diagnostic centers. Physicians and/or centers conclude contracts with the National Health Insurance Fund annually. Inpatient care is ensured by general and specialized hospitals, dispensaries (which were converted in 2012), nursing homes, hospices and hospitals providing services for acute care, long-term care and rehabilitation. The start of the healthcare reform at the late 90s of the twentieth century was characterized by a process of significant reduction in the number of hospital beds; however, Bulgaria still had a wide network of hospitals across the country providing easy access to hospital care, thus leading to excessive and often unnecessary use of beds.

The overall organizational and political model of the healthcare system in Bulgaria has recently been characterized by the domination of extreme neoliberal theories and practices in all areas of public health and organization of the system, representing the "market" as a panacea to

unresolved or poorly resolved problems; denying or severely underestimating the officially supported by the European Commission and the Lisbon Treaty theory and practice of social market economy, and in particular – health being considered (along with education and social protection) as the main social functions of a modern European state where market and market relations play a certain role but under state control.

Typical of the so called neo-liberal "reformist" era in healthcare are primarily the introduction of market mechanisms and the expectations that the latter would improve the provision of services. The adoption of the new legislation and the implementation of market mechanisms led to the complete transformation in the relationships and the facilities in the system, characterized by the privatization of activities within the system itself and the use or receipt of certain public resources in the market environment (the material and technical provision regarding the functioning of medical facilities remained at the expense of the state and the municipalities; preferences were obtained for the use of the property – for example lower rents for general practitioners and donations of equipment from them).

3.1.3 Details on recent reforms

During the reporting period, the key regulatory amendments in the health system covered an amendment to the Health Insurance Act, the Health Act, the Medicinal Products in Human Medicine Act, the Transplantation of Organs, Tissues and Cells Act, the Medical Facilities Act, the Blood, Blood Donation and Blood Transfusion Act.

In 2012, amendments were made to the Health Insurance Act and the Health Act envisaging that as of 1st January 2013 funding switched to the National Health Insurance Fund regarding vaccines delivery, assisted reproduction, intensive care and outpatient follow-up of patients with mental and skin-venereal diseases.

The Health Insurance Act also envisaged re-licensing of health insurance companies under the Insurance Code to joint-stock insurance companies within one year of its entry into force.

The Health Act introduced a ban on smoking in enclosed public places.

The Medical Facilities Act stipulated planning through the National Health Insurance Card and high-tech methods of diagnosis and treatment.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

Health system funding is one of the key factors affecting its operation. Table 1 shows the main indicators and forecasts related to the financial framework of health. Data show a reduction in total health expenditure as a percentage of GDP. According to the forecast, it is expected to continue in the forthcoming years, thus influencing significantly the system operation. Although the government has recently maintained a minimum growth rate of health funding in nominal terms, the ratio of public health spending as a share of GDP is constantly decreasing at the expense of private and household costs.

The relationship between public and private health expenditure in GDP is changing towards a constant increase in the proportion of the private sector costs against public costs, with the ratio public to private spending in 2002 being 61.26/38.74, reaching 53.29/46.39 in 2012. It is forecasted that this trend will continue in the forthcoming years, whereas the share of private health costs reaches 48-49% of the total health costs, i.e. risks will increasingly be covered by household payments.

Health expenditure experiences a steady growth in the cost structure of households and individuals. While in 2000, households spent 3.6% for health, in 2011 the percentage reached 5.6%. The average health cost per Bulgarian household in 2012 was 501 BGN, while the average cost per person was 212 BGN (Figure 1), and quality medical care and services are reflected in the objective assessment of the needs of the population and proper planning of the necessary resources and programmes to meet them, respectively.

General coverage of the population with physicians in primary outpatient care in 2011 was characterized by 6.8 general practitioners (GPs) per 10 000 population, while the average population of one GP was 1508 people. In 2011, contracts with NHIF signed 4996 GPs, whereas the total number of physicians for primary care as required by the National Health Card (NHC) amounted to 5010, i.e. performance of 99.7%.

Although a new type of payment for the provision of constant 24-hour access to medical care to the insured persons was introduced in 2011, where disbursements totalled 5 180 900 lev and represent 13.27% of spending on the primary outpatient medical care, this failed to lead to enhanced quality of service and the satisfaction of both the population and the physicians themselves. Servicing citizens in need of medical care outside working hours remained the concern and responsibility of the emergency medical care system. This leads to the conclusion that the allocated funds did not have the necessary impact and failed to produce the desired result.

Generally, it can be assumed that primary healthcare fails to ensure the necessary quality and quantity of medical services to those in need, and, thus, it is not an appropriate regulator for access to specialized and highly specialized services, being inefficient from both health and social and economic point of view.

The number of inpatient healthcare facilities exceeds the EU average and it is forecasted to continue to grow in the forthcoming years, which is related to the increase in the number of beds, primarily at the expense of hospital beds in the private sector. The territorial distribution of inpatient healthcare facilities, particularly hospitals, is uneven.

Despite the ongoing signals from professional associations regarding the emigration of healthcare professionals, the number of employees in the system is increasing, with this increase forecasted to continue. There is a lack of effective human resources planning. The data registers of the Bulgarian Medical Association and the Bulgarian Association of

Healthcare Professionals show the ratio of physicians to medical specialists 1:1.45. The educational system does not meet this imbalance; rather it contributes to its deepening by preparing almost equal number of physicians and healthcare professionals.

There are regional disparities resulting in unequal access to medical care. Physicians coverage by regions ranges from 25.6 to 50.2 per 10 000 people. It is highest in areas with medical universities and university hospitals. Distribution of healthcare professionals is more balanced.

There is an increase in the average age of physicians employed in health network, with nearly half of them being in the age group 46-60 years, one fifth - over 60 years, only 5% up to 30 years of age, and one fourth - between 31 and 45 years. The same trend is valid for healthcare professionals, where about 15% of them are over 60 years. High average age of medical professionals will increase the deficit upon retirement.

3.2.2 Quality and performance indicators

Although the National Health Strategy 2008-2013 has included various indicators for assessing the quality and performance, those are not monitored and reported. The same applies to the quality indicators included in the National Framework Agreement. One of the main problems of the health system in Bulgaria is the lack of monitoring and control.
The quality and the effectiveness of provided medical services are influenced by several major reasons:

- Lack of research and analysis of the population's needs of the different types of medical services and respective planning of necessary resources;
- Primary care inefficiency, predominantly referring to GPs' activity;
- Market orientation of hospitals – i.e. "induced needs" of the citizens;
- Increasing efficiency regarding the introduction of new and high-efficient technologies; reduced average duration of stay, increased utilization of beds, a high turnover of the same bed;
- Lack of sufficient regulations in the system - medical standards, resource and investment planning, etc.

3.2.3 Sustainability

Although in 2008 the health insurance contribution rate was raised from 6% to 8%, this did not lead to substantial changes in health funding. A problem facing our healthcare system in recent years has been and still is the constant level in the number of non-health insured persons. The lack of objective and publicly available data on the number of persons who fail to pay health insurance contributions make it impossible to predict in this regard. The majority of those who do not have health insurance consist of disadvantaged, marginalized groups, and, primarily, the permanently unemployed. However, in the past two years the National Health Insurance Fund (NHIF) reported over fulfilment of planned resources from health insurance contributions. The money collected for healthcare on NHIF's accounts were transferred from the reserve of NHIF to the general state budget – in 2009 they amounted to 140 million BGN; in 2010 – 1.4 billion BGN; in 2011 – 9 million BGN, and in 2012 – over 41 million BGN.

In 2009, a large part of the state-paid activities through the budget of the Ministry of Health, were redirected to be paid through NHIF's budget with no significant changes in planned funds. This continued over the next years, whereas in 2012 it was decided that all activities paid by the Ministry of Health excluding emergency care, transplantations, psychiatric care and residential medical care homes should be redirected for payment to NHIF. Particularly strong impact on the financial situation and stability of the system had the transfer of the reimbursement of all medicinal products (except vaccines and treatment of AIDS and tuberculosis) from the budget of NHIF.

In 2011, a decision was taken to convert the inpatient dispensaries (oncology, mental and skin ones) in complex centers performing specialized hospital care – 7 complex cancer centers, 12 centers for mental health and 9 inpatient skin-venereal centers. In accordance with that decision, the funding of their activity was transferred to the NHIF based on newly created rules and clinical pathways. This put a further strain on the healthcare system and among patients regarding the provision of such type of health service.

Since 1989, for Bulgaria has been typical a gradual increase in the use of original medicines, an average of 1% annually, reaching 24% for the first 6 months of the current year. For 20 years, the average value of one pack medicine in our country has reached 7.66 BGN.

Data on the size of the pharmaceutical market show an increase in sales of over 10% to 1 billion BNG in 2012, where the growth is not due to the crisis end but caused by dissatisfaction with healthcare. There is an increase in the use of usually prescribed medications. Mostly affected by the economic crisis is the food additives market, with the purchase of food supplements being a certain indicator of the end of the crisis, as experts point out.

Spending on medicinal products and medical devices directly paid by patients is very high. Of the total market costs, state funds amount to less than 40%. Thus, medication costs directly payable by patients (out-of-pocket expenses) become very high and, actually, represent more than 70% of household health costs. These costs are a particularly heavy burden for the poor. The fact that the value of consumption of poor households is significantly lower (80 BGN) than that of other households (140 BGN) shows that the poor probably skip purchasing drugs. Surveys involving Bulgarian patients actually indicate that 23% lack financial resources to buy the prescribed medications, while 56% cannot afford at least some of the prescribed drugs needed for treatment. In 2012, the funds spent on medicinal products, medical devices and consumables dropped substantially compared to 2011 when they were 164.0 million BGN, which is related to the transfer of functions and activities that are within the scope of health insurance to the National Health Insurance Fund.

The total indebtedness of the hospital medical institutions at the end of 2012 was about 360 million BGN, with 148 million BGN in arrears that make up almost half of all obligations. This trend towards retained indebtedness has been observed over the past 10 years and still is without reaching the correct economic and political solution. In the last two years, 17 municipal hospitals ceased their activity.

3.2.4 Summary

The amendments to the Health Insurance Act (2012) have dramatically changed the insurance model, where the supplementary voluntary health insurance that existed in the previous version of the law was changed and focused on insurance principles (Solvency 2 Requirements). No measures were planned and undertaken to solve this problem, which led to full monopsony the National Health Insurance Fund (NHIF) in the disbursements for healthcare services, marginalization of the second pillar of insurance. This in turn results in

complete concentration of payments in a single payer and continuous desire for state intervention in health funding (for instance, the Ministry of Finance unreasonably takes NHIF's reserves) and the infringement of the principle of increased financial autonomy of the health sector. The healthcare system is now in a "stabilized crisis and systemic chaos".

Resources directed to prevention and health promotion policy are insufficient and constantly decreasing. State withdraws from its main function in ensuring the implementation of this policy. Allocated money and resources under that policy are used inefficiently, without setting clear priorities, target horizon, risk determinants and groups assessment and without required monitoring.

Bulgaria still has untapped potential to achieve better health of the population and prevent most of the diseases and premature mortality, respectively. This potential is in the scope of health promotion and disease prevention, particularly social and health policies at national and regional level. More effective prevention can be achieved if it covers practically simultaneously several key areas: improving health determinants (social, behavioral, environmental); public involvement in healthy lifestyles; development and implementation of programmes aiming at the prevention and early diagnosis of chronic diseases, application of interdisciplinary models in their prevention, etc. Health promotion and disease prevention policy must involve all sectors of society, not only healthcare system structures (non-health sectors such as education, social sphere and more, local authorities, businesses, the media, NGOs as well as the population itself should also be taken into consideration). Only if there is such intersectoral interaction, a common position could be developed as to what and how it should be done in order to promote a healthy lifestyle, whereas this complies with the available opportunities and resources. Such an approach would allow for the healthcare system to focus not only on treatment but also on the development of the health potential of the nation and implementation from all healthcare system units of an integrated approach in the field of promotion and disease prevention. Medical services referring to consulting on healthy lifestyle should be placed as key services along with treatment and diagnostic activity of general practitioners. In our country, there were and still are a significant number of prevention-oriented national programmes. Some of them dealt with particular risk factors (smoking), others covered broad subject areas (mental health), while third emphasized on individual diseases (osteoporosis), etc. In many cases this led to a duplication of activities within the various programmes on similar thematic areas, which was unreasonable waste of the already limited financial resources. Moreover, the planning of these programmes, in most cases, lacked the development of the necessary tools for assessing their effectiveness at individual stages.

The main risks associated with healthcare system operation are the following:

- ❒ The impact of the global financial crisis is manifested by negative effects on opportunities for system resourcing and increased demand for health services by the population.

- ❒ Deteriorating staff, insufficient qualification and demotivation of healthcare professionals, particularly in emergency medical care.

- ❒ Progressive deterioration of the age structure of the medical specialists, insufficient number of students undergoing trainings and increased number of medical professionals who wish to seek professional realization abroad.

- ❒ The structures of the national health network are unevenly distributed with growing regional disparities and inequality of the population in terms of access to different types of medical care, especially with regard to primary care.

- ❒ Poor interaction and coordination between the different sectors of the system that violates the integrity of the system and thus reduces the quality and effectiveness of healthcare.

- ❒ Growing dissatisfaction among the population with the access, organization and quality of provided primary medical care.

- ❒ There is still lack of truly guaranteed 24 –hour service for the population provided by general practitioners which burdens the emergency medical care system.

- ❒ Lack of improvement in health promotion and disease prevention activities carried out by GPs.

- ❒ The operation of emergency medical care system is complicated due to the lack of a clearly defined subject of the emergency care, which often suggests that the latter is inadequately burdened with non-specific activities.

- ❒ The high frequency of hospitalizations in the country should be subject to comprehensive actions in the future as well as the need of internal restructuring with a focus on beds for continuing and long-term treatment, hospices, short duration of stays, with clearly categorized and territorially distributed hospitals.

- ❒ Essential are the specialization and optimization of hospital services "portfolio" so as to fully meet the needs of the population with the most efficient use of available resources.

3.3 Reform debates

The pharmaceutical industry and drug policy are common topics raising public controversy. For example, in 2012, it was found that the external control mechanism of the reference price failed to lead to the anticipated effect, thus causing an increase in medicines' prices. Another emerging problem is associated with the gradual transfer of responsibility for the purchase of some expensive drugs from the Ministry of Health to hospitals. Until 2010, the Ministry of Health used to supply the expensive drugs centrally (for instance, regarding cancer diseases and haemodialysis). However, policy-makers decided that this method is inefficient due to a number of reasons, including delays in government procurement and timely delivery of the necessary medicines as well as the imposition by the administration of concrete volumes, thus leading to a shortage of these drugs. The significant number of complaints against the Ministry of Health on the outcome of the government procurement process put additional pressure, which was manifested in the undertaken changes. In 2012, a decision was made to include the expenditures for these drugs in clinical pathways and enable hospitals to purchase them in compliance with their public procurement procedures under the Public Procurement Act along with routine orders for medicines and consumables.

The transition process was disorganized and many hospitals were found to have paid higher price compared to the price that the Ministry had received earlier in centralized tenders.

Subject of considerable criticism and debate is the implementation of the policy regarding the provision of medicines and medical devices, not to its content. Discussions indicate that the

content of many existing legislative acts as well as the undertaken actions comply with the standards of good practice. For example, the criteria to include a drug in the Positive Drug List (PDL) and pricing are not public and transparent, with the decision-making process not being transparent as well. Based on this, the credibility to the respective commissions is low and likely to remain so unless transparency grows sufficiently so as to satisfy the society. The necessary measures will be: performance of full and transparent audit of the existing positive list in order to provide a system with the best efficiency of input resources and significant enhancement of public confidence in the legitimacy of these processes, and last but not least contributing to the continued improvement of decision-making transparency.

Another problem stemming from this policy is the increase in the levels of self-treatment requiring additional control of the allocation of drugs from pharmacies. The factors influencing the increased levels of self-treatment are as follow: inappropriate prescription of drugs by general practitioners and specialists, non-compliance with patients' financial status, prescription mainly of expensive originals under the influence of the marketing policies of pharmaceutical companies, and last but not least – the ever-changing levels of reimbursement by NHIF with constantly increasing self-participation of patients in their purchase, who prefer avoiding the costs and time to consult their GPs.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

The long-term care system in Bulgaria has expanded considerably in recent years as a result of actions aimed at deinstitutionalisation and provision of more community-based services and services in family environment. Despite some progress, the institutionalisation of people with disabilities and elderly people is still predominant. Care is provided mainly in homes for elderly people, homes for elderly people with disabilities, specialised hospitals for continued treatment and rehabilitation and hospices.

In order to improve coordination and integration of social services and ensure equal access to quality social services for people from vulnerable groups, a qualitatively new approach to development and provision of social services through regional and municipal planning on the basis of the analysis of the needs of social services was introduced in 2010. The new approach aims at establishing social services that meet the specific needs of the target groups not only in the municipalities, but also at the district level. The regional and municipal planning provides better involvement of all stakeholders in planning, designing and provision of services.

As part of the implementation of the Concept of Deinstitutionalisation and Prevention of Social Exclusion of People Living in Institutions the Agency for Social Assistance has developed a Plan for reforming the specialised institutions for elderly people and people with disabilities 2010-2011, which outlines concrete measures and activities for the reformation of 14 specialised institutions for adults with disabilities. In 2011 under the process of deinstitutionalisation and in order to improve the quality of life in institutions for elderly people and people with disabilities, 12 specialised institutions were abandoned and 28 new community based services of residential type were established. 150 people were deinstitutionalised and accommodated in community based social services of residential type.

As of July 2012, the number of specialised institutions is 163 with a capacity of 11,326 places.[5]

The transition from the traditional institutional care in Bulgaria to community based services and family based services is mainly realised by expanding the range of services such as Day Care Centres, Social Rehabilitation and Integration Centres, Protected Housing, and the development of the model for services provided at home (personal assistant, social assistant, domestic assistant, domestic social patronage). In 2011 the number of community based social services for elderly people was 329 with a capacity of 6,876 places, while in July 2012[4] there was a certain increase in the number of these services, reaching 370 with a capacity of 8,043 places.

4.1.2 System characteristics

As laid down in a number of important policy documents, the philosophy of the system of long-term care (LTC) in Bulgaria is ostensibly based on the principle of solidarity, equity and access of all clients in need. Its objective is to improve the quality of life of disabled children and elderly people with impaired activities of daily living (ADL) and instrumental activities of daily living (IADL) by means of providing conditions for effective exercise of their right to independent living and social inclusion and for reduced dependence on institutional care.

Although there is no specific legislation for long-term care only, the issue is addressed in a number of policy acts – the Social Assistance Act (SAA) (and the Regulations for its implementation), the Disabled People's Protection, Rehabilitation and Social Integration Act (and the Regulations for its implementation), Ordinance No. 4 on the Terms and Conditions for Social Service Provision, the Ordinance on the Criteria and Standards for Social Service and the Health Insurance Act, which provides a basis for the services rendered as part of the national mandatory health insurance system.

Depending on the specific case, LTC is provided by the state, the municipal authorities and private providers through the systems of social insurance and social welfare. The system is multifaceted depending on the type of provider involved; it is in a phase of transition and reforms aimed at strengthening the processes of decentralization and focusing on the needs of the individual care recipients. The main target groups of long-term care are people with impairments (disability) and elderly people (65+). Services are provided in residential institutions, at home, or in an environment that is close to the family (day care centers).

Currently, LTC services in Bulgaria incorporate two tiers of medical and social services, and each tier is regulated by different bodies and legislation. At the same time the respective legislation also targets other categories of people, and there is no clear framework with respect to the LTC system only, which makes it difficult to integrate the services needed by the recipients of LTC.
At first sight, this system seems to be well-integrated and work well, but in reality its operation is often compromised due to inadequacies in human resources and relevant facilities or due to systematic objectives and subjective impediments. In particular, this is the case in remote regions and villages of the country, which are often left to cope on their own because family physicians or social workers usually live and work in town and are unable to respond quickly to emergencies or organize regular home-based LTC. Occasionally long periods of time elapse before such patients can even be placed in specialised public institutions; LTC arrangements are often impossible, so such clients usually have to stay and receive LTC in hospitals. In most cases the hospital authorities show understanding for their plight, but

[5] The National concept to promote active aging in BULGARIA (2012-2030) , http://www.mlsp.government.bg/bg/docs/indexstr.htm

nowadays this is becoming increasingly difficult due to financial constraints and the inability to account for. Currently, many hospitals, including acute hospitals (hospitals for active treatment) are responsible for long-term care patients who could receive higher quality services at lower cost in an environment better adapted to this purpose. It is difficult, however, to determine in quantitative terms the volume of the care given and the capacity of the healthcare system engaged in such activities[6].

Although since 2010 legislation for another organizational form of long-term care (home for medical and social care) has been adopted to implement continuous medical observation and specific care for individuals of all ages with chronic illnesses, specific care at homes for people with chronic incapacitating diseases, and medical and social problems, at present such homes have not yet been established, and there is no public funding for their activities.

The financial resources for social services development and support are provided from three main sources: the state budget, the local budgets and the incomes of the beneficiaries.

Social services are financed by the state budget with the help of different mechanisms:

- Targeted transfers to the municipalities towards the support of the services which are delegated as state activity; these transfers are determined (since 2003) on the basis of the so-called "financial support standards per one place" (since 2008 these standards are unified, i.e. they cover the total support and salary costs);
- Targeted national programmes fully financed by budget means (for example the Programme "Assistants for People with Disabilities", which also has the characteristics of a subsidised employment programme);
- The Social Assistance Fund under the Ministry of Labour and Social Policy, funding a small number of low-budget projects of municipalities, natural persons, and legal entities registered in the Register of the SAA;
- Grant schemes for the delivery of social services within the framework of the OPHRD The municipalities provide funds from their own revenues (i.e. within the framework of their budgets) for local social services (social services at home, public kitchens, and pensioners' and disabled people's clubs). This means that the amount and quality of social services provided by local authorities greatly vary depending on the municipal budget.

For an increasingly ageing population increased public spending on **long-term care** will also be required as adults and the elderly will constitute the fastest growing social group in the society in the coming future.

Even though the system for long-term care and social services in Bulgaria is in recent years considerably expanding as a result of actions aimed at deinstitutionalization and providing more community-based and family-friendly services, there are serious challenges in this area,

[6] Beside the general health system, health care system provides long-term care for patients with mental disorders within the specialized psychiatric system, including 12 state psychiatric hospitals (SPHs), 12 mental health centers (MHCs) and psychiatric wards within the multiprofile hospitals for active treatment (acute hospitals). The t*otal* number of *psychiatric hospital beds* is 1755. Since 2010 by changing the Law for Healthcare Institutions (LHI) the opportunity has been given to the SPHs to register social services under the Social Assistant Agency. So far, social services have been provided only in two SPHs (one day care center and one sheltered home); one further SPH is currently applying for the provision of social services. In the end of 2011, Bulgaria had a total of 49 hospices with 790 beds, which are funded primarily by private funds.

resulting in insufficiently extensive network of community services and suppliers across the country, which for the majority of Bulgarian citizens impedes access to quality care.

4.1.3 Details on recent reforms in the past 2-3 years

In recent years, no significant reforms in the field of long-term care can be reported. Only more effective measures can be observed in the de-institutionalization of children in orphanages.Given the challenges imposed by the ageing of the Bulgarian population, special emphasis is placed on:

- the improvement of long-term care services and development of innovative cross-sector services;
- adoption of measures aimed at providing comprehensive support to families who care for dependent family members;
- the improvement of the quality of life of elderly people, people with disabilities, people with mental disorders, etc.

In order to achieve these goals, Bulgaria has initiated the development of National Strategy for Long-Term Care with the participation of all stakeholders. The main objective of the Strategy is to create conditions for independent and dignified life for the elderly people and people with disabilities by improving access to social services and their quality, expanding the network of these services in the country, deinstitutionalisation and promoting an interaction between health and social services. The implementation of the strategy will provide a complex support to families who care for elderly family members and family members with disabilities.

The specific objectives include:

1. Developing and offering a network of social services according to the needs of elderly, people with physical disabilities, people with mental disorders and people requiring palliative care: not only fixed, such as day centers, social rehabilitation and integration etc., but mobile forms of social services provided in people's homes;

2. Legislative regulation of a wide range of fixed and mobile services in the community for people in the target groups and their families, relying on the best practices and applying innovative approaches;

3. Ensuring sustainable financing of long term care services;

4. Improving coordination mechanism between the systems of social and health care;

5. Gradually restructuring and reducing the capacity of specialized institutions for the elderly, people with physical disabilities, people with mental disorders and people requiring palliative care and transforming them into new forms of community services;

6. Gradually restructuring the system for inpatient treatment of patients with mental disorders and the development of deinstitutionalization;

7. Implementation and provision of sustainable funding for palliative care.

This strategy has not yet been adopted, and continues to be a project. An Action plan for its implementation will be developed following the adoption of the Strategy. The activities will be funded through the state budget and the European structural funds for the next programming period.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

There is no national definition of "need of care"; instead, specific eligibility criteria are defined in different pieces of legislation for the different types of services.

Assessment of needs is individual and normally based on an application to the respective welfare service. The applicant is assessed on a number of criteria which vary depending on the type of service. Generally, the minimum eligibility criteria are defined in the legislation (the Regulations for the implementation of the respective law) and they are nation-wide and binding. These may include the applicant's income, property status, family status, potential care providers (friends or relatives), type and severity of the disability, etc. The severity of disability is assessed by independent bodies. In the case of disabled children aged 16 and under, for example, these are the Regional Expert Consultative Panel, and the Central Expert Consultative Panel[7], and for adults – the Territorial Expert Consultative Panel and the National Expert Consultative Panel[8].

At the same time, since there is still a high demand for institutional care, especially for the elderly, people with physical disabilities, people with mental disorders and people in need of palliative care increase, and capacities of existing forms and programs are insufficient.

4.2.2 Quality and performance indicators

To improve the quality of care of older people, people with physical disabilities, people with mental disorders and people requiring palliative care it is necessary to improve the facilities, the structure and professional capacity of staff, and to increase control on compliance with the criteria and standards for the delivery of social and health services. Further efforts towards improving the coordination between social and healthcare systems are necessary in order to achieve practical results and to provide qualitative and affordable integrated services for elderly people, people with physical disabilities, people with mental disorders and people in need of palliative care.

4.2.3 Sustainability

Against the background of an ageing population[9] the formal and informal LTC services seem highly inadequate. In most cases the care for elderly sick parents is an immeasurably heavy burden on their offspring, especially for those working in strenuous jobs. In such cases the only solution is placing the parent in a home for the elderly or in a hospice, or hire a professional care. Some elderly people are abandoned to their fate and meagre pensions and live alone without proper care or help. Placement in an institution is often difficult or very expensive, if the institution is private. Currently the number of available public homes for the elderly in the country is quite inadequate, considering the growing number of elderly people increasingly dependent on LTC. In many cases one has to stay on a waiting list for at least half a year in order to be placed in an elderly home. The situation is being aggravated by a deteriorating health due to the long timespan without any care. Most elderly people cannot

[7] Ordinance 19, MoH

[8] The major eligibility criteria for placement in residential institutions include: 1) Disability degree above 70%, or 2nd group disability; 2) Impaired ADL and IADL (and absence of income to hire an assistant); 3) Absence of close relatives (parents, spouse, children, guardians and trustees), or impossibility of these relatives to take care of him/her (due to advanced age, caring for other disabled people, bad relations, etc.);

[9] At the end of 2012, Bulgaria's population numbered 7 282 041 people, 2,208,400 (30,4%) of whom were pensioners

afford payments for care as their pensions are well below the poverty threshold. Thus, thousands of elderly people in Bulgaria are compelled to live in sickness and poverty[10].

4.2.4 Summary

Despite the government's announced measures and strategies, there has been no significant improvement. The existing national programmes fail to meet the growing demand for LTC services or for improvement of their quality, largely due to the limited financial resources for their implementation (especially at local level). While the community-based forms of LTC are hailed with enthusiasm as a major vehicle of de-institutionalisation, in fact their efficiency and accomplishments have not been studied in depth. Moreover, they seem to be ridden by a lack of resources and staff problems. Another missing element in the puzzle is the lack of an operating LTC system linking the different units of the system and permitting the efficient exchange of data and information.

Urgent measures are necessary to establish a viable network of different types of LTC services on the basis of well-defined and developed quality standards and efficient central and local mechanisms of supervision as an alternative to the expensive placement in specialised institutions and treatment in hospitals. The key to the solution of this problem is to develop mechanisms for the provision of types of service that are considerably less expensive than hospital and specialised institutions. To that end the informal long-term care givers should be formally recognised and supported

4.3 Reform debates

In late 2009 the political debate on LTC has intensified. The initiative was undertaken by the NGO sector and the National Social Security Institute (NSSI). LTC was for the first time defined as "a social risk" also in terms of social insurance[11]. It was suggested that the solution to the problem should be sought along the lines of establishing special schemes for social security (through the system of social and health insurance). Awareness about the fact that "Bulgaria needs a new concept for LTC, legislative and institutional solution, as well as financial provisions, bound with the state budget, the social insurance funds and the social programmes"[12] was raised. Some of the measures proposed include: LTC to be integrated in the social security system as a mandatory social security risk; establishment of an independent LTC fund; financing LTC from public funds, or an insurance fund and fees from the families of persons in need; increase of the health insurance fee so that LTC and palliative care are covered, etc.

For the first time the European Charter for Family Carers was promulgated in Bulgaria, too.

Bulgaria's priorities in the field of social services as a component of the long-term care development policy are:

- To extend the range of services targeted specifically at elderly people and people living alone, people with disabilities and others and improving their quality of life;
- Transition from institutional care to services permitting such people to live in their community and family environment;

[10] More than 330,000 pensioners live alone in Sofia (which has a population of about two million), but there are only 6 homes for the elderly and only one municipal establishment providing meals and some limited care at home, serving some 1,900 people over the age of 60 or people with 71% disability.

[11] Concept for the development of long-term care (draft). Ministry of Health (2012)

[12] Mitigating the Economic Impact of an Aging Population: Options for Bulgaria. Document of the World Bank 78979, 2013

- To reduce the number of people using services in specialised institutions for social services delivery and reduce the number of the institutions themselves through the development of a modern network of community services;
- To create incentives for informal carers by providing financial support and replacements for certain periods of time;
- To strengthen the capacity of the LTC system by providing education and training of staff and involving young people.

5 References

ADEMOV, H., (Minister of Labour and Social Policy) (2013): The stability of the insurance system should not be achieved with the efforts of only one generation, statement before the Parliament, Sofia, retreieved on 1 November 2013 at http://www.mlsp.government.bg/bg/news/news.asp?newsid=3302&catid=12

ANNUAL REPORT OF THE MINISTER OF HEALTH, "The state of public health in 2011 and implementation of the national health strategy." Годишен доклад на Министъра на здравеопазването „Състоянието на здравето на гражданите през 2011 г и изпълнение на националната здравна стратегия“.

ANNUAL REPORT OF THE MINISTER OF HEALTH, "The state of public health in 2012 and implementation of the national health strategy." – Draft (ÑCPHA)

ANNUAL REPORT ON THE IMPLEMENTATION OF THE NHIF BUDGET FOR 2011 AND 2012 Годишен отчет за изпълнението на бюджета на НЗОК за 2011 г.

ATANASOVA, D. (2006). Citizen participation in decision-making related to health. - Social Medicine, N 3, pp. 18-22 Атанасова, Д. (2006). Гражданско участие във вземането на решения, свързани със здравеопазването. – Социална медицина, N 3, с. 18-22.

CHERNEVA, K., (2013): Rearrangement, article, retrieved on 20.09.2013 at http://www.capital.bg/politika_i_ikonomika/bulgaria/2013/09/20/2144989_pensionna_reforma_prenarejdane/

CHOBANOV, P., (Minister of Finance) (2013): I expect critisism by the IMF because of the halted pension reform, interview, Sofia, retrieved on 31 October 2013 at http://www.faktor.bg/ikonomika/biznes/13975-chobanov-ochakvam-kritiki-ot-mvf-zaradi-spryanata-pensionna-reforma.html

COUNCIL OF MINISTERS. (2012). Strategic Report of the Republic of Bulgaria, 2012. December 2012. Министерски съвет. (2012). Стратегически доклад на Република България, 2012. Декември 2012.

DELCHEVA, E. (2008). Conceptual model of the competitiveness of the health system. - Health Economics and Management, N 1, pp. 9-15. Делчева, Е. (2008). Концептуален модел на конкурентоспособността на здравната система. – Здравна икономика и мениджмънт, N 1, с. 9-15.

ECONOMIC AND SOCIAL COUNCIL (2012): Active ageing and solidarity between generations, Opinion, Sofia, retrieved on 1 October 2013 at http://www.esc.bg/bg/activities/opinions

ECONOMIC RESEARCH INSTITUTE AT BAS. (2012). Annual Report 2012. Economic Development and Policy in Bulgaria: Ratings and expectations focused Health. Sofia Goreks Press, 131 pp. Институт за икономически изследвания при БАН. (2012). Годишен доклад 2012. Икономическо развитие и политика в България: Оценки и очаквания с фокус Здравеопазване. София, Горекс Прес, 131 с.

EUROPEAN COMMISSION, INTERNATIONAL MONETARY FUND, ORGANISATION FOR ECONOMIC COOPERATION AND DEVELOPMENT, UNITED NATIONS AND THE WORLD BANK. (2009). System of National Accounts 2008. New York.

EUROSTAT. (2013). Labour Costs in the EU-27. – Eurostat, News Release 54/2013, 10 April 2013.

GANEV, K. (2005). Measurement of total factor productivity: Growth Accounting for Bulgaria. - Discussion Papers 48, National Bank Ганев, К. (2005). Измерване на общата факторна производителност: Счетоводство на икономическия растеж за България. – Дискусионни материали 48, БНБ.

GUTSUZYAN, M., (2013): The pension reform in the „freezer“ until 2016, article, Sofia, retrieved on 31 October 2013 at http://www.trud.bg/Article.asp?ArticleId=2406671

ILIEV, I., PETROVA NIKOLOVA, R., 2012, Age friendly goods and services – an opportunity for social and economic development. Social services and employment for the elderly, (Warsaw, 29-30 October 2012). Comment paper Bulgaria Peer Review on age friendly goods and services, Poland 2012

KUZNETSOVA, D. (2013). Problems of medical training through the eyes of the students. - Policies, N 1, an electronic journal Кузнецова, Д. (2013). Проблемите на обучението по медицина през погледа на студентите. – Политики, N 1; електронно списание - http://politiki.bg/?cy=262

NATIONAL SOCIAL SECURITY INSTITUTE (2013): Analysis of old age and contributory service pensions for the period 2000-2012 (publication), 10 October 2013, Sofia, can be retrieved in Bulgarian language at http://www.noi.bg/aboutbg/st/analyses/2468-analizpensii2000-2012

NATIONAL STATISTICAL INSTITUTE (2013): Statistical Yearbook 2012 (book), 13 September 2013, Sofia, can be retrieved in English language at http://www.nsi.bg/otrasal-publikaciaen.php?n=398&otr=52

RANGELOVA, R. (2008). Criticism of the Concept and Measure of total factor productivity. - Economic thought piece. 3, pp 30-49.Рангелова, Р. (2008). Критика на концепцията и измерителя за общата факторна производителност. – Икономическа мисъл, бр. 3, стр. 30-49.

SALCHEV, P. et al. (2011). Primary health care in Bulgaria - facts and analyzes. Institute "Open Society", pp. 55-74. Салчев, П. и колектив. (2011). Първичната здравна помощ в България – факти и анализи. Институт „Отворено общество”, с. 55-74.

SURUDJIISKA, D., (2013): The „freezing“ of the pension reform may be valid for 2 years, article, Sofia, retreieved on 31 October at http://novanews.bg/news/view/2013/10/31/61084

THE EUROPEAN HEALTH REPORT. (2005). Public Health Action for Healthier Children and Populations. World Health Organization.

WHO REGIONAL OFFICE FOR EUROPE. (2006). The European Strategy for the Prevention and Control of Noncommunicable Diseases. Copenhagen.

ZACHARIEV B., VILAMOVSKA, A. M. (2013). Trends and Challenges in medical education. - Policies, N 1, an electronic journal Захариев, Б. Виламовска, А. М. (2013). Тенденции и предизвикателства пред медицинското образование. – Политики, N 1; електронно списание - http://politiki.bg/?cy=264&lang=1&a0i=224015&a0m=readInternal&a0p_id=1035

ANNUAL REPORT OF AGENCY OF SOCIAL ASISTANCE

MITIGATING THE ECONOMIC IMPACT OF AN AGING POPULATION: Options for Bulgaria Poverty Reduction and Economic Management. Document of the World Bank N 78979

NATIONAL STATISTICAL INSTITUTE – www.nsi.bg

NATIONAL CENTER OF PUBLIC HEALTH AND ANALYSES – www.ncpha.government.bg

MINISTRY OF HEALTH – www.mh.government.bg

HEALTH ACT. (2004). Закон за здравето. (2004).

HEALTH INSURANCE ACT. (1999). Закон за здравното осигуряване. (1999).

HEALTH ESTABLISHMENTS ACT. (1999). Закон за лечебните заведения. (1999).

DECREE № 5 OF MINISTERS of 10.01.2013 laying down volumes and prices of medical services under Art. 55, para. 2, Item 2 of the Health Insurance Act 2013 Постановление № 5 на МС от 10.01.2013 г. за приемане на обемите и цените на медицинската помощ по чл. 55, ал. 2, т. 2 от Закона за здравното осигуряване за 2013 г.

Annex – Key publications

[Pensions]

DOMELAND D., KOETTL J., ILIEVA S., AJWAD M., DANCHEV P., DE LAAT J., GEGINAT C., BASSET R., COUFINHAL A., DIMOVA A., RAGGLA., KUPETS O., KEYFETS I., SHOPOV G., ZVINENIE A., ONDER H., PESTIEU P., ABELS M., SALCHEV P., DIMITROVA D., VICHEV M., LEY E., BOGETIC Z., ONAL A., SAMIR KC. Mitigating the Economic Impact of an Ageing Population: Options for Bulgaria. 08/2013; Publisher: World Bank, Washington D.C., Editor: Doerte Domeland

ILIEV, B., VRACHOVSKI D., JORDANOV P., ERUSALIMOV R., VASILEV V., PANTELEEVA S., PANEVA A., IN Scientific Research Almanac**,** Volume 16 **,** 2012**;** D. A. Tsenov Academy of Economics - Svishtov
Insurance and social security in the context of the economic profile of social security in a market economy
A widespread understanding connects the individual, respectively social security, too, with reaching the state of a guaranteed opportunity for meeting a particular level of socially accepted human needs in all life situations, including ones caused by contingent risks accompanying one's daily life. Presented in such a way, this security has distinct economic dimensions. In a market economy, social insecurity of individuals increases. This brings to the foreground problems related to individuals' security. Those who are competent to solve these problems are insurance companies, as well as pension and health insurance companies, whose activities in the outlined trend are the subject of the current research, first of its kind for the Bulgarian theory and practice.

SHOPOV, G., 2013, *Social Reforms in Bulgaria – examples, prerequisites, research, Bulgarian Academy of Sciences*
Political and economic context for undertaking reforms – the example of the pension reform:

- Macro political context
- Specific context for policy formulation
- The determining moments in the political context
- The realization and role of politicians, and the way they think

TSANEVA P., 2013, "Economic thought" Magazine, issue 2, 100-119.
Characteristics of investment activity of pension funds in Bulgaria

[Health care]

HRISTIAN GRIVA, SALCHEV P., ATANASOV P., KUNDURDJIEV T., DIKOVA K. Analysis of the situation and problems of the functioning of the municipal hospital and the reasons for their closure. Sofia, retrieved on 09/2013 from http://ncpha.government.bg/pechat/305-дирекция-"класификационни-системи"/857-анализ-на-състоянието-и-проблемите-на-функционирането-на-общинските-мбал-и-причините-за-закриването-им.html;

TODOR FINKOV, PETKO SALCHEV. Epr unlimited – brief epr overview and prognosis, bulgarian perspective. Bulgarian Journal of Public Health 06/2013; V(2):148-152. http://ncpha.government.bg/files/BJPH_br2_2013.pdf

SALCHEV P., ATANASSOV P., DIMITROVA T., GRIVA C. (2013), Economic analysis and evaluation of the effectiveness of hospital care services in bulgaria by using the data envelopment analysis for the period 2010-2012. Journal of Public Health Dentistry (Impact Factor: 1.19). 06/2013; V(2):96-129. http://ncpha.government.bg/files/BJPH_br2_2013.pdf

SALCHEV P. Тема на фокус "Политики в здравеопазването – икономически анализ и оценки".05/2013; ISBN: 978-954-616-2311- retrieved from: https://www.researchgate.net/publication/236951091The_Spotlight_Health_policies_-_economic_analysis_and_assessments.?ev=prf_pub

The Spotlight, "Health policies - economic analysis and assessments.

In the book: Annual Report 2013. Economic developments and policies in Bulgaria: estimates and expectations., Edition: I, Chapter: The Spotlight "Health policies - economic analysis and assessments.", Publisher: GoreksPres, Editors: Iskra Beleva, Mitko Dimitrov, pp.115-156

DIMITROV P., SALCHEV P. IN Bulgarian Journal Of Public Health 03/2013; Vol.5 (1):3-15. http://ncpha.government.bg/files/BJPH_br1_2013.pdf

ZACHARIEV B. VILAMOVSKA, A. M. (2013). Тенденции и предизвикателства пред медицинското образование. – Политики, N 1; електронно списание retrieved from http://politiki.bg/?cy=264&lang=1&a0i=224015&a0m=readInternal&a0p_id=1035

Trends and Challenges in medical education. - Policies, N 1, an electronic journal

KUZNETSOVA, D. (2013). Проблемите на обучението по медицина през погледа на студентите. – Политики, N 1; електронно списание Retrieved from http://politiki.bg/?cy=262

Problems of medical training through the eyes of the students. - Policies, N 1, an electronic journal

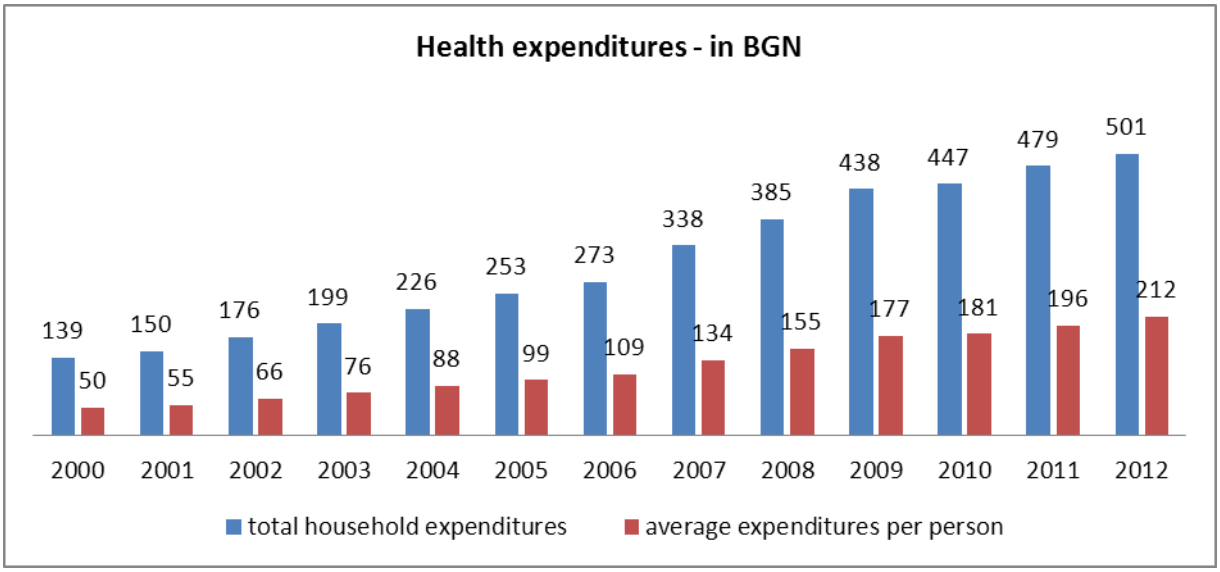
SALCHEV P. (2013) Българското здравеопазване в "окото на урагана" на икономическата криза Social Medicine 05/2013; retrieved from https://www.researchgate.net/publication/236846159_Bulgarian_healthcare_in_the_eye_of_the_hurricane_of_economic_crisis_(_____)?ev=prf_pub

Bulgarian healthcare in "the eye of the hurricane" of economic crisis

DIMOVA A, ROHOVA M, MOUTAFOVA E, ATANASOVA E, KOEVA S, PANTELI D, VAN GINNEKEN E. (2012) Bulgaria: Health system review. *Health Systems in Transition*, 2012, 14(3):1–186. Retreived from http://www.euro.who.int/__data/assets/pdf_file/0006/169314/E96624.pdf

Annexes

Figure 1 Health expenditures



Source: MF, Salchev

Table 1 Health network and beds in 2011 and 2012

Types of healthcare facilities	2011		2012	
	Number	Beds	Number	Beds
Inpatient healthcare facilities (hospitals) - total	**315**	**44811**	**312**	**45 726**
Multi-profile hospitals	**120**	**25500**	**114**	**24 912**
Multi-profile hospitals for active treatment	119	25460	113	24 872
Specialized hospitals	**76**	**7837**	**73**	**7 755**
Specialized hospital for active treatment	39	3837	37	3 700
Specialized hospital for long-term treatment and aftercare	5	241	5	251
Specialized hospital for long-term treatment, aftercare and rehabilitation	13	935	12	980
Specialized hospital for rehabilitation	19	2824	19	2 824
Psychiatric hospitals	**12**	**2448**	**12**	**2 438**
Private hospitals	**89**	**5799**	**92**	**6 916**
Healthcare facilities providing outpatient care (consistent with the healthcare facilities' reports)				
Outpatient primary medical care – individual practices	3569	-	3 575	-
Outpatient primary dental care – individual practices	4850	-	5 046	-
Outpatient primary medical care – group practices	219	-	223	-
Outpatient primary dental care – group practices	264	-	300	-
Outpatient facilities providing specialized medical care – individual practices	2858	-	3 050	-
Outpatient facilities providing specialized dental care – individual practices	62	-	76	-
Outpatient facilities providing specialized medical care – group practices	146	-	149	-

Outpatient facilities providing specialized dental care – group practices	1	-	1	-
Medical centers	559	617	575	588
Dental centers	49	6	49	7
Medical and dental centers	35	38	33	15
Diagnostic and consultative centers	121	263	121	228
Independent medical-diagnostic and medical-technical laboratories	1006	-	1 026	-
Other medical and healthcare facilities				
Comprehensive cancer centers	7	1152	7	1 144
Centers for skin-venereal diseases	10	100	8	80
Mental health centers	12	1328	12	1358
Emergency medical care centers	28	-	28	-
Independent centers for transfusion haematology	4	-	4	-
Residential medical care homes for children	31	3756	30	3 624
Hospices	49	790	41	802
National centers without beds	7	-	7	-
Regional Health Inspectorate (RHI)	28	-	28	-
Sanatoriums	**4**	**674**	**1**	**244**

Source: National Center of Public health and analyses

Table 2 Policies and programmes' expenses (in compliance with the budget of first-level budget spending authorities), 2010 – 2012

Policies and programmes	**Report for 2010** (in thousand lev)	**Report for 2011** (in thousand lev)	**Report for 2012** (in thousand lev)
Policy in the field of PROMOTION, PREVENTION AND PUBLIC HEALTH CONTROL	**93 705.4**	**113 843.7**	**112 772.3**
Programme 1 "Health Control"	19 219.8	21 504.90	27 284.8
Programme 2 "Non-communicable Diseases Prevention"	9 205.6	9 019.8	8 630.9
Programme 3 "Prevention and Surveillance of Communicable Diseases"	60 151.9	77 944.7	74 517.9
Programme 4 "Secondary Prevention of Diseases"	3 644.7	3 625.2	0
Programme 5 "Drug Demand Reduction"	1 483.4	1 848.1	2 338.7
Policy in the field of DIAGNOSIS AND TREATMENT	**348 222.8**	**497 067.3**	**345 060.9**
Programme 6 "Outpatient Care"	4 845.9	3 058.1	3 641.3
Programme 7 "Inpatient Hospital Care"	91 817.4	244 429.3	137 462.3
Programme 8 "Dispensaries"	15 697.8		
Programme 9 "Emergency Medical Care"	76 903.5	84 102.4	110 053.2
Programme 10 "Transplantation of Organs, Tissues and Cells"	3 298.4	4 067.1	4 782.9
Programme 11 "Provision of Blood and Blood Components"	12 115.8	16 150.1	14 106.5
Programme 12 "Medical and Social Care for Disadvantaged Children"	30 893	33 418.7	32 991.1
Programme 13 "Expert Investigation of the Degree of Disability and Permanent Disability"	6 689.9	7 480.2	6 130.8
Programme 14 "Haemodialysis"	49 913.9	62 209.1	0
Programme 15 "Intensive Care"	55 648.8	42 152.3	35 892.8
Policy in the field of MEDICINAL PRODUCTS AND MEDICAL DEVICES	**141 099.0**	**94 745.4**	**12 752.5**

Programme 16 "Affordable and Quality Medicines and Medical Devices"	141 099.0	94 745.4	12 752.5
Programme 17 "Administration"	**7 857.2**	**12 442.9**	**9 531.6**
Total expenses of the first level budget spending authority	**590 794.4**	**718 099.3**	**480 117.3**

Source: MoH, Salchev

Table 3 Government expenditure on LTC according to government expenditure data (BGN) - 1€ = 1,9853 BGN

	Capacity			Expenditures			Expenditures per capacity		
	2010	2011	2012	2010	2011	2012	2010	2011	2012
LTC institutional									
Homes for elderly	5,318	5,427	5,462	30,014,946	31,621,851	31,036,724	5,644	5,827	5,682
Homes for adults with disabilities	4,159	3,734	5,317	40,346,110	39,072,828	37,765,306	9,701	10,464	7,103
Centers for social rehabilitation and integration	1,958	2,547	3,139	4,754,425	5,833,034	6,687,367	2,428	2,290	2,130
LTC community-based									
Domestic social patronage, public canteens	38,030	38,390	38,554	43,228,311	45,540,252	46,569,962	1,137	1,186	1,208
Clubs for pensioners, disabled people	n.a.	n.a.	n.a.	6,283,563	7,476,566	6,584,993	n.a.	n.a.	n.a.
Daycare for elderly	1,388	1,413	1,423	2,493,591	2,760,346	3,030,603	1,797	1,954	2,130
Daycare for adults and children	2,376	1,913	3,388	15,877,149	17,799,745	18,706,607	6,682	9,305	5,521
LTC home-based									
Foster care for children and adults	627	993	1,286	5,897,778	8,889,981	11,377,950	9,406	8,953	8,848
Shelters	875	959	941	5,415,328	5,975,322	6,488,754	6,189	6,231	6,896
Total	**54,731**	**55,376**	**59,510**	**154,311,201**	**164,969,925**	**168,248,266**	**2,819**	**2,979**	**2,827**

Source: Administrative data.

Source: Mitigating the Economic Impact of an Aging Population: Options for Bulgaria. World Bank Document 78979

Box 1 Schemes of social assistance

1. Scheme "Care in family environment for independent and decent living of people with different types of disabilities and people living alone – activities "Social Assistant" and "Domestic Assistant" /phases I, II and III/ – the scheme covers the period from 2007 to 2013. Its total budget (European and national co-financing) is EUR 21.7 million. The social services are provided by non-governmental service providers.
2. Scheme "Improvement of the service "Personal assistant" for people with disabilities and people who live alone" /phases I and II/ - the scheme covers the period from 2007 to 2013. The total budget of the scheme is EUR 18.8 million. The service is provided by the Agency for Social Assistance in partnership with municipalities.
3. Scheme "Alternatives" – the scheme covers the period from 2010 to 2013. The total budget of the scheme is EUR 30.6 million. The service is provided by the Agency for Social Assistance in partnership with municipalities

Table 4 Number of social services (specialized institutions and social services) for adults by July 31, 2012 [13]

№	Type	Number	Capacity
Specialized institutions for adults			
1	Nursing homes for adults with mental retardation	27	2210
2	Nursing homes for adults with mental disorders	15	1102
3	Nursing homes for adults with physical disabilities	22	1345
4	Nursing homes for adults with sensory disorders	4	148
5	Nursing homes for adults with dementia	14	836
6	Nursing homes for the elderly	81	5685
	Total:	163	11326

№	Type	Number	Capacity
Community based social services for adults			
1	Day centers for adults with disabilities	60	1672
2	Day centers for elderly people	52	1499
3	Centers for social rehabilitation and integration for adults	61	2092
4	Social-educational centers	9	509
	Total:	182	5772

№	Type	Number	Capacity
Community-based social services - residential care facilities for adults			
1	Protected homes	117	1047
2	Supervised homes	16	100
3	Transitional homes	9	80
4	Centers for family-type accommodation for adults	32	402
5	People's crisis centers	3	36
6	Temporary accommodation centers for adults	11	611
	Total:	188	2276
	Total community based social services for adults, including those of the residential type:	370	8048

[13]Source: Ministry of Labour and Social policy, Salchev

Table 5 Annual funding for the maintenance of a person shall be[14]

	Institution type	A uniform expenditure standard for 1 person
1	Nursing homes for adults with mental retardation	BGN 5 940 (3 037 €)
2	Nursing homes for adults with mental disorders	BGN 6 570 (3 359 €)
3	Nursing homes for the elderly with dementia	BGN 7 110 (3 635 €)

Table 6 Total annual allowance [15]

	Institution type	**Total annual allowance**
1	Nursing homes for adults with mental retardation	BGN 13 953 060 (7 134 086 €)
2	Nursing homes for adults with mental disorders	BGN 8 205 930 (4 195 625 €)
3	Nursing homes for the elderly with dementia	BGN 5 993 730 (3 064 545 €)
4	Total	BGN 28 152 720 (14 394 257 €)

[14] Source: Ministry of Labour and Social policy, Salchev
[15]Source: Ministry of Labour and Social policy, Salchev

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27. EFTA-EEA and EU candidate and pre-candidate countries.

For more information see:
http://ec.europa.eu/progress