

HEALTH CARE REFORM AND INEQUALITY OF ACCESS TO HEALTH CARE IN BULGARIA

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1. INTRODUCTION

1.1 Background

The socio-political changes that have taken place in Bulgaria since 1989 have had a big impact on the health care system. The previous communist model of health care had offered universal and free access to full range of health care services and the sole funder and provider of health care was the central government. Informal payments by patients for health care services and medicines were common in Bulgaria, although not officially sanctioned by the authorities. All this led to constant crises in connection with the delivery of health care and this required radical reform to be implemented.

The Bulgarian Government's strategy includes the reform of the health sector as part of the social protection systems. The aim is to enhance sector efficiency, increase resources allocated to the health sector by tapping alternative sources of financing, and target public resources to the most cost-effective interventions.

A new law on health insurance was passed by the Bulgarian Parliament in June 1998. Initially, this law provided for the collection of insurance premiums to commence on July 1, 1999, and for the health insurance financing to begin operations by January 1, 2000 for ambulatory care services and by January 1, 2001 for hospital services. Collection of premiums started as scheduled. However, later in the year the Bulgarian Government decided to postpone the effective start of the reform by 6 months - July 1, 2000 for ambulatory care, and moving to July 1, 2001 for hospital services.

In connection with the above, a National Health Insurance Fund (NHIF) was also established. Modifications to the premium rates for social security and unemployment insurance have been made to provide the fiscal room for the introduction of the health insurance premiums. The compulsory health insurance is a system for social and health protection of the population, which guarantees a package of health-related services, and is administered by the NHIF and carried out by the 28 Regional Health Insurance Funds. Voluntary health insurance is optional and is carried out by limited liability companies, registered according to the Commercial Law.

The Health Insurance Act also regulates the signing of the National Framework Contract between the NHIF and the professional associations of health care providers - doctors and dentists. The National Framework Contract provides for the parameters and procedures related to the functioning of the health insurance system as a whole. It defines the order, the contents and the payment of the health care activities and services to be provided to the insured population. The National Framework Contract is valid for one year, until the signing of the next one. The first National Framework Contract was signed on 27 April 2000.

1.2 Scope of the paper

This paper explores and analyses four distinct dimensions of the new organisation of the health care system:

- A description of the current system of health care in Bulgaria
- An analysis of the implications of the current health care system regarding inequality of access to health care at primary, secondary and hospital level by social groups and income level.
- Information on the current operation of the private health care system
- An examination of the cost of medicines to the NHIF and the reasons for the rapid rise in costs.

The paper also draws upon a small number of case studies - interviews with primary doctors and hospital managers exploring financial issues faced by the providers. The paper also analyses the health care system in the light of compulsory and voluntary health insurance and the private health care system.

The data in this paper have been collected from various sources, namely official publications of the World Health Organisation, International Labour Office, International Monetary Fund, National Health Insurance Fund, Bulgarian Ministries of Health and Finance, Bulgarian National Centre of Health Informatics and National Statistic Institute.

2. THE CURRENT SYSTEM OF HEALTH CARE IN BULGARIA

2.1 Health care facilities

Reform of the health care system included the enactment by the National Assembly of the Health Care Establishments Act (Official Gazette, 1999) which regulates the organisation of medical (inpatient and outpatient) and dental care. The existing public and private health care establishments were re-organised according to this act.

The health care establishments are organisationally autonomous structures in which medical providers independently or with the help of other medical or non-medical staff conducts all or some of the following activities:

- Diagnosis, treatment and rehabilitation;
- Observation of pregnant women and obstetric care;
- Observation of chronically ill people and people under threat of disease;
- Prevention and early detection of diseases;
- Improving and protecting health.

Outpatient health care establishments

Ambulatory care is provided by health care establishments for primary and specialised medical care. Establishments for primary care are individual and groups for medical and dental care.

Those for specialised outpatient care are:

- Individual and group practices for specialised medical or dental care.
- Medical, dental and combined medical-dental centres;
- Diagnostic and consultation centres;
- Stand-alone medical-diagnostic and medical-technical laboratories.

Inpatient health care establishments

Inpatient care covers general and specialised hospitals; emergency medical care centres; transfusion centres; dispensaries; nursing homes and hospices; hospitals providing acute, chronic and long term care, and rehabilitation.

According to the geography of the area served, the hospitals may be regional, district, inter-district, or national.

Other types of health care establishments

The following establishments remain state-owned:

- Emergency medical care centres;
- Blood transfusion centres;
- Psychiatric hospitals;
- Medical facilities intended for medical surveillance and specific care of children;
- Establishments run by certain Ministries (Defence, Interior, Transport, Justice).

2.2 Ownership of the health care establishments

Equal treatment of public (state and municipal) and private establishments is provided for by legislation. A specific feature of the reform is the changing ownership of establishments. Assets, such as buildings and equipment etc., are owned by the practitioner or group of practitioners or by the municipality or a private owner and the medical professionals are contracted or pay rent as the rent normally is not significant. Individual practices are owned

by general practitioners and dentists and a range of other health care establishments are organised as commercial partnerships or co-operatives.

Public health care establishments have been transformed as follows:

- Hospitals belonging to the high medical schools, national centres providing medical activities, state pulmonary hospitals and the Scientific institute of emergency health care have been transformed into sole commercial partnerships owned by the Ministry of Health;
- Public health care facilities - district hospitals in the district centres have been transformed into medical establishments as shareholder companies with mixed ownership where 51 % belongs to the Ministry of Health and 49 % to the municipalities
- Other public health care facilities have been transformed into medical establishments or dispensaries as limited commercial partnerships, owned by the municipalities.
- Public health care facilities for outpatient care have been transformed into state or municipality medical establishments.

Privatization of health care establishments

Privatization is the ultimate model of decentralization and rejection of central planning (ILO, 2001). The Health Care Establishments Act also included procedures for privatization of both state and municipality medical establishments. With privatization, out-patient health care facilities, which are the property of the municipalities, may be sold or rented to general practitioners. None have been sold yet. Similarly, hospital privatization has not produced any result and so far they remain in the public sector whilst the number of privately operated facilities is very small and is just 6 % of total number of all hospitals.

In March 2002 the newly elected government repealed the provisions for privatization this turned privatization to be more slogan than reality. However it is not clear how this process will continue to take place.

Although privatization has not yet taken place as scheduled it has not prevented some primary care practitioners from owning their own practices.

2.3. Financing of health care establishments

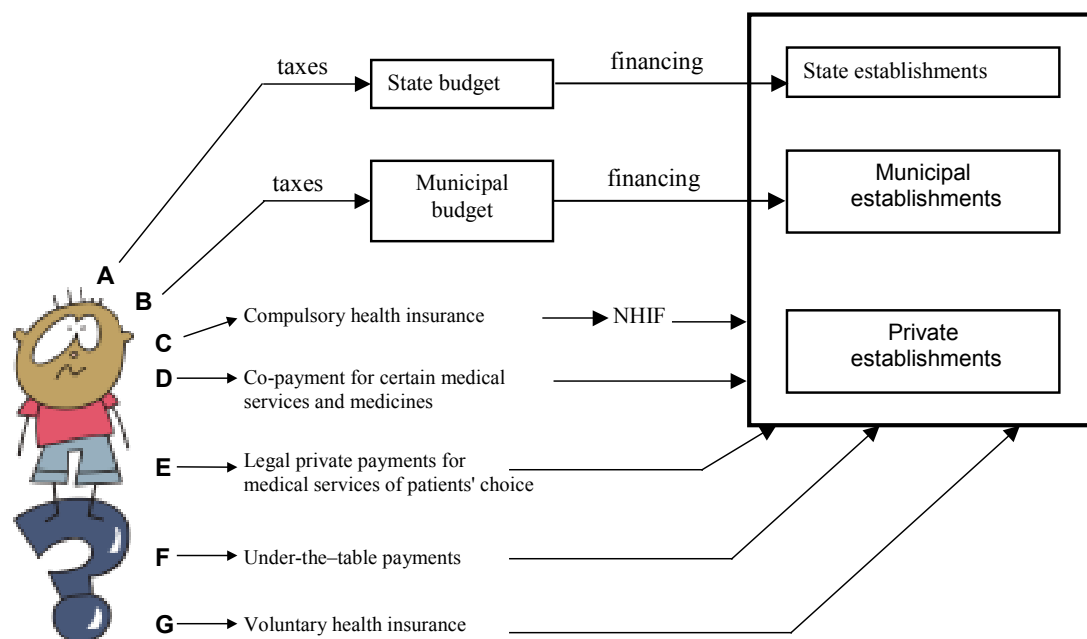
Sources of financing are:

- The National Health Insurance Fund;
- State and municipality budgets;
- Voluntary health insurance funds;
- Local and foreign legal bodies and individuals;
- Co-payment.

Figure 1 shows the money flow to the health care establishments.

Figure 1

Financing of Health Care Establishments



The health care establishments make their revenue from payments such as contracts for providing health care; direct payments made by legal bodies and individuals as well as fees-for-visit under the Health Insurance Act; reimbursement of expenses by a third party; subsidies from the state budget when provided in the annual State Budget Law; subsidies from the municipality budget when provided in it; the leasing of equipment and premises; donations, wills, financial aids and others.

The state and municipalities subsidise the public (state and municipality) hospitals in accordance with the State Budget Law for each year and municipal budgets. The subsidies are used for acquisition of long-term assets; capital repairs for restructuring the medical establishment; information technology and to aid the financial recovery of hospitals which have been insolvent.

In fact most, if not all state and municipality hospitals have considerable financial problems. The budget for hospitals for 2002 is 530 million leva (265 million USD) as financing is coming from the Ministry of Health (350 million leva or 175 million USD), the NHIF (100 million leva or 50 million USD) and municipalities (80 million leva or 40 million USD). This appears to be highly insufficient for the debts of the hospitals, which in September 2002 amounted to nearly 90 million leva (45 million USD). The figure is expected to reach 120 million leva (60 million USD) at the end of 2002. The main creditors are the electricity and water suppliers, as well as pharmaceutical companies. Those who suffer most are the university and district hospitals, which normally treat more patients than any other hospitals. The Ministry of Health has declared that hospitals have money only for wages and social insurance contributions.

However, amounts paid by the NHIF to the hospitals that they have contracted with cover only 10 % of the cost of the activities performed and reimbursed by the NHIF.

Experts in the field of health care agree that the severe under-funding of hospitals is due to the excessive number opened up during the communist era. From then to the break down in the 1990s all hospitals were 100 % funded by the State. Instead of closing down ineffective hospitals they were left open and no investments were made. This led to old buildings and medical appliances, which were not properly maintained.

As the economic situation in Bulgaria changed and central planning came to an end, budget subsidies together with compulsory health care contributions have not been sufficient to cover the expenditure of hospitals. The hospital sector appears to be in need of significant refurbishment and replacement of key diagnostic and therapeutic equipment.

In 1999 the World Bank gave Bulgaria a loan of 63.3 million USD for restructuring the health sector (World Bank, 1999, Health Sector Reform Project). One of its four components is hospital care reform. In general the objectives of this component are quality of care and accreditation and quality assurance and management.

The idea of reforming hospital health care was also included in the Memorandum on Economic Policies of the Bulgarian Government and the Bulgarian National Bank for 2002 presented to the International Monetary Fund (IMF, 2002 Country report). The Bulgarian government has stated that it "will finalise accreditation of all hospitals by end-June 2002 to identify providers of high quality health services..... and will redirect around 10 % of medical activities from hospitals to outpatient service providers, reduce expensive and non-effective activities in hospitals, and privatise or close down 10 % of hospitals in 2002."

So far this has not been done. The government has not had the political strength to implement its programme concerning closure of ineffective hospitals or structures. The reason for this is resistance by health personnel working in the hospitals. This has led to support for hospitals that cannot even ensure minimum care standards and thus has decreased subsidies available for well performing hospitals.

In addition to this, each year 10 % of state subsidies are being reduced which leads to an even greater financial deficit in the hospitals and increased pressure on both health care providers and patients.

After the International Monetary Fund mission in Sofia at the end September, Jerald Schiff the IMF mission leader for Bulgaria said that health care reform was falling way behind schedule. He said that one of the aims of the reform was to close down inefficient hospitals in order to increase subsidies available to the remaining hospitals but none of this has happened yet. He added that the state budget has allocated too little to health care in 2003.

Pirita Sorsa, Resident Representative of the IMF in Bulgaria confirmed that health care reform has virtually stopped and there are no indications that it will restart at the present time. The IMF mission in mid November again confirmed the impression expressed earlier in September.

2.4 Financing of the health care system

The experience of Central and Eastern European countries in the last 10 years shows that improving the financing of the health care system is a condition for the success of reforms.

The Ministry of Health has adopted a strategy for reform based on the principles of equity, cost-effectiveness and quality of care. The first step was made with the adoption of the Health Insurance Act in 1998 and the second with the Health Care Establishments Act, effective since 1999, which outlined real change in the health care system. The Health Insurance Act introduced compulsory and voluntary health care system as an alternative to central budgeting.

The health care system is financed through three main sources:

- State and municipal budgets.

State and municipal budgets cover free of charge emergency care; psychiatric care; blood transfusions; obligatory immunisations and obligatory treatment according to the Law for the national health; epidemiological and anti-epidemic studies and activities; health programmes and projects of national, regional and local importance; state sanitary control; investment spending; education, science and qualification; health care construction, basic repairs, modernisation, improvements and reconstruction, as well as equipment for over 10 thousand leva; health administration; national centres and institutes with no direct treatment activity; expensive treatment out of the range of the obligatory health insurance by an order determined by the Minister of Health; expenses related to the public health care; expertise of the permanent working incapacity and professional diseases.

- Compulsory and voluntary health insurance funds;
- Out-of-pocket payments.

Level and structure of health expenditures

Bulgaria's health expenditures as a percentage of the GDP have been among the lowest in Central and Eastern Europe during the transition period, and well below the average for Western European Countries. The share of GDP devoted to public expenditure in the health sector in Bulgaria has remained between 3.6 and 4 percent over the past 5 years (table 1).

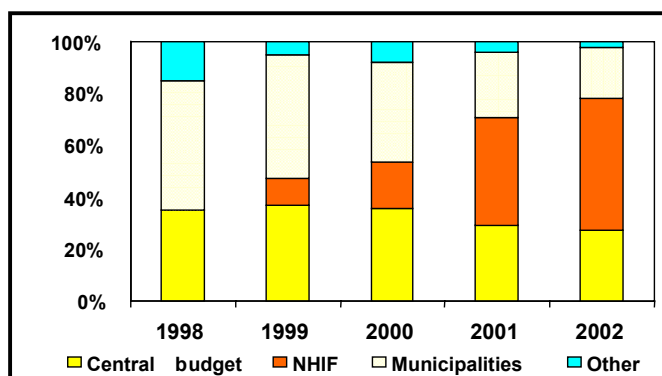
Table 1
Total health expenditures as % of GDP

Year	1998	1999	2000	2001	2002
% of GDP	3.6	3.6	3.5	4	4

Under the unreformed system, all public expenditure in the sector was allocated through the Ministry of Health and other ministries, either directly or via grant-financed activities of the municipalities. As a result of decentralization and the establishment of the NHIF the flow of funds changed. Figure 2 shows the institutional composition of health expenditure from 1998 through 2002.

Over this period, the share of health spending in the state budget remained approximately constant at around 33 to 40 %. However, the advent of the NHIF has been associated with a sharp reduction in the share of municipality spending: from about 50% in 1998 to 2000, to 15 % of all health care expenditure in 2001. As the NHIF has assumed more responsibility for expenditure, particularly in the hospital sector, its share has increased correspondingly each year. In 2001, about 551 million leva (nearly 275 million USD), or 46 % of the total, was channelled through the Ministry of Health, 428 million leva (214 million USD) through the NHIF (36%) and 183 million leva (91 million USD) through the municipalities (15%).

Figure 2 Institutional Composition of Health Expenditure



Source: Ministry of Health

2.5. Compulsory health insurance

Compulsory health care is a system for social protection that guarantees access to different kinds of medical care and use of medicines. The government has stated that access to health care is a "universal right for every Bulgarian citizen and a national priority".

The advantages of compulsory health insurance are that it:

- Guarantees a basic package of health care services for all citizens regardless of their income or social status;
- Establishes a new system for managing and controlling health care expenditure;
- Guarantees higher standards of medical care and adequate financing of health care providers.

The Health Insurance Act (Official Gazette, 1998) defines the beneficiaries of compulsory health care. These are:

- all Bulgarian citizens who are not also citizens of another country;
- Bulgarian citizens who are also citizens of another country but permanently live within the territory of the Republic of Bulgaria;
- Foreign citizens or persons without citizenship who have long-term residence permits for the territory of the Republic of Bulgaria, unless otherwise provided by any international agreement to which the Republic of Bulgaria is party ;
- Persons with refugee or humanitarian status or who have been granted the right of asylum.

The obligation to insure and the rights of the insured apply:

- To all Bulgarian citizens - from the enactment of the law and for the newly born - from the date of birth;
- To all other subjects - from the date of obtaining permit for permanent residence; from the date of starting procedures for granting refugee status or right of asylum respectively.

People who do not pay health insurance instalments have no right to the benefits of compulsory health insurance. The medical treatment undergone and consumed medicines have to be paid out of the patient's own pocket.

The compulsory health insurance system represented by the NHIF is funded primarily from payroll-based contributions made by working individuals, and general revenues, from which contributions are paid on behalf of the non-working population.

The compulsory health insurance contribution is 6% of a person's defined income. It is divided between the employer and employee in the ratio of 75 to 25 for 2002 and from 1 January 2007 will be 50:50. The contributions are mandatory, and are not related to the expected cost of care.

Contributions may only be paid by the insured, the state or municipal budget or the employer. Insured who have to pay for themselves are: sole entrepreneurs, individuals who have established limited liability companies; partners in trade companies; persons registered as freelance practitioners or craft industry; persons who work without legal terms of employment under contract with assignor; retired person who receive pensions under international agreements, entirely for the account of the foreign insurance institute; persons who are not insured by employer or state and municipal budget.

The problem with the latter is that they may be people who need social assistance but are not entitled to it. These people are usually from low-income groups or have no income and so

cannot afford to pay the instalments. Consequently they cannot benefit from the compulsory health insurance system, but also cannot afford to pay for private medical care.

According to some unofficial estimates nearly 1 million Bulgarian citizens do not pay compulsory health insurance instalments.

The high rates of social security contributions legislated in Bulgaria have led to the practice of employers officially paying employees the minimum wage whilst paying additional remuneration on the side. This situation, of course, further diminishes the ability of the NHIF and government to adequately support health care costs in Bulgaria.

The IMF Resident Representative in Bulgaria Piritta Sorsa in an interview published in the Bulgarian newspaper Capital claims that only 2.2 million workers pay social security contributions (including health insurance) and these support over 600 000 unemployed and 2.4 million pensioners.

According to the official statistics of the Ministry of Labour and Social Affairs in November 2002 the number of unemployed is 644 298.

State or municipal budgets pay for pensioners; persons receiving unemployment benefits; parents (or foster parents) or spouses who take care of the disabled with lost labour capacity over 90 percent, who permanently need help; persons and members of families with a right to social welfare and for underage orphans; conscripts; war veterans and the military disabled; those disabled during or on the occasion of the defence of the country, during natural calamities and accidents and for the affected in fulfilment of their official duty for employees of the Ministry of Interior; persons under proceedings for refugee status or right of asylum; the legally detained or imprisoned; persons without income, accommodated in homes for children and youth, homes for children of pre-school age and in social care; for persons studying in high schools, until reaching the age of 26; for children until reaching the age of 18.

The problem is that often municipalities do not transfer the funds for compulsory insurance and thus the NHIF must operate with fewer financial resources; this diminishes the NHIF's ability to adequately support health care costs.

Employers pay for persons working under official contracts of employment; for persons taking unpaid leave who are not subject to insurance on other grounds; for employees of the Bulgarian Orthodox Church and other religions acknowledged by normative order; persons receiving compensations for temporary labour incapacity due to illness, pregnancy, childbirth or raising of a child.

Again, there is a risk that the employer may delay or not transfer instalments due.

According to the Health Insurance Act, people whose instalments are not paid are not entitled to compulsory health insurance. In fact they receive health care because the NHIF, or the respective Regional Health Insurance Fund and health care providers lack an information system that would distinguish insured from non-insured people.

2.6. Methods of payment for compulsory health insurance

Each year the NHIF, together with the Bulgarian Medical and Dentists' Unions negotiate methods of payment to the health care establishments. These are:

- Cost-covering method – calculating expenditure for all medical services covered and assessing the minimum price per defined service.

- Budgeting method – setting a minimum of service to be paid for by the NHIF and calculating the maximum price per service.
- Negotiate final prices as an element of the National Framework Contract.

They vary according to the type of health care establishment.

Elements of payment for primary health care:

1. Per-capita monthly payments per insured person on the patient list of a general practitioner.
2. Payment for completion of a package of services for priority cases. It is also a per-capita payment combined with periodic balancing.
3. Monthly sum as a bonus for working in remote places and in difficult conditions.
4. Fee-for-visit.

Primary health care practitioners are subsidized only from the NHIF and private out-of-pocket payments and they do not receive any government subsidies. Their financing is only private when they do not hold contracts with the NHIF.

Elements of payment for specialized outpatient care:

1. Payment for initial visit with a payment for follow-up visits half of the fee for the first visit.
2. Payment for services that require expensive equipment or additional specialization.
3. Payment for expertise of permanent working incapacity and professional diseases.
5. Payment for diagnostic tests.
6. Fee-for-visit.

Dental care payment:

1. Fee-for-visit.
2. Payment for service.

The NHIF together with the Bulgarian Dentists' Union negotiates defined prices for a limited number of dental services.

Different levels of co-payment are set for adults and children as shown below:

Table 2: Copayments for dental care

Dental service	Percentage of negotiated price paid by NHIF for children	Percentage of negotiated price paid by NHIF for adults
Check-up	100%	50%
Filling	80%	30%
Extraction	70%	30%
Pulpitis treatment	50%	0%
Surgery	50%	30%
Complicated extraction	70%	30%
Check-up following complicated treatment	70%	30%

Inpatient care payment:

1. Payment for inpatient treatment is per case, and there are 485 diagnoses, grouped in 40 clinical pathways¹.

The criteria for choosing diagnoses paid by NHIF are the following:

- National health priorities – heart and lung disease, cancer, diabetes, obstetrics and child care;
- Diseases that require a high frequency of inpatient care.

2. Fee for per day hospital treatment.

2.7. Perceptions of the health insurance system

In 2001 USAID carried out research on the issue of health insurance system in Bulgaria. The major objective of this research was to collect reliable information on the advantages and disadvantages of the Bulgarian health insurance system.

The research showed that only three of all 46 participants interviewed were satisfied with the level of health services, which they had received. These participants provided examples of the perfect health services, which they had received absolutely free. They did, however, admit that these had been provided by doctors whom they had known for years.

The most significant criticisms expressed by participants were that:

- The mechanism for collecting health insurance contributions from employers (enterprises) did not work in practice.
- The existing health insurance system operates in the conditions of an underdeveloped private sector.
- Information about reform was insufficient.
- Different expectations regarding the NHIF and physicians led to great disappointment, as they could not be satisfied.

Participants believed that although health reform had been well planned its execution had been unsuccessful. The main reasons for this were:

- The moment to start reform had not been well chosen. Respondents believed that a more appropriate time for such reform would have been in 1990/1991 when the country had been economically more stable.
- People find it difficult to accept the idea of not having free health care. Placed under the conditions of health insurance they felt somehow abandoned by the state.
- The package of services offered by the NHIF was characterised as insignificant.
- Clumsy bureaucracy - in fact the service of a patient is accompanied by a huge amount of paperwork.

¹ A pathway is a set of procedures, including, for example, diagnosis, admission, acute care, surgery, and recovery deemed appropriate for a particular condition.

3. ACCESS TO HEALTH CARE

3.1. Regulatory framework

The legal base for access to health care is given in the Health Insurance Act and in the Ordinance for access of health insured persons to health care establishments for outpatient and inpatient care (Official Gazette, 1999).

The insured person is entitled to select a general practitioner and dentist only in health care establishments located in the health region where he or she currently lives.

If there is no opportunity in the health region where the person currently lives, the insured can select a general practitioner and dentist at the medical establishment located in the closest region to his residence.

The amendments to the Health Insurance Act stated that the choice of general practitioner and dentist should be valid in the whole country and could not be geographically and administratively limited.

However the new provision might challenge system in two ways:

1. It requires an integrated information system to be established in the NHIF and all regional health insurance funds. This has not been done so far and information concerning patients and performed medical activities cannot be provided.
2. Unlimited access to outpatient care might lead to a large number of patients being concentrated in health care establishments with highly qualified providers such as in large urban areas and Sofia. This would leave small and remote establishments without financial strength and would diminish their competitiveness.

General practitioners and dentists are the "gatekeepers" of the compulsory health system. They determine the necessity for specialised outpatient care by issuing referrals for medical consultation or joint treatment.

General practitioners, dentists and specialists in outpatient medical establishments direct insured persons as necessary to regional state or municipal hospitals or dispensaries or to medical establishments belonging to the Council of Ministers, the Ministry of Defence, the Ministry of the Interior, the Ministry of Justice and the Ministry of Transport and Communications.

If the population of the corresponding health area is serviced by a district hospital, the insured person is directed to that hospital.

A patient may be directed to a district, inter-regional or a national hospital when a regional medical establishment cannot provide the necessary treatment.

Compulsory health care requires that all outpatient and inpatient medical establishments that provide medical activities covered by compulsory insurance contract with the respective Regional Health Insurance Fund.

The amendments of the Ordinance for access of health insured persons to health care establishments for outpatient and inpatient care at the end of December 2002 provided access to all inpatient establishments on the territory of the administrative area where a person resides. Thus the patient has free access to his choice of district, inter-regional or national hospital if such hospitals are located on his or her administrative area and have contracts with

the respective regional health insurance fund. This provision created the possibility for private hospitals to be included in the compulsory health care system¹².

With the aim of guaranteeing access to health care the Ministry of Health prepared a National Health Map of the country, identifying areas with a less than adequate number of outpatient and inpatient health care establishments. It also specified the territorial coverage of healthcare establishments and the necessary number of specialists in accordance with the health needs of the population.

From 2000 to 2002 the regional health insurance funds had to contract with the minimum number of providers included in the National Health Map. Since 2003 following the amendments to the Health Insurance Act this requirement will be repealed and the number of contracts cannot be limited.

When looking at access to health care by social group and income level, access to health care appears to be limited by income, geography and ethnicity but access is not based on gender, religion, race or any other feature. According to the latest figures available from the World Bank, 12.8 % of the population lived below a poverty line of two thirds of defined per capita income per day in 2001 and poverty rates in Bulgaria remain at more than double the level of 1995. Poverty in 2001 appears very much concentrated among vulnerable groups such as large families with many children, the unemployed, ethnic minorities, people living in rural areas, and the poorly educated. Ethnic minorities are particularly vulnerable, as Romanies were found to be ten times poorer than others, and ethnic Turks four times poorer.

Access to health care system is not systematically restricted for minority groups. However, the utilisation of health care services by the Romanies is lower than for the general population. This is due to several factors. Firstly, the high unemployment rate and poverty among them contributes to a lower use of health care facilities as they cannot afford the out-of-pocket expenses associated with medical services. Secondly, they cannot afford transportation costs to go to facilities, which are far away.

Responsibility for health statistics is shared by the National Statistical Institute and the National Centre for Health Information. However, there is no information about access by income groups available from either institution, nor from any official statistical body. For the purposes of the compulsory health insurance system, income in different regions determines the amount of health insurance instalments paid by each citizen to the NHIF.

Regions with different income groups are shown in **Table 3**. Section 1 shows the lowest amount paid per citizen and section 4 the highest amount paid per citizen. It shows that higher amounts of health care instalments are derived from higher income.

¹ So far only state and municipal hospitals could contract with the regional health insurance funds.

Table 3:
Regions by income group according to the amount of health insurance instalments paid to the NHIF in 2001 per citizen

INCOME GROUP	AMOUNT OF THE HEALTH INSURANCE INSTALMENTS PER CITIZEN (IN LEVA)	REGIONS
1	from 46 to 55	Silistra Kardjali Pazardjik Razgrad Sliven
2	from 56 to 65	Targovishte Dobrich Smolian Montana Shumen Blagoevgrad Haskovo Vidin Jambol Pernik
3	from 66 to 75	Lovech Pleven Sofia-district Ruse Plovdiv Vraca Veliko Tarnovo Kjustendil
4	over 76	Varna Burgas Gabrovo Stara Zagora Sofia-capital

Regions with a higher income per capita are urban centres with a developed infrastructure, industry activity and with low unemployment rates. They are also where general practitioners and specialists prefer to live and the concentration of health care establishments (typically these would be establishments for outpatient care) is higher than in rural regions. Consequently higher income relates to a higher number of health care establishments, allowing better access to healthcare. In Bulgaria the age distribution of the urban-rural population also accentuates this disparity - by 1998 the elderly constituted 32 % of the rural population. Access is a particular problem in rural areas where poor transportation, high levels of poverty, and an ageing population deter the population from seeking health care.

3.2. Access to outpatient care

Access to **primary** care is not constrained and every Bulgarian citizen is free to choose a general practitioner/dentist within the health region where he/she resides and to change him or her once every six months if desired. However, the access sometimes can be limited by the financial ability to pay the co-payment.

Access to **specialised** outpatient care is limited due to the restricted financial resources provided by the NHIF. The experience of the last two years has proved that resources were insufficient and led to a reduction in the number of visits to specialists who were

financed by the NHIF. The Fund pays for a defined number of monthly visits to specialists and medical-diagnostic laboratories. Any examinations that exceed this number are put on a waiting list or are paid for by the patients themselves. The average waiting period is 15 days.

Whilst people with higher incomes can afford to pay for specialised outpatient treatment, this is not possible for patients from low income groups which represent a significant proportion of the population. Pensioners, pregnant women, children and patients with chronic illnesses need more specialised consultations and medical tests and quite often they have to wait or pay themselves to receive adequate medical treatment. The delays in providing the necessary specialised care result in the medical condition becoming worse which can require expensive hospital treatment later.

Recent unofficial evidence shows that there is a "black market" for referrals to specialised outpatient care. Referrals are sold by some general practitioners to patients who are willing to pay for them to avoid the waiting period and be able to visit the specialist privately.

Many patients complain that after the first visit to a specialist they have to visit him or her privately in the time for paid consultation and around 20 % of them have paid to visit a specialist whilst the service provided is paid for by the NHIF. For the last 12 years **dental** care has been mostly paid for out-of-pocket. This has led to declining preventive care and encourages the use of dental services only in cases of emergency, as the costs of dental care are significantly high.

Consequently with the introduction of compulsory health care the access to dental care was the most restricted service covered by the NHIF. From the beginning of 2000 till the end of 2001 the NHIF had only paid for a limited number of hours of dental care services. The time provided for the NHIF service was highly insufficient and a waiting list was formed with an average waiting period of 30 days.

Since April 2002 this system has been changed as the NHIF pays for a defined number of dental services and level of co-payment. The level of co-payment is shown in **Methods of payment for compulsory health insurance**. The number of services is so far very narrow and most people are forced to pay privately.

3.3 Access to hospital care

The financial problems of state and municipal hospitals mentioned previously are mostly felt by patients. Though a vast number of municipal hospitals are ineffective the local mayors still refuse to close them down. Many cases have been reported of patients who have already been treated in municipal hospitals having to go for further treatment in district, inter-district or university hospitals. Generally, the reasons for this are a lack of specialists, proper medical equipment and financing. Quite often small municipal hospitals take patients whom they cannot treat properly and this result in worsening health for the patients and leads to an overall rise in health care expenditure.

The financial instability of hospitals impacts very negatively on the standards and quality of medical care, which they are supposed to provide.

Many hospitals require that patients should bring their own bed sheets and pyjamas, pay for medicines and consumables (surgical gloves, alcohol, syringes etc) themselves and in all cases should bring money to cover other additional expenses.

All hospital must keep a defined number of blood transfusion units, but as this is financially impossible, patients are forced to pay for blood transfusions themselves or to bring relatives who will donate blood for them.

The lack of blood transfusion units is due not only to insufficient financial resources but also to a decreasing number of blood donors. In mid November 2002 the National Blood Centre officially claimed that significant difficulties were experienced in collecting the necessary blood for all scheduled operations. Only 20 % Bulgarians are willing to donate blood compare to 50 % in the Western European countries.

Before being operated on all patients must present a document from the National Blood Centre confirming that two person has already donated blood for him or her. A cardiovascular operation for children requires four donors. Patients who do not reside in Sofia have to bring their donors with them.

Managers of some of the biggest hospitals have stated that some scheduled operations have been postponed and even cancelled because of the lack of blood.

Having known this problem some people, mainly from minority groups are offering to sell blood to the relatives of the patients.

As a matter of fact one of the authors of this report evidenced the blood donation problem at first hand.

The problem with blood transfusion is even more serious in emergency operations that often require immediate transfusion necessary to save patient's life.

As a result of the financial crisis some hospitals have even refused to take emergency cases. A case of a young man who died of heart attack was reported in the biggest cardiology hospital "St. Ekaterina" in Sofia. The hospital refused to take him and later that day he died. The financial director of the hospital claimed that they did not have the medicines to treat him. More patients who required emergency treatment were also sent back that same day but fortunately without fatal consequences.

Patients from different districts in Bulgaria say that they have to pay for "quality treatment" and for "good attitude from the health personnel". Some of them have complained officially to the Ministry of Health and the managing boards of the hospitals. However, the Ministry of Health has declared that 11,000 official complaints are received annually but only a third are dealt with satisfactorily.

Cases were reported that in hospitals patients were charged for undergone treatment and drugs although they were fully covered by the NHIF. Many people admit that for financial reasons they would refuse hospital treatment even though this could damage their health further. Clearly, health care is a significant expense for households and one whose burden is most keenly felt by the poor. Both patients and health personnel support the fact that access to appropriate health care (compulsory, voluntary, or private) is mainly restricted to the more affluent.

An example is the private access to hospital "Lozenetz" (which belongs to the Bulgarian Council of Ministers) where a consultation with a specialist costs 18 leva (nearly 9 USD) and a single day's hospital treatment 26 leva (nearly 13 USD).

3.4 Fee-for-visit

As a comparison to the private visits a visit to general practitioner, dentist or specialist from the compulsory health system, cost the patient 1 leva for each visit, and 2 leva for per day for hospital treatment, but for no more than 10 days per year. These fees are defined in the Health Insurance Act. Since 2003 this fees were rise to 1.10 leva and 2.20 respectively.

The compulsory health care system exempts some patient groups from paying fee-for-service when visiting a health care provider. These are: children under the age of 16; the unemployed members of the family; conscripts; war veterans, war invalids and persons who have been disabled in defending the country or by being involved in its defence in some other way; persons under arrest or in prison; persons who do not earn any income and are residents in institutions for children and teenagers, institutions for pre-school children and social welfare institutions; pregnant women.

Patients suffering from tuberculoses, cardiovascular disease, diseases of the respiratory system, diseases of the nervous system, disabled people who needs attendance, people with malignant formations are also exempt from paying fees for visits. Although the above mentioned groups should not officially pay this fee they are made to pay it by a large number of practitioners. This is a serious violation of the patient's rights but is difficult to prove, as people do not make official complain and a receipt is not normally issued.

Another popular violation is non-issuance of a receipt by the practitioner when the fee is paid in order to avoid taxes.

The purpose for the fee-for-visit is to maintain providers' practices, buy medical equipment and consumables (syringes, surgical gloves, etc.) as well as to restrict unnecessary visits to general practitioners and specialists.

In fact this fee is a barrier for all pensioners and people on social assistance. The minimum social pension in Bulgaria is 47 leva (23 USD) and the fee is a financial burden for pensioners who visit health care providers more often than any other group (for drug prescribing, consultations with a specialist, diagnostic examinations).

Since the current minimum wage of 100 leva (50 USD) per month is below the "subsistence minimum" level of income, even provider co-payment reduces the resources available for food and other basic living expenses.

Theoretically the law provides equal access to health care but practice has proved to be the opposite.

3.5. Access to drugs

People's access to drugs faces some specific restrictions resulting from the limited budget of the NHIF for drugs. Despite these restrictions some groups such as chronically ill people, the elderly, children under the age of 18, and pregnant women that require higher usage of drugs have relatively good access to drugs.

The restrictions are the following:

1. Patients must be suffering from a disease on the list of diseases for which drug treatment is reimbursable.
2. Only a specialist for particular diseases can prescribe certain drugs.
3. Drugs for diseases such as MS, chronic hepatitis, and arthritis are granted reimbursement only when a special committee in the NHIF has approved them. These drugs, however, are fully reimbursed.

Reimbursement normally is granted in the form of a fixed amount and the co-payment charge is made on the difference from the reference price.

As a rule no patient group is exempt from co-payment.

As the health care system is a system for social protection some patient groups are granted 100 % reimbursement for all drugs (like children under 18 years of age, pregnant women, people in financial need and in difficult economic circumstances) and are exempt from making a co-payment.

However, all patient groups are fully exempt from co-payment for the cost of insulin.

In January 2002 the government introduced Value Added Tax and this led to an increase the prices of all drugs and to the co-payment charge being raised. This naturally hit vulnerable groups such as pensioners (about 2.5million), the unemployed (nearly 17 % of the population) and people who live below the poverty line hard. A VAT of 20 % on drugs means that the purchasing power for drugs is diminished by 17 %.

A survey made by the NHIF for the period 24 June - 1 July 2002 of 1065 people, found that 23 % of the interviewees used drugs for which the NHIF pays, but 18 % says that all drugs are expensive, and 33 % said that the prices of drugs should be decreased. The results of the survey supported the fact that increasing prices has a highly negative effect on consumers. Another survey made by the "Open Society" foundation confirmed that the high prices of drugs are a problem and showed that it is valid for 8 out of 10 Bulgarian citizens.

In order to guarantee better access to drugs, the NHIF through its regional funds contracts with pharmacies to dispense medicines for the reimbursement system. The number of contracts (1870) often causes the NHIF and regional funds significant difficulties in their administration and control. The number of pharmacies is higher in bigger towns and often insignificant in small and remote locations. Thus the elderly and chronically ill that are very likely to reside there need to make long and expensive monthly trip to the nearest pharmacy. As a result of this some people do not take the prescribed medicines or pay themselves.

The Law on drugs and pharmacies provides that in the less populated areas a pharmacy can be managed solely by an assistant-pharmacist, but only allows such pharmacies to dispense medicines on OTC products not on prescription. Such pharmacies cannot contract with the regional health insurance funds as all medicines reimbursed by the NHIF are provided on prescription. Again this restricts the access to drugs for people in small and remote places.

3.6. Access to health care outside compulsory health insurance

The access to health care other than compulsory health insurance is based on Ordinance N 22 for payment for health services of a patient's choice (Official Gazette, 1997). There are no legal, administrative or geographical restrictions to access when patients go for private medical treatment, and they can choose any health care establishment that operates in Bulgaria.

Outpatient and inpatient health care establishments are free to determine the prices of all the treatments they offer and the state does not control or regulate them as the health care market itself controls prices.

In case of complications in treatment, patients are not charged additional amounts. Prices charged in Sofia are not significantly different from those in smaller locations. In practice not many people can afford private treatment due to poor living standards in Bulgaria, and the high percentage of people living with low incomes.

4. OPERATION OF THE PRIVATE HEALTH CARE SYSTEM

4.1 Out-of-pocket payments

Private health care in Bulgaria was introduced in 1991 through amendments to the Peoples Health Act (first published in Official Gazette in 1973). These amendments gave rights to all practitioners and dentists to have private practices. In 1999 the Bulgarian Parliament passed the Health Care Establishments Act which defined the current situation in the country, and so is the new base for private health care facilities as well as all other medical establishments.

In 1997 the Bulgarian government introduced legal co-payment for medical services, and for outpatient and inpatient care without a referral from the family doctor (Ordinance N 22 for paying for health services of patient's choice - Official Gazette, 1997). In 1998 The Health Insurance Act came into force, thus making this ordinance only applicable in the private sector. According to the ordinance, inpatient or outpatient health care facilities must issue invoices with 3 and 4 copies respectively. If this is not done under-the-table payment has taken place. The legal co-payment in the public sector was introduced with the Health Insurance Act (see sections 3.4 Fee-for-visit and 3.5 Access to drugs).

Some unofficial estimation suggest that in 2000 the share of out-of-pocket payments from all health care expenditures is 30% for outpatient care, 50 % for medicines and 50 % for inpatient care. The WHO (Selected health indicators for Bulgaria) estimated that in 2000 private expenditure on health was 22.4 % of total expenditure on health and includes mainly out-of-pocket spending.

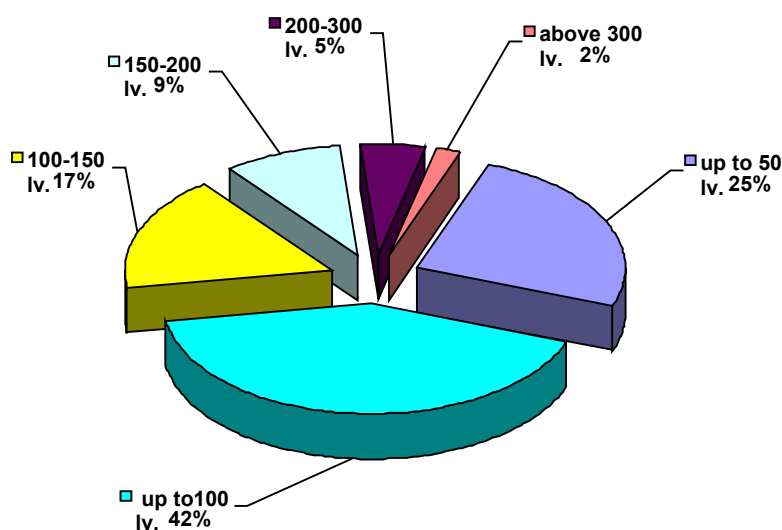
Although this figures are not officially confirmed and cannot be statistically reliable they represent a certain trend on the Bulgarian health care system.

In a survey conducted in 2001 by USAID/Barents Consulting Group KPMG - "Bulgarian health project", private out-of-pocket payments were around 430 million leva (215 million USD). They included fees for private visits, instalments for private contracts with health care providers, instalments for voluntary health care, payments for medical insurance and unofficial payments. Unofficial payments are widespread primarily in inpatient care. However these payments have not been studied with methods that which would guarantee the trustworthiness of the data.

The same survey carried out in 2002 by USAID shows that every one in ten Bulgarian pays an average of 197 leva (nearly 100 USD) under-the table for 17 days hospital treatment. It also appears that informal payments represent a significant proportion of household income as 12 % of the interviewees claimed that they were forced to make this payments in order to obtain medical treatment even though this is fully covered by compulsory or state health care. There is no reliable evidence that any effective measures have been taken to stop this practice.

The 2002 survey also shows that people from different income groups (shown in Figure 3) spend different amounts on health care. 66 % of the population earns the minimum wage, which is 100 leva (50 USD), or less and spend 33 leva (16 USD) per month. But people with income of 500 leva (250 USD) or more spend 89 leva (45 USD) on average. These amounts do not include compulsory health care instalments. The survey concludes that poorer people spend proportionally more on health care than the more affluent.

Figure 3
Income groups in Bulgaria (per member of family)

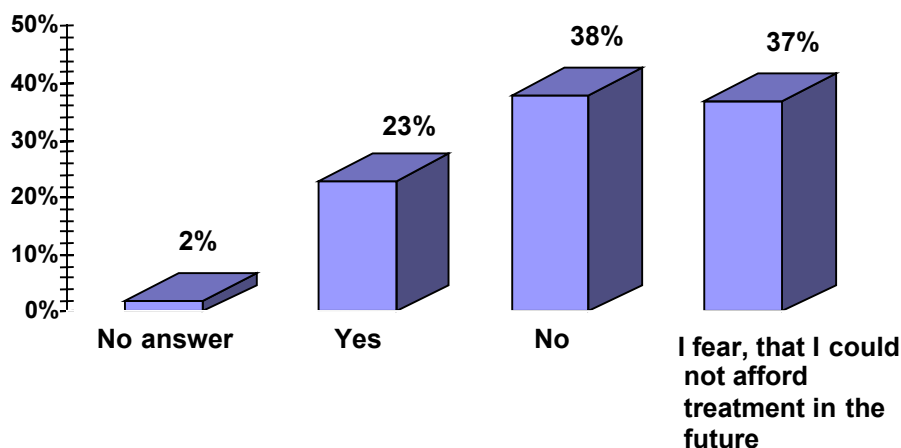


Source: (USAID, 2002)

Another survey (Figure 4) for the period May - June 2002 found that 38 % of Bulgarians could not afford to pay for required medical treatment, including drugs. The survey was conducted by "Alfa Research" and commissioned by the "Open Society" Foundation.

Figure 4.

Do you have money for medicines and medical treatment?



Source (Open Society Foundation, 2002)

4.2 Voluntary health insurance

Another aspect of the private health care system is voluntary health insurance. Under the Health Insurance Act 1998, voluntary health insurance provides extra insurance for any individual. Beyond the package covered by the NHIF all citizens are free to buy different insurance packages on the market at their own expense. Private insurance can also cover the cost of services covered by the NHIF. Voluntary health insurance funds are allowed to own medical establishments themselves.

So far in Bulgaria the Ministry of Health has only licensed two voluntary health insurance funds - "Doverie" and "Zakrila". Voluntary health insurance fund "Zakrila" officially insures 18 000 people.

The latter has already opened a modern medical centre that can only be used by its subscribers, but is planned to deliver medical services to NHIF patients as well.

Medical establishments that provide services covered by voluntary health care can be either private or state (municipal) and can be any type of medical establishments including individually owned practices.

To compensate employees for increased cost of health care some big companies are paying voluntary insurance for them. As a rule these are financially sound companies such as Siemens Bulgaria, the nuclear plant in Kozludui, and the big mining companies, for example. As a rule voluntary health insurance companies require higher insurance premiums for children, elderly people and people with chronic diseases for these groups will need more medical treatment than healthy individuals. As they are the most vulnerable groups in Bulgaria they practically cannot afford to pay for voluntary health care. For example "Zakrila" offers insurance premium for people of age above 55 is 100 leva (50 USD) whilst for people age of 18-54 varies from 26 to 78 leva, for children below age of 1 is 48 leva (24 USD) and for children age of 1-18 the premium is 20 leva (10 USD).

According to the head managers of the existing funds between 5% and 10 % people can afford to take voluntary health insurance. The "Open Society Foundation" survey showed that the real number of voluntary insured people is less than 3 %.

So far voluntary health insurance is only taken by high-income groups and some private and public companies.

The survey on perceptions, inclinations and expectations regarding Bulgarian health insurance system and voluntary health insurance funds conducted by USAID (2001) showed that the following disappointments have been placed on the voluntary health insurance system:

- *Country's fluctuating economic state.* The general level of the population comparatively low incomes restricted their personal and company's investment in health. Struggling for survival, it is difficult for people to make decisions and invest even when it concerned their own health and life. The level of unemployment is rising and the number of people engaged in the shadow economy is high, many people work with no contracts. This creates a feeling of economic uncertainty and social inadequacy.
- *The general economic climate had an unfavourable influence on the development of the small and medium-sized businesses.* In fact, only some of the employers from the powerful and financially stable enterprises welcomed the idea of additional responsibility for their employees' health.
- *Lack of effective supervision of the funds.* People believe that there is risk in investing money in a structure, which may later redirect and use the funds for a different purpose. The trade unions warn that the way to win the major employers' confidence is through trade union headquarters. They would not however assume responsibility for unstable funds, as they might get into a situation which is analogous to voluntary pension insurance /the trade unions backed certain funds which did not justify the people's confidence and their discontent was partially directed to trade unions.

- *Corruption among the medical staff.* There is a risk that physicians and health professionals who have become used to corruption in health care practices will introduce them in the new system. Whatever their remuneration would be they will expect patients to pay additionally. This is one of the great disadvantages of the present system, which generates negative attitudes.

Despite the existence of some typical conditions in Bulgaria which act as restrictive factors regarding the introduction and development of voluntary health insurance, many people think that the disadvantages of compulsory health insurance and the negative attitudes to it could be used to develop a strategy and win the confidence of the population by turning the idea of voluntary health insurance into a part of Bulgarian people's insurance culture.

- Being terribly disappointed in the mechanisms of formation and functioning of compulsory health insurance, people are looking for a new alternative. They see voluntary health insurance funds as specific structures which will contribute to the quality improvement and the timely provision of services.
- People are beginning to realise that health care services are an expensive social sphere, which requires solid financial resources. Furthermore, in the present they have to pay under the table to get expedient health care in the state institutions or look directly for the services of private practices. They are aware of the need of additional structures, which operate independently from the NHIF and accumulate additional funds and organise a system for quality services.

4.3. Other types of private health care

Apart from voluntary health care and individual access to private health care some employers conclude contracts directly with private medical establishments for the benefit of their employees and families. These contracts provide regular prophylactic check-ups, early detection of diseases, and medical treatment when needed.

5.COST OF DRUGS

5.1 Pricing

The Ministry of Health is responsible for the pricing of medicines, including medicines for hospital use, generics and OTC products. It is defined in the Regulation of Prices of Drugs (Official Gazette, 2000) and applies to reimbursed and non-reimbursed pharmaceuticals.

The Ministry of Health deals directly with pharmaceutical companies or their representatives in Bulgaria. The Minister of Health officially publishes registered prices for medicines in the Official Gazette.

The reimbursed price of medicines offered to the HIF cannot exceed this registered price. It is a trend that the pharmaceutical companies often offer higher prices to be registered on the Bulgarian market than in other countries, although there is no specific reason for this. According to a WHO study on Trends in Consumer Prices (WHO, 2001) Central and Eastern European Countries did not appear to have lower consumer prices for medicines than the European Union countries. In a sample of 25 medicines 9 in Bulgaria had the highest consumer prices then another countries.

5.2 Reimbursement

Under article 55, paragraph 2.7 of the Health Insurance Act, the National Framework Contract contains the reimbursement list of drugs covered by the NHIF. The drugs that are subject to reimbursement are negotiated with the pharmaceutical companies, pharmaceutical wholesalers and pharmacies.

According to the Law on Drugs and Pharmacies (2000) the reimbursement list is approved and monitored by a Transparency Committee attached to the Council of Ministers. This Committee approves the criteria for contracting the reimbursed drugs as well as the methodology defining the level of reimbursement.

The NHIF draws up a list of diseases, for which drug treatment is reimbursable. When preparing this list the principles accepted in the EU and recommendations made by the World Health Organisation are taken into account. The list includes diseases with high social impact and those defined as a national health priority.

After this list has been agreed the list of reimbursable drugs is then prepared.

The reimbursement list is implemented by the NHIF. The drug is reimbursable if it:

- has marketing authorisation from the Bulgarian Drug Agency;
- is for treatment of a disease defined on the list of diseases;
- is provided on prescription;
- does not contain more than two active substances.

Medicines used only in hospitals are not included in the reimbursement system.

When preparing the reimbursement list, the NHIF does not define brand names but International Non-proprietary Names. Thus patient and generic products can be included without giving any priority to local or foreign medicines.

The reimbursement list provides three levels of reimbursement:

- 100 % reimbursement for drugs that are for illnesses priority of the National Health Strategy (drugs for severe and chronic illnesses).
- 75 % reimbursement for drugs with documented efficacy of therapeutic relevance for illnesses that are not included in the National Health Strategy, but have social impact as defined by the Ministry of health.
- 50 % for all other drugs.

The levels of the reimbursement system are set according to three major factors - the NHIF limited budget for drugs; levelling the drug prices on the European markets; rapid rise in costs for drugs that could not be compensated with the slow income increase of the population. Reimbursement only takes place when a general practitioner (or specialist) prescribes a drug and it is supplied to the patient by a pharmacy which has contracted with the respective regional insurance fund. Expenditures for reimbursement are set in the Law for the Budget of the NHIF for each year.

5.3 Reference price

The purpose of the reimbursement system in Bulgaria is to protect individuals who need large amount of medicines from the high costs of these medicines. Thus individuals with a temporary need for treatment pay a larger proportion of the cost than individuals with chronic diseases who need to use medicines over the long term. Reimbursement is therefore crucial for drugs used in the treatment of chronic or persistent diseases. Generally, reimbursement is related to patient category and to disease. A reference price system was introduced in January 2002, whereby the reimbursement price for a whole group of generics is based on the cost of the cheapest drug in the group.

5.4 Contracting

A specific feature of the Bulgarian reimbursement system is contracting with the pharmaceutical manufacturers and importers, the wholesale distributors and pharmacies. Each year the NHIF concludes framework agreements with the pharmaceutical manufacturers and importers that fulfil the criteria set by the Fund. The main task in the process of contracting is to negotiate lower prices than the registered price published in the Official Gazette. This is not always possible in the first instance, but can sometimes be achieved at a later stage.

After the framework agreements with the pharmaceutical manufacturers and importers have been signed, the NHIF concludes framework agreements with wholesale distributors.

The final step is signing contracts with the pharmacies that will sell all the products, which are eligible for reimbursement.

5.5 Rise in costs of drugs.

After close observation there is concern about the high proportion of health budget which is spent on drugs. Such expenditure, in times of economic constraint, limits the funds available for improving primary health care and for ensuring adequate health care for the whole population.

The Law for the Budget of the National Health Insurance Fund for 2002 provides 131 million leva (approximately 65 million USD) for reimbursement of drug costs which represents 27 % of all health care expenditure. As a comparison in more Western countries this is below 30 % as well.

A negative effect on drug expenditure was caused by the introduction of Value Added Tax (VAT) in January 2002, when a 20 % rate was imposed on all drugs that have marketing authorisation. The budget for drug costs could not compensate nearly for 42 million leva (around 21 million USD) in additional cost arising from VAT.

Analysing the prices on the pharmaceutical market after January 2002 Ministry of Health estimated that the rise in costs is between 12-20 % compared to 2001.

Applying VAT to medicines is common in all countries in Western and Eastern Europe, but in some the rate is lower than in Bulgaria. For example in Italy is 10 %, in Slovenia is 9 % (when the standard rate is 19 %), in Finland is 8 % (with standard rate of 22 %), in Portugal is 17 %. Imposing VAT affected all drug costs on the Bulgarian pharmaceutical market, including OTC products regardless of their consumption either through reimbursement or private health care system.

5.6 Control of drug expenditure.

Rising drug expenditure is due to several reasons and in particular:

- Demographic - patterns of drug prescribing show that half or more of the total drug consumption is by people aged 60 years and over. The proportion of this age group in 2001 is very high at nearly 30 % and is growing (Bulgarian National Statistical Institute)
- Use of new medicines in the same therapeutic category. Compared to the Essential drug list recommended by the World Health Organisation towards countries with developing and transition economies, the Bulgarian list of reimbursable drugs includes new expensive drugs that are omitted in the reimbursement systems of the developed countries or are covered mainly by the voluntary health care. These are medicines for curable diseases.
- New expensive drugs for incurable diseases like multiple sclerosis, hepatitis, and glaucoma, for example, which were not treated before.
- Imposition of the 20 % rate of VAT on drugs. The government gets this 20 % back but the income is not used for expenditure on health care.
- Over-prescription of drugs by the providers due to ineffective control of prescribing practices.

Responding to the higher expenditures in drugs the NHIF took steps to stay within budget limits.

Regular check-ups were initiated on all pharmacies that dispense medicines for the reimbursement system. In Sofia 47 pharmacies were checked and in 36 of them some sorts of violations were registered. The most common are the following:

When prescribed drugs are dispensed by the pharmacy on the prescription an additional expensive reimbursable drug is added by the pharmacy itself with or without patient's knowledge. Usually this additional drug is not actually given to the patient but is charged to the National Health Insurance Fund or the relevant Regional Health Insurance Fund.

Some practitioners or specialists perpetrate similar violations when prescribing particularly expensive drugs without the patient's knowledge and which are not actually given to him or her. Again, the prescribed drug is charged to the Fund. Moreover, in some cases the drug is charged to two Regional Health Insurance Funds.

Unfortunately and due to lack of information system a payment has been made in all the cases mentioned above.

Other violations that could be mentioned as significant are the prescribing of drugs to dead people; over-prescribing; prescribing by a general practitioner instead of by a specialist when this is necessary; post-dating the prescription, and prescribing inappropriate drugs, such as anti-pregnancy pills for men, for example.

Also other major types of violation are reported to be widespread in both Sofia and other regions. A significant number of pharmacies earn higher margins than those negotiated with

the NHIF and thus charge higher prices to the patients. They also practise the re-sale of drugs already charged to the NHIF previously but not actually given to the patient. Another violation is the charging different Regional Health Insurance Funds and receiving double payment.

This behaviour of some pharmacies and practitioners has caused considerable financial loss to the Fund.

All Regional Health Insurance Funds control the execution of the contracts concluded with the pharmacies, general practitioners, specialists and hospitals. As a result fines have been imposed and contracts ended, depending on the degree of violation.

As a measure to cut the expenditure on drugs the NHIF took a step to curb the fraudulent re-sale of drugs. It launched a drug sticker scheme aiming at curbing the re-sale of drugs and their prescription to non-existing patients. The new trading regime would involve pharmacies and wholesalers. The stickers will be provided by the wholesalers and attached to the bulk orders from the pharmacies. When the pharmacies sell the drug, part of the sticker would be removed and attached to the prescription. The rest remains on the packaging while the marked prescription would be accounted by the Fund.

A second step taken by the NHIF to control the spending on drugs is to analyse specific data such as:

- Expenses for drugs in all pharmaco-therapycal groups;
- Expenses for drugs in each pharmaco-therapycal group;
- Average expenses for each diagnosis of the list of diseases and for each patient;
- Number of patients and expenses for drugs for each disease.

It is too early to have any meaningfully statistical data but it is hoped that it soon will be possible to detect the anomalies in the prescription and dispensing medicines.

5.7 Bulgarian pharmaceutical market.

The Bulgarian pharmaceutical market is experiencing legal changes from January 2003 that will have a significant impact on both the reimbursement system and the free market itself.

Bulgarian pharmaceutical companies face a new problem after the introduction of VAT on drugs and the considerable sums they have to invest to meet the Good Manufacturing Practice (GMP) standards as defined by the EU and the WHO. The problem is data exclusivity and is part of EU Directive 2001/83/EC of the Community code relating to medicinal products for human use. The Directive envisages that the information on the results of pre-clinical and clinical trials of a drug cannot be used by companies other than the owner of the drug without the owner's express permission. This information becomes generally available to the public six years after the registration of a drug. This regulation is a second line of defence of intellectual property rights in the pharmaceutical industry, after patents. Bulgarian manufacturing plants which produce mainly generic drugs (that is drugs, whose patents have already expired) will only be able to register the production of such drugs after a delay of several years as a result of this requirement and will lose market share in Bulgaria 2003.

The new regulations regarding intellectual property are part of the harmonisation of the Bulgarian legislation with that of the EU, and which were initially planned to come into force on December 31, 2005, but was unexpectedly brought forward to January 2003 to speed up accession towards the EU.

Bulgaria was originally supposed to adopt this legislation within five years of the signing of the association agreement with the EU (which took place in 1993).

As this has not yet been done, Bulgaria has to introduce the new regulations as soon as possible.

The implementation of the new regulations will take the process of registration of new generic drugs in Bulgaria to two years.

Currently registration takes nearly three years. This process is quite lengthy even without the new regulations. Speed is crucial in the launching of generic drugs as the life cycle of a generic drug last two to three years after the expiry of the drug patent. The profit margin of the locally produced medicines will remain high during this period as there is no competition for at least two years and this will translate into higher-priced products in the local market to compensate the cost of meeting GMP. The Bulgarian pharmaceutical producers could be cushioned from these regulations by the possible adoption of the Bolar provision (Pre-Patient Expiry Development and Registration Work for Generic Medicines). This rule gives the right to a drug maker to file for registration of a drug's before its patent has expired, in order to start manufacturing the drug immediately on expiry of the patent. This provision has been recently accepted in France, and has been implemented in the United States, Japan, Hungary, Croatia, and Canada.

Bulgarian drug makers proposed to the government that the local pharmaceutical industry could be helped if the NHIF would increase the share of Bulgarian drugs in its purchases. This can be done by including only Bulgarian drugs in the list of products, for which patients will be reimbursed, so that no foreign drugs will be bought by the fund if there are locally produced equivalents. However, this contradicts EU regulations which exact transparency in the drafting of lists of drugs that are subject to reimbursement, as well as WTO rules, as this will be an indirect barrier to imports, and so was unacceptable to the Bulgarian government.

6. FINANCIAL ISSUES OF THE HEALTH CARE PROVIDERS

The authors of the report met a small number of general practitioners, specialists and hospital managers in order to obtain information about the financial issues they face under the new system. However the names of the providers will be kept in strict confidence.

6.1 General practitioners

Under the old system most healthcare was delivered through polyclinics and hospitals where the medical staff there worked under a labour contract with a monthly salary of 200 leva (100 USD). With the introduction of the concept of the General Practitioner and new methods of payment, the salary under the labour contract was transformed into a remuneration based on capitation; defined type of medical activities; plus a single lump-sum payment of 300 leva (150 USD) and an additional 100 leva per month if working in remote areas¹, and fee-for-visit. As the general practitioners are fully funded by the NHIF the average income 1,800 leva (900 USD) per month. If practitioners have more patients or patients with certain chronic diseases or which are priority cases their income increases as they are paid more for this. This income does not include the fee-for-visit from the patients and any private payments. However practitioners did not declare the amount of fee-for-visit and any private payments they received.

General practitioners admit that they are considerably better off than in the past, but they are struggling to invest in modern equipment and new premises². Lots of practitioners rent assets in the former polyclinics, which were transformed into commercial companies owned by municipalities. The rent is quite often low (it rarely exceeds 100 leva) and is a not a financial burden.

Even accounting for the on-going cost of running a GP practice, compared to the average annual income of a polyclinic physician before 1999 of about 2.400 leva (1.200 USD), it is far more rewarding to be a doctor now than in the past.

General practitioners claim that they work harder than before, now spending "half their time filling in forms". However this is a duty they need to follow strictly in order to receive their payments.

Practitioners are largely dependent upon the NHIF for survival as failure to obtain a contract equates to certain financial ruin for most providers.

6.2 Specialists

Specialists, like general practitioners, are also permitted to charge a fee-for-visit, but in contrast to them, they are paid on a per visit basis, receiving 8 leva (4 USD) for an initial visit, and 4 leva (2 USD) for each subsequent visit. The ratio between an initial and secondary visit is 1:1 as the number of secondary visits should be the same as the number of initial visits. Further visits associated with same illness or any visits that are not referred by a general practitioner (or in some cases another specialist) are not reimbursed by the NHIF. In

¹ This represents approximately 15 % premium on monthly income earned in less remote areas (not accounting for income from private sources, which may be significant in urban areas).

² Under a World Bank "Health Sector Reform Project" significant efforts are focused towards development of primary care via the re-equipping outpatient facilities in rural areas and these in remote places. Under the same project 4000 personal computes will be distributed among nearly all practitioners (there are 5279 registered practitioners).

the latter case the specialist is permitted to charge a fee which is negotiated directly with the patient.

Specialists complain that general practitioners have monthly limits for referrals for specialised medical consultation or joint treatment. The limit can be increased depending on the structure of morbidity, age groups of the patients and the number of people with chronic illnesses. However the increased number of referrals does not significantly change payments to specialists, as patients are not constrained geographically.

The way specialists are paid depends on whether they work in an individual practice, group practice or medical-diagnostic centres/medical centre.

Those working *individually* are paid directly according to the number of referrals accounted to the regional health insurance fund. They are allowed to earn income from private visits as well.

The *group practice* of specialised medical care is organised as a commercial company under the Commercial Law. Payment is made to the company and then distributed to all specialists as negotiated between them. They are also allowed to earn income from private visits¹.

Specialists working in *diagnostic-consultation /medical centres* are normally working there under labour contracts. These centres are organised as commercial companies and payment is made directly to the company and not to the specialist. The managers of the diagnostic-consultation/medical centres are given discretion to pay the specialists additional amounts. The NHIF requires that manager pays no less than 30 % of revenue realised under the NHIF contract and fee-for-visit based on the personal contribution of the specialist who provided directly specialised medical care. Although managers declare they do this, specialists report that they are not paid and the money is used for covering administrative costs and salaries of the managing board and even not investing in modern equipment

One specialist said that the manager stopped him living in the diagnostic-consultation centre where he was working and to establish his own practice for specialised medical care. He claimed he would earn more money if he worked on his own and had more private patients than those covered by the NHIF.

Practically managers of the former polyclinics established the diagnostic-consultation centres. Specialists from outpatient care think that those working in hospitals are wealthier as they still receive significant percentage under-the-table payments.

All specialists think that prices paid under the compulsory health insurance are quite low and these are not real prices but are invented administratively by the NHIF². As one specialist said "if Bulgarians can afford to pay European prices for petrol they can afford such prices for medical care".

6.3 Hospital care

Hospitals are managed by a Board of Directors, which collectively signs a management contract with the Ministry of Health. This board, acting through an executive director, can choose the size and the structure of the hospital's labour force, and has the right to hire and

¹ However it is not clear how private payments are distributed among the specialists.

² Prices are subject to negotiation with the Bulgarian Medical Union, which represents the medical profession in Bulgaria.

fire, and receives guidelines from the Ministry of Health regarding such items as wages and employment.

Hospitals have greater incentives to assess investment needs more carefully than they did previously, primarily because such investments can either reduce costs (heating, water) and thereby free up resources for quality improvement and thus improves their competitiveness. On the financial level, hospital managers appear to be the most critical of all health care providers. As they are still mainly financed by the state and municipal budgets and only around 10 % by the NHIF they are more sensitive to the overall financial problems in the health system.

Managers complain about severe under-funding from the state and define as "insignificant" the payments received from the NHIF. If they are to respond to the new environment and attract patients the money allocated for hospitals must be doubled.. One manager said that was difficult to be a doctor "whilst thinking how to pay the hospital's bills".

Like all commercial companies state and municipal hospitals make profits and have the possibility of retaining the tax on profit they owe to the state on condition that it is reinvested in their main activity (purchase of medical equipment, consumables, etc.)¹.

Since January 2003 this possibility does not exist as equal treatment for state and municipal health care establishments must be provided.

Moreover, state and municipal health care establishments have not used this provision as they have not made any profits in the last few years.

In 2001 , 24 out of 46 state hospitals claimed losses amounting to 7 million leva (3,5 million USD). The same applies to municipal hospitals. Managers claim that each year hospitals are running out of money well before the end of the year because of poor financing. They state that prices paid by the NHIF for working on clinical pathways are not realistic as they not represent the real cost for hospitals.

The NHIF requires medical staff that have labour contracts with hospitals are entitled to additional compensation of 40 % of the revenues from clinical pathways. However hospital management do not follow this requirement explaining that these revenues are used for covering the debts of the hospital.

In 2001 the NHIF only contracted with state and municipal hospitals to give them more financial flexibility. Since 2002 it has also been possible to contract with private hospitals. One of the first private hospitals that was opened up in 1991 was "Higij" in the town of Pazardik. Both patients and medical providers think that the hospital performs to European standards and offers food delivery from restaurants, and has a hairdresser. At the beginning of 2003 the hospital concluded a contract with NHIF covering 24 clinical pathways.

The owner of the hospital thinks that differences between private and state and municipal hospitals are sizeable. As the NHIF does not fully cover the cost of clinical pathways a private hospital must pay the difference itself whilst state and municipal hospitals will pay from their own budgets. He says that private hospitals can rely on three factors to gain financial strength:

- Good medical conditions and modern equipment;
- Qualified specialists and personnel and quality assurance;

¹ This provision was legalised in the Law for the corporate income levying (1997).

- Good management, including price negotiation with patients, and delivery of consumables and medicines;

He adds that private sector cannot afford ineffective management of financial and other recourses.

In case of the "Higij" hospital patients pay the same prices as in the state/municipal hospitals but the quality of treatment and overall conditions are better.

Whatever their ownership all hospitals may gain income from private payments. They have the discretion to charge patients market prices. Some state/municipal hospitals offer newly equipped and comfortable rooms for the price of 20-30 leva (10-15 USD) per a day for hospital treatment. This is an additional source of revenue but it underlines the need for capital investment.

At the moment data on the revenues of hospitals cannot be divided by source, so the balance between public and private income is not clear. Some hospitals organise private payments as donations and thus avoid taxation. The inability of hospitals to retain tax on income will stimulate the understatement of revenue.

7. CONCLUSION

Bulgaria has embarked on a fundamental transformation of its health care system in hope of improving its relatively poor health status indicators and using the available resources more effectively.

The starting point of the reform was the establishing of the National Health Insurance Fund, which undertakes both risk pooling and medical care purchasing functions on the behalf of the population and represent the compulsory health insurance system.

The compulsory health insurance system is funded primarily from payroll-based contributions made by working individuals, and general revenues, from which contributions are paid on behalf of the non-working population.

Health care contributions are obligatory for all beneficiaries of compulsory health care and the system largely depend on the regular payment of these contributions. If they are not paid on regular basis or not at all this diminishes the ability of the NHIF to adequately support health care costs in Bulgaria.

Another problem arises when people do not pay health insurance contributions and thus they cannot benefit from the compulsory health system and should pay for medical private care. These people are usually from low-income groups, including minorities, people who need social assistance but are not entitled to it or people that have no income at all. People whom the state or municipal budget pays health care contributions are generally protected from the risk to pay the full cost of health care, but still make significant payments due to the co-payment for some services and most drugs and some under-the-table payments.

The difficulties setting up modern and working health system is also the lack of information system between the NHIF, regional health insurance funds and health care providers. One of the advantages of this system would be distinguishing insured from non-insured people. As this is not possible at the moment this leads to receiving health care services from people who are not entitled to it.

The efficiency and stability of the health system needs to be strengthened through a set of measures to improve access to health services by the poor and possibly reduce both the premium rate and the level of co-payment for "working poor".

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