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Administrating and Financing the Health Care System in Bulgaria (1990-2005)

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Abstract

This paper provides an overview of the administration and the financing of the health care system in Bulgaria, starting with the model under communism, and continuing with the transition period.

Keywords: Healthcare system, Administration, Financing, Bulgaria

1. Introduction

Well-functional health care system is a necessity in any contemporary society. Bulgaria, a country in transition, launched a series of structural reforms in its health care sector almost three decades ago. The goals of the reforms are to deliver to the people adequate and modern health care services and to design a viable mechanism through which the health care system can be financed. This paper describes the main directions of development in administrating and financing the Bulgarian health care system in recent years. It also provides analysis of the major issues endangering the smooth operation of the reforming health care system.

2. Administrating the Health Care System in Bulgaria

Through the years following the coming of the communist party in Bulgaria to power, the Soviet "Semashko" health care model was implemented. Existing private hospitals were nationalized and brought under the state control. The existing health insurance system was abolished and the government became the sole funder of health care services. Family doctors network was replaced by polyclinics, which in many cases were integrated with the hospitals. Primary health care was organized within a district and patients were allocated to polyclinic doctors according to their address.

Although the health care system had the intentions to provide equal health care to all citizens, this was not possible because of lack of resources. Soon a differential health care provisional system began to take shape that looked quite different from the initial egalitarian "Semashko" system. This differentiation started as numerous factory polyclinics, which served the workers in a particular factory or industrial conglomerate, were established. Another direction in which this "growing parallelism" (Mihalyi, 2004) took place was the establishment of sector hospitals and polyclinics serving the Ministries of Defense, Internal Affairs, and Transport. A third direction of the differentiation occurred with the transferring of the medical schools under the rule of the Ministry of Health. Well-equipped medical schools' hospitals were established which were meant to treat complicated cases of direct importance to the development of medical science but in fact they also treated groups of patients who could ensure their access to those hospitals by either their social status or through illegal payments. This growing parallelism in the supply of health services inevitably led to greater variance of the quality of health care within the system. As years passed this variation created a mechanism of illegal payments which could ensure the provision of health care of higher quality to the bribers. These two characteristics were in sharp contrast with the initial "Semashko" model of equity in health care and free access to it. Besides, the overlapping layers of the health system were in direct controversy with the main of idea of centrally delivered health care.

As the economic situation in Bulgaria worsened, the funds needed to finance the health care system were largely unavailable and demand exceeded the supply for services by great proportions. In such environment the informal payments by patients which were already a common practice led to constant crises in the delivering process of health

services. This inefficiency initiated the health care system reforms in the early 1990s. There were three directions in which the initial reforms took place: first, laws were passed to allow private health services; second, medical associations were established; and third, responsibility for many health care services was devoted to the municipalities. However, the reforms that shaped the current system of health care were largely developed by the end of the 1990s. They included the introduction of a system of social health insurance, development of primary health care based on a model of general practice, and optimization of the health care delivering mechanism.

The new organizational structure of the health care system is summarized in Figure 1.

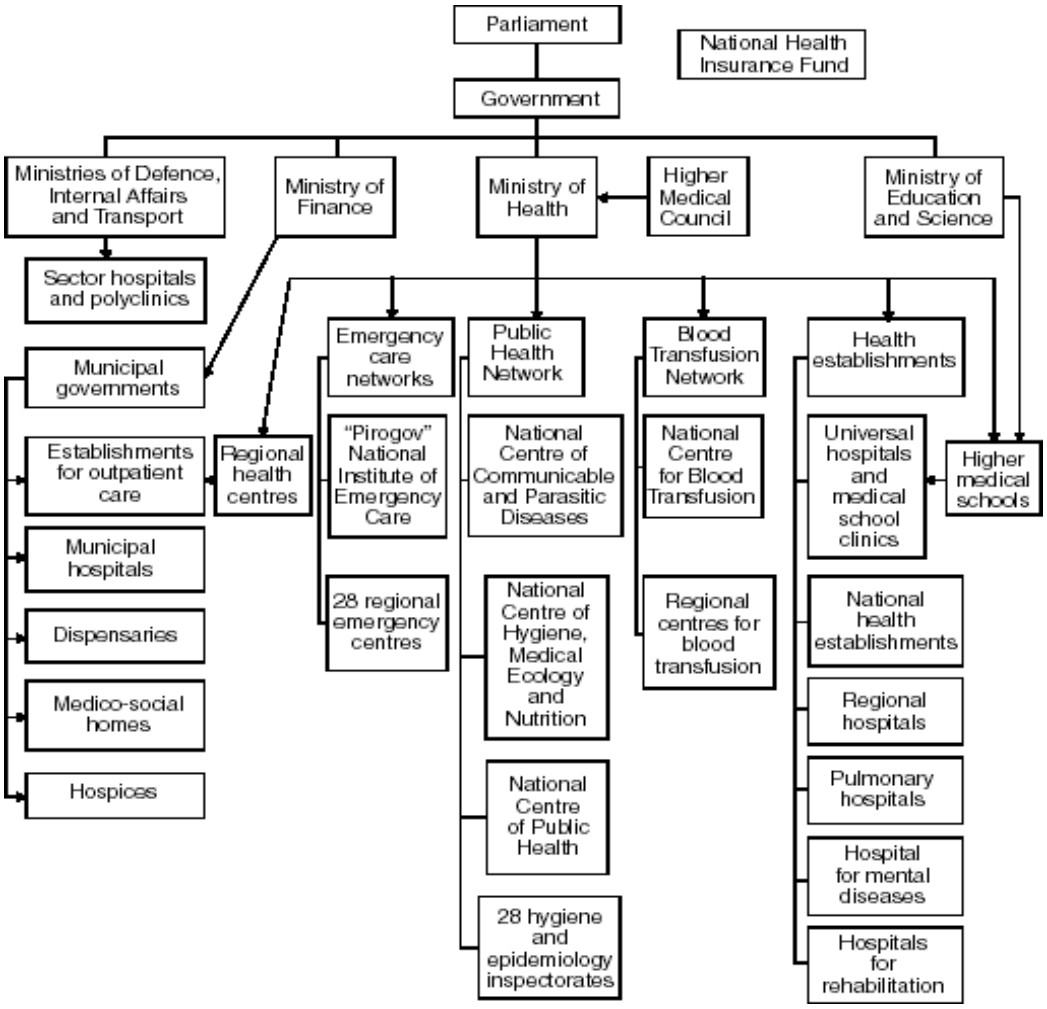

Figure 1. Organizational Structure of the health care system

Source: Ministry of Health of the Republic of Bulgaria.

The main changes in the administrative structure of the health care system were related to the mechanisms of financing and decision making of health care policies. Two new bodies were established, and in addition to that local governments assumed some responsibility in the health care system:

- **Higher Medical Council -** This consultative body, chaired by the Minister of Health, has 24 members. Eight of the members are representatives of ministries (five from the Ministry of Health and one from each of the Ministries of Transport, Defense and Internal Affairs); eight from the doctors' and dentists' associations; and eight from the medical universities. The Council meets at least four times a year and acts as a consultative body concerning health policy, the hospital network, medical education and postgraduate medical training. The Council is also responsible for registration of private health care facilities for ambulatory and hospital care. The Council determines the main priorities of national health policy and medical aspects of demographic problems in the country. It provides opinions about draft laws and the legislative regulations of the Ministry of Health and advises on financial and investment policy, medical technologies'implementation and human resources planning and qualifications.

- **National Health Insurance Fund (NHIF)** – This new body is an autonomous institution for compulsory health insurance that was established in accordance with Bulgarian legislation. The Health Insurance Law adopted by the Bulgarian parliament in 1998 introduced a health insurance system, with only one health insurance agency and mandatory health insurance payments deducted from personal income. Parliament decides the size of health insurance payments and each year determines the budget of the National Health Insurance Fund. The NHIF is the biggest purchaser of health care services, signing contracts with providers. The main function of the NHIF is the management of financial resources for medical care of the population, with a view to the eventual total coverage of needs and guarantee of accessible, affordable and high- quality health care. Through its regional bodies, the Regional Health Insurance Funds (RHIFs), the NHIF finances the entire health care network for outpatient care, and since 1 July 2001 began to participate in the financing of those hospitals that have signed a contract with the Fund.

- **Municipalities** - Municipal Councils and mayors are elected under the 1991 Local Self-Government Law. The ownership of many health care facilities has been transferred to municipalities. Partial responsibility for financing was transferred to the municipalities in 1991, and ownership of most facilities devolved in 1992. Health care facilities were recognized as legally constituted entities under amendments to the Health Law in 1997. At present the municipalities own a large number of diagnostic and consultative centers, municipal hospitals for acute care, some specialized hospitals and outpatient clinics, all of which predominantly serve the needs of the respective municipality. In addition, municipalities are responsible for specialized paediatric and gynaecological hospitals and for specialized regional dispensaries (for pulmonary diseases, oncology, dermato-venereology, psychiatry and sports medicine).

The reform in the health care system on administrative level, although well intentioned, had a huge drawback. The two new institutions were placed in the system that governs the health care sector with almost no adjustments in the already involved administrative bodies. This potentially may lead to blurred responsibilities in the decision making process when new policies are discussed, and to an inadequate financial framework for the health care system.

As seen from Figure 1, the overlapping layers system, which is a legacy of the communist times, still exists. Apart from the inefficient resources allocation, which is a direct consequence of the parallelism, this overlapping layers system leads to further variation of the quality of the health care services. This fact, coupled with the initial rationing implemented by the family doctors could potentially lead to further severe decline in the health of the nation as a whole.

The organizational structure of the new health care system has one more feature not depicted in *Figure 1*. Privatization is the ultimate model of decentralization and rejection of the central planning. With privatization, the out- patient health care facilities, which are property of the municipalities, may be sold or rented to general practitioners. However, up to now privatization has not achieved significant results. At the same time, hospitals' privatization is still in initial phase. In 2002 only around 6% of the total number of hospitals were private.

3. Financing Health Care System in Bulgaria

Initially, the reform of the health care system in Bulgaria tried to shift the financial responsibility from the central government and to share it with the municipalities. Until 2000 the health care system was financed by general taxation from the republican and the municipal budgets. In addition, the health care financing included a private, out-of-the pocket component, a significant portion of which is assumed to be illegal under-the-table payments.

In this sense the real reform in the financing of the health care system started in1999 when social insurance contributions (split between the employer and the employee) were introduced. These contributions were collected by the newly established National Health Insurance Fund (NHIF). The idea behind the health insurance system was to be implemented following the Bismarckian model of healthcare. However, as stated by the legislation NHIF is the only health insurance agency which is responsible for the provision of mandatory health insurance. These two facts seriously undermine the Bismarckian intentions behind the health insurance system and potentially lead to poor financing of the system close in structural form to the previous centralized system. In 2000 the NHIF covered only 13% of all public health care expenditures. The intention of the financing mechanism is to shift smoothly the financial burden from the republican and the municipal budgets to the NHIF as the Fund has the available resources accumulated. The current mechanism of financing is depicted in Figure 2.

The health insurance contribution was at 6% of income as the employer and the employee share the contribution in proportion 5:1. The contribution of the employer is planned to decrease over the years and finally should be set down to a proportion of 1:1 in 2007.

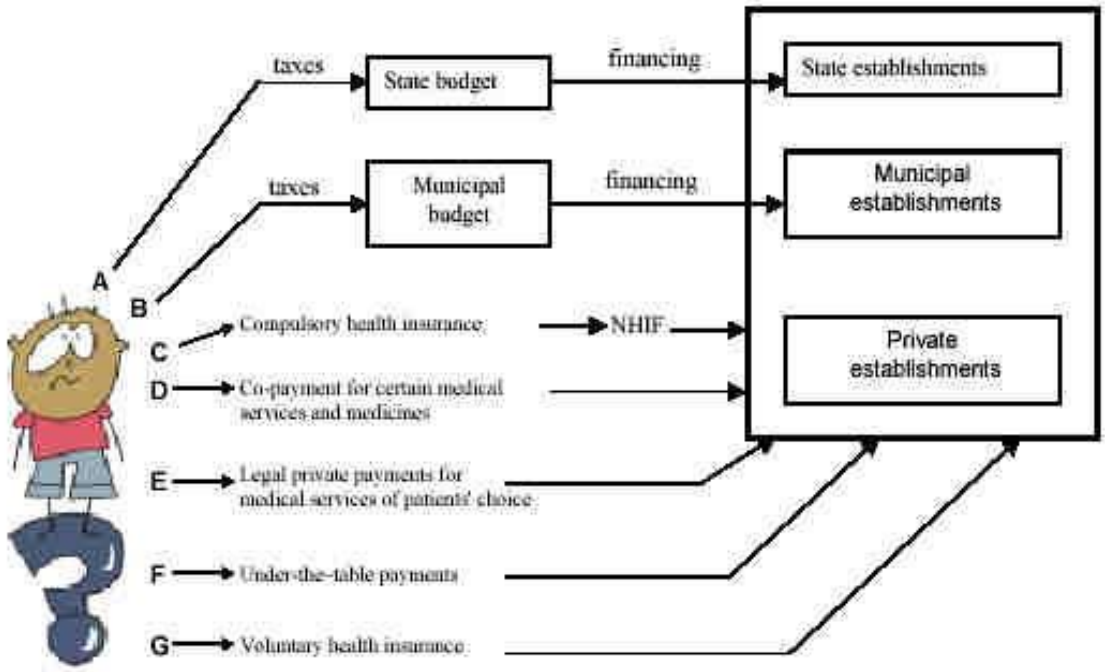

Figure 2. Current financing mechanism of the health care system in Bulgaria[1]

[1] The flow *"State Budget"* includes expenses for health care from the budgets of Ministry of Health,

Source: Datsova, B. (2003): Health Care Reform and Inequality Access to Health Care in Bulgaria, UNRISD Paper.

In the period 2001-2003 the relative share of the total health care expenses covered by NHIF has risen from 36% in 2001 to 41% in 2002 and 46% in 2003. For the last two years there is steady increase by 5% of the expenses covered by NHIF, however, the total relative share covered by the insurance scheme is still less than the contribution of the state and the municipal budgets. From this point of view the initial plan to extend coverage of all services by social health insurance seems unfeasible. NHIF specialists argue that contribution rate of 6% is insufficient to cover health care expenditure. They estimate that the necessary health insurance contribution should be at least 12% in order to cover the majority of the expenses. However, having in mind the difficult economic situation in Bulgaria such a contribution fee is impossible to be implemented and the Bulgarian Parliament does not have any intention to increase the fee in near future.

Table 1. Expenses for health care for the period 2000- 2003 (thousands of leva)

CONSOLIDATED STATE BUDEGET	2000	2001	2002	2003
TOTAL EXPESES FOR HEALTH CARE	980 063	1 195 976	1 438 884	1 697 681
% of total expenses for health care to GDP	3.7%	4.0%	4.5%	4.8%
NATIONAL HEALTH INSURANCE FUND	126 832	428 182	585 084	775 039
% of total expenses for health care of NHIF to total expenses for health care	13%	36%	41%	46%
MUNICIPALITIES	416 217	183 772	209 664	218 802
MINISTRY OF HEALTH	291 936	493 432	572 585	598 426
OTHER MINISTRIES AND AGENCIES	125 622	74 845	70 042	103 793
CENTRAL REPUBLICAN BUDGET	19 456	15 745	1 469	1 621

Source: Ministry of Finance of the Republic of Bulgaria.

Another important massage extracted from *Table 1* is the fact that health care expenditure on health care in Bulgaria is less than in most of the other countries in the European region. For example, the expenditure in 2002 in Hungary was 7.8%, Czech Republic – 7.1%, Estonia – 5.1%, Germany – 10.9%, and the average expenditure for the whole European region was 6.53% (WHO). This fact comes to say that the general financial framework of health care expenditure in Bulgaria is quite tight. There is growing evidence that Bulgarian hospitals are severely under-funded which results in general decline in the level of in-patient health care.

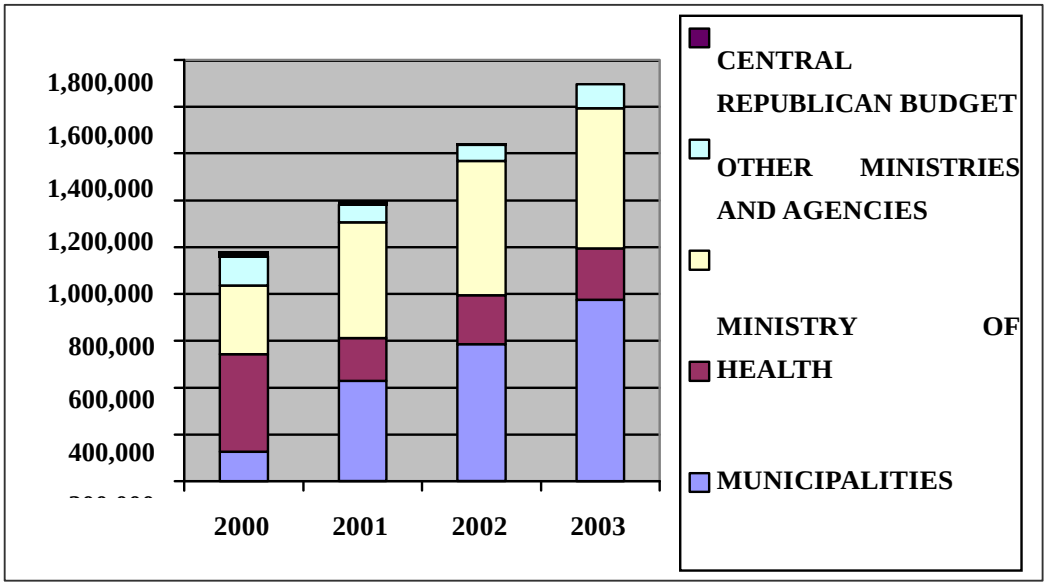

Figure 3. Structure of the expenses for health care (thousands of leva)

Experts point out that the reason for the under-funding stems from the fact there are too many hospitals left from the communist period. After the start of the transition instead of shutting down the ineffective hospitals, they were refused further investments, which resulted in old buildings, and medical appliances, which were not properly maintained. On the other, the effective hospitals also suffered financially as they had to share the burden of the ineffective ones.

NHIF currently covers all the out-patient health care expenditures, part of the pharmaceuticals for out-patient health care, and 20% of the in-patient health care expenditures. *Table 2* and *Figure 3* depict the budget breakdown per item for the total expenditure of NHIF.

Table 2. Budget of the National Health Insurance Fund for 2000 – 2003(thousands leva)

Years	2000		2001		2002		2003	
		%		%		%		%
Primary out-patient care	32862385	33.7	86148219	21.3	97301069	17.2	103443746	13.7
Secondary out-patient care	11806570	12.1	57406919	14.2	72635598	12.9	82859415	11.0
Dental Care	13623171	14.0	38389025	9.5	24651051	4.4	45589696	6.0
Medical Diagnostic Activities	5053484	5.2	29098727	7.2	37914104	6.7	39277404	5.2
Pharmaceuticals	34137193	35.0	182280007	45.1	239017824	42.3	270832403	35.9
In-patient Care	0	0.0	10781132	2.7	93275555	16.5	213023498	28.2
Total	97482803	100	404104029	100	564795201	100	755026162	100

Source: Bulgarian National Health Insurance Fund.

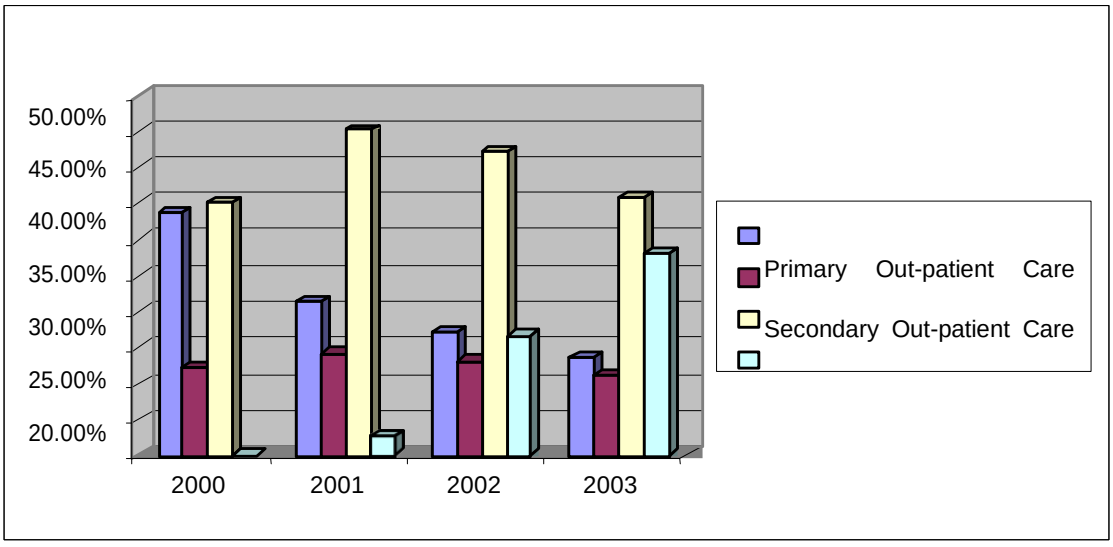

Figure 3. NHIF Budget by Structural elements

The most serious short-run challenge faced by NHIF and the health care sector in Bulgaria is how to overcome the crisis in the in-patient health care financing. A natural solution of the problem is shutting down the inefficient hospitals or trying to privatize them, if possible. The fact that NHIF cannot contribute significantly to the expenses of the in-patient health care points out that the insurance mechanism in this form does not work. Insurance system in its core promises adequate insurance sum paid to the insured upon the occurrence of certain events. It is not the case, however, when one looks at the Bulgarian system of health care insurance. Creation of variety of insurance funds can bring competition to the market and thus, real insurance schemes may emerge.

Another deficiency of the health care insurance system stems from the fact patients cannot opt out. The mandatory nature of the current system does not allow patients with higher income to seek higher quality medical help. Recent surveys (Delcheva 1999) show that around of 54% the respondents have paid illegal under-the table payment for in-patient services which are covered by the basic package of health care provided to the insured. These payments are widespread way of accessing higher quality service. Although the state legislation introduced a scheme of co-sharing this problem is far from being settled.

4. Conclusion

The transformation of the health care system in Bulgaria started almost a decade ago and still continues. This has proven to be a painful process for the consumers of health care since the chaotic nature of the health care system does not allow efficient supply of services. This inefficiency can be coped with further restructuring of the health care system in administrative and financial sense.

A major improvement in the administrative system of health care delivery is the removal of the overlapping layers of institutions. In first place, the institutions maintained by the different ministries should be transformed into private health care units, or alternatively shut down.

When it comes to financing the health care system in Bulgaria, the efficiency enhancing mechanisms include the creation of more health insurance funds and giving the possibility of opting out to the insured. These two measures can assure strong competition on the health insurance market (thus improvements in the insuring mechanism, and), and natural differentiation between the insured which can remove the illegal under-the-table payments.

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