



ESPN Thematic Report: Inequalities in Access to Healthcare

Bulgaria

2018

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May 2018



EUROPEAN COMMISSION

Directorate-General for Employment, Social Affairs and Inclusion

Directorate C — Social Affairs

Unit C.2 — Modernisation of social protection systems

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European Social Policy Network (ESPN)

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Summary/Highlights

The current Bulgarian healthcare model is a decentralised and pluralistic system of compulsory health insurance. The National Health Insurance Fund (NHIF) is the single public purchaser of services from healthcare providers under the mandatory health care insurance. The NHIF acts as a single agency providing basic financial flows for health service funding to insured persons. The contribution rates for health insurance funds for the ordinary professions in 2017 were 8% (split into 4.8% paid by the employer and 3.2% paid by the employed person¹). The health insurance contribution of self-insured persons is entirely at their own expense and also amounted to 8% in 2017². There are also private insurers playing a marginal role in the system, offering coverage for additional medications and treatments that are not part of the health insurance package of the NHIF. Informal payments exist in the Bulgarian healthcare system. They are not always easy to distinguish from formal co-payments. There are a large number of people without healthcare insurance.

By international comparison, Bulgaria has no shortages of medical staff, but emigration of medical doctors and nurses and the high average age of those remaining in post pose a strategic challenge.

Hospital funding generates a chronic deficit that persists despite numerous attempts to curb it. Bulgaria uses so-called clinical pathways to fund hospitals. Among the disadvantages of this method that adversely affect access are the fact that it does not take into account the severity of cases with the same diagnosis, does not allow treatment of multiple diagnoses at the same time and in addition does not include quality criteria. For many years there was an imbalance in the funding of different pathways, a few being overfunded while many others were underfunded. This creates a disincentive for hospitals to admit cases in some clinical pathways and an adverse incentive to overuse some clinical pathways. Underfunding of clinical pathways is one of the drivers of hospital deficits. In 2015 a cost analysis was initiated which is expected to result in a rebalancing of reimbursement prices.

The biggest challenge in terms of access in Bulgarian healthcare is the presence of up to 1.7 million persons without health insurance. Poverty and lack of access to the formal labour market are the main barriers to health insurance. Estimates of the real number of persons without health insurance who actually live in Bulgaria vary due to large-scale migration to other EU Member States. Around 900,000 seems the best estimate provided by the Ministry of Health, which represents 13% of the total population. Persons without health insurance only have access to emergency healthcare in life-threatening situations. The poorest of them also have access to a special fund which, however, has very restrictive access, a low budget and bureaucratic reimbursement procedures making its use unattractive for medical staff in hospitals and outpatient care.

Access to healthcare for mothers without health insurance continues to be a challenge. They have access to a limited number of checks by a gynaecologist, which are insufficient, and a limited number of medical tests.

Roma are among those most affected by all of the factors reducing access to healthcare. In particular, many Roma do not have health insurance because of their difficulty in gaining access to the labour market and because of widespread poverty.

Access to healthcare for the rural population is more difficult. This is due to a set of factors. Healthcare continues to be unevenly distributed in geographic terms despite the introduction of a 'national health map'. Small municipal hospitals very often run up deficits and many of them have been closed. In contrast, in larger cities, due to the lack of restrictions in contracting new medical care providers over many years, a significant oversupply has emerged. The national health map can serve as a mechanism for

¹ Ministry of Finance. National Revenue Agency. Budget Act of the National Health Insurance Fund for 2016 (Art. 2 LBNHIF). <http://www.nap.bg/page?id=473>.

² Ministry of Finance. National Revenue Agency 2017. <http://www.nap.bg/page?id=591>.

restricting contracts with new healthcare providers, but cannot correct the imbalances that already exist.

Bulgaria is among the EU Member States with a relatively large gap in self-reported unmet need for medical examination as between the bottom and the top quintiles (6.5 times). Overall, the rate of self-reported unmet need for healthcare (both for medical and dental examination) looks lower than might be expected, based on the high out-of-pocket costs and the large number of persons without health insurance. But both self-perceived health status and demand for healthcare could depend on the social status and ethnicity of the individual.

1 Description of the functioning of the country's healthcare system for access

The National Health Insurance Fund (NHIF) is the single public purchaser of services from healthcare providers under the mandatory health care insurance. The NHIF acts as a single agency, providing basic financial flows for health service funding to insured persons. The contribution rates for health insurance funds for the ordinary professions in 2016 were 8% (split into 4.8% paid by the employer and 3.2% paid by the employed person³). Retired persons receiving pensions from the state pension system or from professional pension funds, as well as children and persons receiving unemployment benefits, are insured by the state⁴. Insured persons have the right to choose among healthcare providers and get free medical services within a specified package which is quite broad but has important limitations. There are also private insurers playing a marginal role in the system, offering coverage for additional medications and treatments that are not part of the health insurance package of the NHIF. Informal payments exist in the Bulgarian healthcare system. For the patient they are not always easy to distinguish from formal co-payments. Out-of-pocket payments taking the form of gratuities and bribes are often not registered in the system of national healthcare accounts.

The basic medical package, guaranteed by the budget of the NHIF, contains health activities, services and goods including early disease detection disease prevention procedures performed by physicians and dentists; non-hospital and hospital medical care; rehabilitative care; urgent medical care; maternity care; nursing care at home; prescription and dispensation of medicinal drugs. Psychiatric assistance and dental care procedures included in the package are quite limited⁵.

In Bulgaria, the gap in access to healthcare is between those who have regular employment and work in the formal economy and those who work in the informal economy. There are a large number of people without healthcare insurance⁶, estimated at about 900,000 persons by the Ministry of Health. Statements made by high-ranking officials in the Ministry of Finance have suggested an even higher number, of as many as 2 million persons⁷. A report published in 2017 by the WHO estimated that in 2011 1.7 million people (including unemployed people) did not have access to publicly financed health coverage (WHO, 2017). The difference derives from the fact that it is not known precisely how many of the non-insured have emigrated and use healthcare services in other countries. There is no reliable information on the composition of the non-insured beyond that based on triangulation with other sources of information and old sample surveys. The conclusion can be reached that about 500,000 persons do not have health insurance because they cannot afford to pay for it. Among the Roma population, the percentage of those who are non-insured is much higher. According to data from a survey carried out by the UNDP, the World Bank and the European Union Agency for Fundamental Rights in 2011, 45% of Roma had health insurance, compared with 87% of the non-Roma who lived in close proximity⁸. A survey conducted by the

³ Ministry of Finance. National Revenue Agency. Budget Act of the National Health Insurance Fund for 2016 (Art. 2 LBNHIF). <http://www.nap.bg/page?id=473>.

⁴ The categories of insured persons are defined in Section 5, Art. 40 of the Health Insurance Act.

⁵ Health Insurance Act, Section 6; Ordinance № 2 of 25 March 2016 defines the basic package of health activities guaranteed by the budget of the NHIF.

⁶ Data on people without health insurance provided by different institutions are controversial. The differences come mainly from the inclusion/exclusion of different groups of Bulgarians residing abroad. The figure of 900,000 quoted by the Ministry of Health seems a good estimate of the persons without health insurance who have their permanent residence in Bulgaria.

⁷ Statement of the minister of finance quoted by the media, available at: http://www.standartnews.com/balgariya-zdraveopazvane/nad_2_miliona_sa_zdravno_neosigureni-225304.html.

⁸ FRA and UNDP, *The situation of Roma in 11 EU Member States. Survey Results at a glance*, European Union Agency for Fundamental Rights and UNDP, 2012.

Bulgarian government in 2013 showed that 68.1% of Roma remained outside the social security system. Roma living in rural areas have very limited access to regular healthcare and either have to wait a long time to see a doctor or travel longer distances. In general there are significant difficulties in healthcare provision for people living in rural areas of Bulgaria⁹.

Overall compared with most EU Member States Bulgaria has a higher number of general practitioners and specialists. In 2015 the number of specialist medical practitioners per 100,000 inhabitants was 342 – one of the highest in the EU. The number of generalist medical practitioners per 100,000 was 63 – the 8th lowest in the EU. These figures show that Bulgaria has not faced a direct shortage of physicians at national level. In the case of nurses the situation is different – there is already an acute shortage. In 2015 Bulgaria had 485 nurses per 100,000 inhabitants – the second lowest among the EU countries for which data are available. This is equivalent to one nurse per 206 inhabitants – a number which is quite low in comparison with countries at the level of development of Bulgaria. An analysis by the World Bank also concluded that Bulgaria has many physicians and health workers by international comparison but that 'age structure, migration, specialisation, and distribution create major HR challenges'¹⁰. The Bulgarian Medical Association (BMA) keeps a register of physicians containing information related to age: this information is not publicly available but the BMA often makes statements and presentations referring to it. In October 2017 the Deputy Chairperson of the BMA said that according to their register 60% of physicians were aged 55 or more¹¹.

The most recent available national data published by the National Statistical Institute show that the population per one physician in 2017 was 234 and the population per one dentist 844. A breakdown by urban and rural settlement is not available: but even if it were it would not very informative, as there are many villages situated close to big towns and cities where distance is not an obstacle to access, and many small and some mid-sized towns which may have a problem with the availability of medical services. At the level of the six NUTS-II regions, disparities are visible which are correlated to some extent with the level of urbanisation and the density of population. The north-central region has fewest physicians – 307 persons per physician. At the level of the 28 districts, Razgrad, Targovishte and Dobrich in north-central and north-eastern Bulgaria have a much lower number of physicians, as well as some districts in south-eastern Bulgaria. Most of those districts have a larger-than-average Turkish population. In rural areas, the population density is half the average for the whole country (35.8 vs. 69.9 inhabitants per km²). The overall population of Bulgaria is declining but the rate of population decline in rural areas is considerably higher. Furthermore, the poverty rate is significantly higher in rural areas and the GDP per capita is less than half or even less than a third according to some estimates¹² that of urban regions. A major problem in rural areas is the high level of long-term unemployment, which again adds to the number of people who are not able to pay for medical care¹³.

Additionally, in rural areas there exists an unmet need for medical care due to distance. Most of the healthcare facilities are situated in urban areas. Travel distances and availability of doctors has a huge impact on accessibility.

⁹ Glaser, H., Kastenholz, A. and Spies, A., 'Inequalities in access to healthcare in Bulgaria'. II Term thesis. Internal publication. Department Social Medicine, FPH, MU-Sofia. 2018; 15pp.

¹⁰ Couffinhal, A. and Schieber, G., Health Financing in Bulgaria. Diagnostic, National Conference on Health Financing April 27-28 2015 Sofia, The World Bank, 2015.

¹¹ <https://www.mediapool.bg/okolo-60-ot-lichnite-lekari-sa-nad-55-godini-news270382.html>, last accessed on 15 June 2018.

¹² Turlakova, T., Regional differences in the entrepreneurial activity in Bulgaria - metrification and trends, 2018, available from http://research.ue-varna.bg/admin/kcfinder/upload/files/TOM_1-238-250.pdf

¹³ Trading economics, Bulgaria – Rural population, 2018, available from <https://tradingeconomics.com/bulgaria/rural-population-wb-data.html>, based on the World Bank indicator database <https://data.worldbank.org/>.

Healthcare is funded primarily from mandatory healthcare contributions, but also includes private expenses in the form of out-of-pocket payments, funding from taxes coming through the Ministry of Health and municipalities, premiums under voluntary health insurance, and some other sources of minor importance. According to the system of health accounts in 2015 around 2.44 billion BGN (1.25 billion EUR) was spent on hospital care, 1.08 billion BGN (550 million EUR) was spent on outpatient care and 3.14 billion BGN (1.6 billion EUR) was spent on pharmaceuticals and retail purchases of medical appliances. Government schemes and compulsory contributory healthcare financing schemes accounted for 87% of expenditure on hospital care, 52% of expenditure on outpatient care and 19% of retail purchases of pharmaceuticals and optical/sanitary appliances. Out-of-pocket payments by households accounted for 12.8% of expenditure on hospital care, 46.6% of expenditure on outpatient care and 81% of expenditure on pharmaceuticals and appliances, which are actually the largest item of spending in the national health accounts. Voluntary healthcare insurance schemes make no contribution to expenditure on pharmaceuticals and a very marginal contribution to expenditure on hospital care (0.11%) and outpatient care (1.61%). Under the current growth rate it would take many decades before they became of any importance for the healthcare system. In Bulgaria there are no restrictions preventing physicians working with both public and private healthcare providers or having their own private practice while also working for a public provider. In the official register of medical establishments there is no information about the contracts with the NHIF, but there is hardly any private health service provider operating in a field covered by the statutory health insurance who would not have a contract with the NHIF.

These data show that private expenditure is rather high in comparison with other EU countries. It is between 45% and 50% of total healthcare expenditure and is thus bigger than the funding from mandatory healthcare insurance. Some of it is statutory, such as the payments and co-payments for pharmaceuticals, which account for the largest part of private expenditure. There are also out-of-pocket payments for co-payment for examinations by GPs, for services offered by private providers, or in the form of 'gratuities' to doctors. Informal payments are estimated to be half of the total out-of-pocket payments. In the 2017 Special Eurobarometer dedicated to corruption, 60% of the Bulgarians interviewed responded that in healthcare the giving and taking of bribes or the abuse of personal power were widespread – twice as many as in the EU as a whole. This was the second most corrupt sector according to the perceptions of Bulgarians (Eurobarometer 470, Bulgaria Factsheet). According to the 2017 report of Transparency International, public medical care is the sector with the highest incidence of bribery while among the citizens of other EU Member States Bulgarians are among those who believe least in the social acceptability of reporting corruption – only 15% believe it is acceptable (Global Corruption Barometer 2017).

The Bulgarian healthcare system suffers from a chronic financial deficit generated mainly by the hospital sector. Underfunding of clinical pathways is one of the drivers of hospital deficits¹⁴. The mechanism for funding hospitals is changed almost every year in an effort to contain the deficit. The deficits of publicly owned hospitals are sometimes covered by special government outlays, but this is subject to discretionary decisions. Government outlays in Bulgaria represent a smaller share of healthcare expenditure than the EU average. They are only used in hospital care and in 2015 represented 13.9% of the total expenditure on hospitals – 338 million BGN (173 million EUR).

Most small towns have at least one doctor, but patients can register with a doctor of their choice in any town. Doctors are responsible for referring patients to specialists and hospitals, but not all of them are well trained in general practice. GPs tend to defer making referrals to specialists or hospital due to monthly limits on the number of referrals. Patients who visit specialists without a referral must pay for any services

¹⁴ Hinkov, H., Zahariev, B. and Avramova, S., An analysis of the funding of clinical pathways in a large district hospital, Open Society Institute – Sofia, 2013 (in Bulgarian).

administered. Some companies have their own clinics, which employ a GP to serve the medical needs of their workforce¹⁵.

There are no official waiting lists in Bulgaria, but referrals to specialists in outpatient care are somewhat limited. GPs who are supposed to act as gatekeepers have a monthly quota of referrals. They often reach their quota long before the end of the month, which means that remaining cases have to wait until the next month. The alternative is to visit a specialist without a referral and pay out of one's own pocket. The current healthcare reform envisages the introduction of official waiting lists for non-emergency diagnoses and conditions.

In recent years, Bulgaria has experienced a high level of migration by doctors and highly qualified medical staff to other EU Member States¹⁶. There is as yet no shortage of doctors at national level: but the current rate of emigration of about 500 doctors per year, combined with the forthcoming retirement of large cohorts, means that a shortage can be envisaged in the near future. There is already a significant shortage of nurses. Ageing of the population, combined with the relative unattractiveness of the medical profession in Bulgaria due to low pay rates, contributes to general labour market instability in the health sector (Buchan et al.: 2014: 45)¹⁷.

2 Analysis of the challenges in inequalities in access to healthcare in the country and the way they are tackled

The challenge of providing access to healthcare for persons without health insurance remains acute. Under a change to the Health Insurance Act, from 2016 citizens whose health insurance has been discontinued due to payment arrears can have their access to the health package covered by NHIF restored after payment of all due insurance amounts for the previous five years (60 months). Until the end of 2015, the period for which arrears had to be paid in order to regain access was three years. This change made it even more difficult for uninsured persons to re-enter the health insurance system.

Access to medicines is also a challenge in some municipalities. There is a problem with physical access to both pharmacies and drugstores¹⁸. According to the official register, there are just under 1,000 drugstores in Bulgaria and over 4,000 pharmacies. About half of the pharmacies have contracts with the NHIF and not all of them work with the full list of pharmaceuticals reimbursed by the NHIF. However, as reported by the Bulgarian Pharmaceutical Union in 2018, there are 87 municipalities without pharmacies working with the NHIF, i.e. pharmacies where prescription drugs fully or partially covered by the NHIF can be obtained¹⁹. Even some of the 28 districts have very few pharmacies. According to a statement made in a presentation by the Chair of the Bulgarian Pharmaceutical Union, in the whole district of Shumen there is only one pharmacy offering prescription drugs reimbursed by the NHIF²⁰. There are about 80 municipalities (almost a third of all municipalities) without drugstores.

Another concern related to access to healthcare that has recently been publicly discussed is the treatment of Bulgarians in other EU countries. The NHIF has delayed payments to hospitals in other EU Member States, mainly in Germany and Austria. The minister of health has assured that over the next few years the budget for treatment

¹⁵ Accessing healthcare, NHS choices, 21 October 2016.

¹⁶ OECD International Migration Outlook 2013: Bulgaria, OECD Publishing, 2013.

¹⁷ Buchan, J., Wismar, M., Glinos, I. and Bremner, J., Health Professional Mobility in a Changing Europe. New dynamics, mobile individuals and diverse responses, 2014, World Health Organization.

¹⁸ A pharmacy offering only non-prescription drugs which requires a much lighter procedure to register.

¹⁹ <http://bnr.bg/post/100931096/ilko-getov-v-86-obshtini-nama-nito-edna-apteka-koato-da-raboti-sas-zdravnata-kasa>.

²⁰ https://bphu.bg/БФС_В_МЕДИИТЕ_/archive/Проведе_се_специализираният_форум_-_Digital_Health_and_Medical_.htm.

abroad will be increased and that the timing of payments has been negotiated with foreign creditors.

The chairperson of the NHIF expressed concern several times in the first quarter of 2018 about the insufficient funding of the Bulgarian healthcare system and recommended an increase in the health insurance contribution rate, which is currently 8%²¹.

Out-of-pocket spending for medical care is a key barrier to access, especially amongst the poorest population groups. The poorest groups are still the most likely to be unable to access healthcare if needed. In 2014, according to Eurostat, Bulgaria had an overall rate of self-declared unmet need for healthcare (including the self-declared need for medical or dental examination) of 17.3%, which is lower than the EU average (26.5%). But the proportion of those who declared financial reasons (costs) as the main reason for unmet needs (17%) was higher than the EU average (14.8%). This means that cost factors explain the entirety of unmet healthcare need in Bulgaria, the other two factors playing an auxiliary role. The self-declared unmet need for medical examination alone was significantly lower – 4.7% in 2015 – but could again be explained by financial reasons.

Screening programmes are available for certain communicable and non-communicable diseases. Among the communicable diseases, HIV and tuberculosis are of primary concern. Until 2015, screening and treatment was funded under the Global Fund to Fight Aids, Tuberculosis and Malaria, which was quite successful in reaching out to Roma neighbourhoods with the support of Roma NGOs. When the operations supported by the global fund ended, screening was stopped for two years; but it was then restored in 2017 with government funding due to rising numbers of cases, especially of tuberculosis.

Some risks remain of epidemics in vaccine-preventable diseases, especially among the Roma population. The incidence of measles over recent decades has been restricted to isolated cases or small outbreaks, affecting no more than about 150 persons per year, with the exception of 2010 when a major epidemic led to more than 22,000 registered cases²² and resulted in a significant death toll, especially among Roma children. In 2017, fears spread that a major measles epidemic might take place again in Bulgaria after some cases were registered in Roma neighbourhoods; but it seems that vaccination rates improved in the years after the 2010 epidemic, and measures were also undertaken by the Ministry of Health involving Roma health mediators.

The officially reported vaccination rates against measles exceed 95%²³. A 90% vaccination rate is usually considered enough for creating good community-level protection, based on the empirical observation that the probability of an epidemic drops significantly above that point²⁴. However, this is not the case when the remaining 5-10% of persons without immunity happen to be concentrated in certain deprived and marginalised communities, as appears to be the case with Roma in Bulgaria.

Pensioners in Bulgaria are insured and do not have to pay health contributions even if they continue to work; but many pensioners tend to live in rural areas where the availability of healthcare services is limited. The deficiency of palliative care affects many elderly people, as mentioned in the 2017 report of Bulgarian ombudsperson²⁵.

²¹ <http://www.mediapool.bg/kamen-plochev-sistemata-na-zdraveopazvaneto-shte-ruhne-do-edna---dve-godini-news274527.html>.

²² Healthcare 2015 Statistical Yearbook, National Statistical Institute, p.36.

²³ Health and Healthcare, Ministry of Health, 2013, Annex 1, p.13. This analysis produced by the government reports vaccination rates between 93.5% and 97% for the major vaccine-preventable diseases which are part of the immunisation calendar in Bulgaria. This includes measles but the report seems to have 'forgotten' the epidemic, as it lists measles among the transmittable diseases which have been already almost extinguished.

²⁴ Malhotra, R. et al., Human Rights Indicators. A Guide to Measurement and Implementation, UN Human Rights Office of the High Commissioner, 2012, p.20.

²⁵ <http://www.zdrave.net/Новини/Нито-един-хоспис-няма-договор-с-НЗОК/n6148>.

Hospitalisation rates in Bulgaria are nearly 40% higher than those in other countries having accessed EU since 2004, and outpatient contacts are relatively low – 5.5 visits per year per person against an average of 7.23 in the other countries²⁶. The need to transfer funds from hospitals to outpatient care is mentioned in the National Health Strategy 2020 (NHS 2020). Among the reasons for the high hospitalisation rates is the underdeveloped state of preventive healthcare. The NHS 2020 estimates that about 20% of hospital procedures could be implemented in outpatient care, while 10% of hospitalisations and related procedures could be avoided altogether if better outpatient care were available²⁷.

The current government has an ambition to target this problem. This means trying to limit in some urban areas the further oversupply of hospital services contracted by the NHIF. In parallel, some incentives need to be created for using outpatient services.

In the first quarter of 2018, the minister of health promised to submit to the autumn session of Parliament a package of proposals for changing the mechanism for financing the healthcare system²⁸. Although there has also been a promise that the expected new model will be discussed and negotiated with all stakeholders, it is only described in very general terms and no details are yet known.

From 2016 to 2018, several failed attempts at reforming or simply restricting the funding of hospitals were made, which could have had a negative impact on access to healthcare if consistently implemented. Some were attacked in the Constitutional and Administrative Court. In 2016, the introduction of a fingerprint ID system for people admitted to hospital aroused the criticism of medical professionals and society. Designed as a mechanism to control health costs, to make savings and make more efficient use of money, the system went through many ups and downs. In April 2017, the NHIF announced that it had stopped operating the system in hospitals, after the publication of the final decision of the Supreme Administrative Court on revoking the new registration system.

Another reform revoked by the Constitutional Court was the planned division of the health insurance package into primary and secondary parts. The idea was that the basic (primary) package would cover serious and socially significant diseases that required immediate hospitalisation, and the secondary package would cover conditions that allowed for planned hospital admission. This would effectively lead to the formation of official waiting lists. Waiting lists have never played an important role in the Bulgarian healthcare system and have never been officialised.

Bulgaria has a so-called 'national health map', which was last updated in May 2018. The map sets mandatory minimum and maximum territorial allocation requirements for each type of healthcare facility. The number of GP practices and dentists needed is defined at municipality and even settlement level. When it comes to specialised outpatient care, however, the numbers are defined at the district level without determining where they should be based. In the case of hospital care, the necessary number of beds in different types of departments is defined at district level. Through staff requirements in specific departments, the approximate number of specialists needed in hospital care (doctors and nurses) is then also defined at district level. Generally, most specialists are based in healthcare establishments in district cities and some in lower-level towns. Visiting them is a source of serious additional obstacles and costs for residents of the territorial periphery.

The national health map was prepared by the ministry of health with input from their devolved structures and probably with some input from municipalities. So it is based more on expert observations and perceived needs rather than on thorough demographic

²⁶ Couffinhal, A. and Schieber, G., Health Financing in Bulgaria. Diagnostic, National Conference on Health Financing April 27-28, 2015 Sofia, The World Bank, 2015.

²⁷ National Health Strategy 2020, Ministry of Health, 2015.

²⁸ <http://www.mh.government.bg/bg/novini/intervyuta/kiril-ananiev-ministr-na-zdraveopazvaneto-nyama-da/>.

and epidemiological research. Use of the map was made mandatory in September 2015 by an amendment to the Law on Medical Establishments. This means that the NHIF will not contract any medical operators in excess of the estimated needs.

3 Discussion of the measurement of inequalities in access to healthcare in the country and current adequacy

Bulgaria is not an OECD member and is not included in the OECD health database, even among non-OECD member countries. There are no publicly available data sources of similarly defined indicators produced by a Bulgarian authority, which could be used for international comparisons or feed into the internal policy debates on healthcare. The World Bank global database of healthcare indicators is an alternative. However, the indicators related to access to healthcare are available for Bulgaria irregularly and with a significant delay – the most recent ones are from 2010. Moreover, most of those indicators are tuned to capture global differences in access to healthcare and poverty generated by out-of-pocket payments for healthcare, which makes them a rather crude instrument for detecting developments, even in countries at the level of development of Bulgaria. The database contains information on domestic private health expenditure per capita, coverage of essential health services among the general population and the most disadvantaged groups, and other indicators.

There are data indicating that subjectively assessed health might differ between income groups. Roma, for example, tend to assess their health as being similar to the majority population, whereas their life expectancy is much shorter and access to health services more constrained. In Bulgaria, the gap between the lowest and the highest income quintile in self-reported unmet need for medical examination is larger than the average for the EU, but it looks too small. In 2016, only 6.3% of persons in the lowest quintile and 3.2% of persons in the second quintile reported unmet need for medical examination. A very large proportion of persons without health insurance belong to these quintiles, which means that they have to pay for any visit to a GP or a medical specialist.

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