CRC 1342 | No. 19

Social Policy
Country Briefs

Bulgaria

Antoniya Dimova

The Health Care System in Bulgaria

Global Dynamics of Social Policy CRC 1342

DFG Deutsche Forschungsgemeinschaft

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CRC 1342 Social Policy Country Briefs, 19
Edited by Achim Schmid
Bremen: CRC 1342, 2021

SFB 1342 Globale Entwicklungsdynamiken von Sozialpolitik /
CRC 1342 Global Dynamics of Social Policy

A04: Global developments in health care systems and long-term care as a new social risk

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[DOI https://doi.org/10.26092/elib/2021]
[ISSN 2700-4392]

Funded by the Deutsche Forschungsgemeinschaft
(DFG, German Research Foundation)
Projektnummer 374666841 – SFB 1342

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Content

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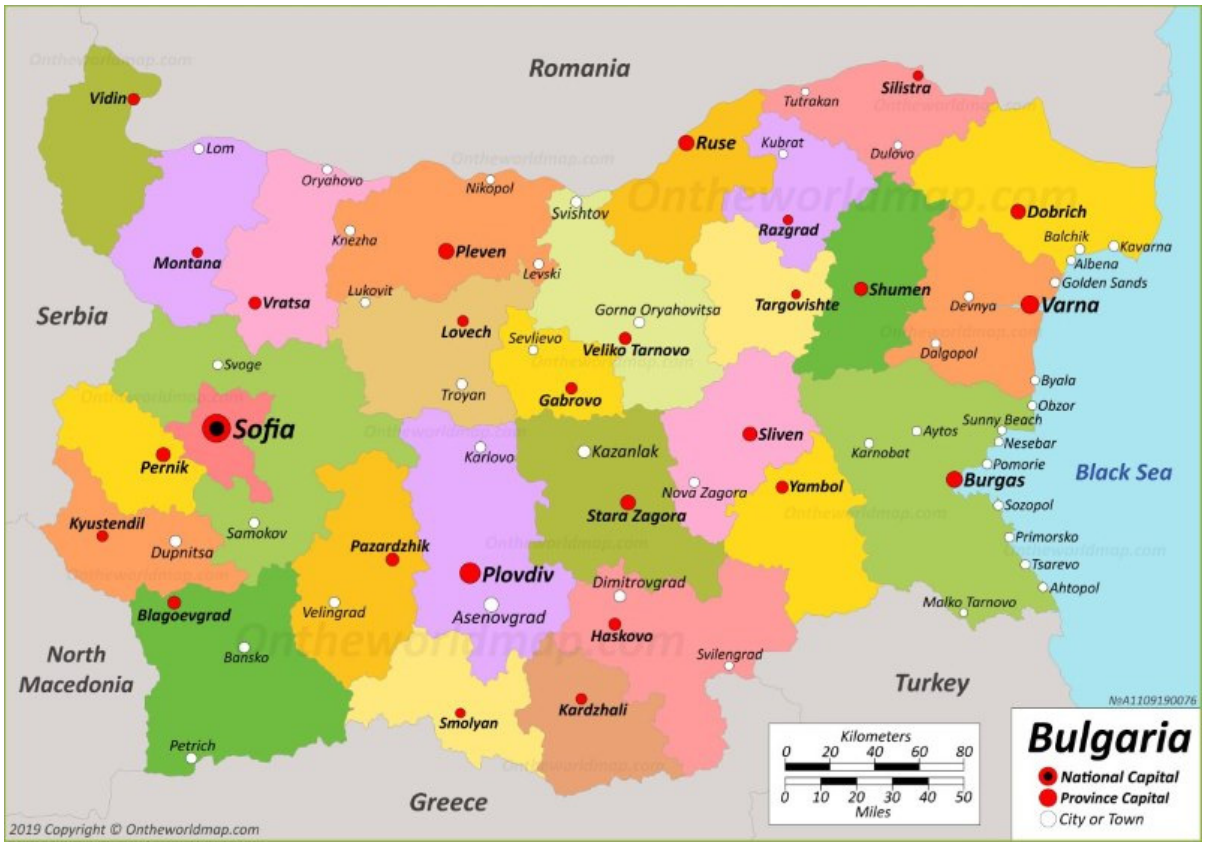
1. Country Overview



Source: On The World Map 2021 (https://ontheworldmap.com/bulgaria/map-of-bulgaria.jpg, ac-cessed October 2021)

- Sub-Region: Eastern Europe
- Capital: Sofia
- Official Language: Bulgarian
- Population size (2020): 6.9 million
- Share of rural population (2020): 24.3 %
- GDP (2020): 69.1 billion US-$
- Income group: Upper middle-income group
- Gini Index (2018): 41.3
- Colonial period and Independence: In 1878, Bulgaria gained autonomy within the Otto-man Empire. Full independence from the Ottoman Empire was declared in 1908.

2. Selected Health Indicators

Indicator	Bulgaria	Global Average
Male life expectancy at birth (2019)	71.7	70.9
Female life expectancy at birth (2019)	78.6	75.9
Mortality rate, under-5, per 1,000 live births (2019)*	6.7	37.7
Maternal mortality ratio per 100,000 live births (2017)	10	211
Prevalence of HIV among adults aged 15-49 in % (2019)	<0.1	0.7
Incidence of tuberculosis per 100,000 people (2019)	21	130

Source: World Health Organization 2020; * United Nations Inter-agency Group for Child Mortality Estimation (UN IGME) (2020). Under-five mortality, September 2020. Available at: https://data.unicef.org/topic/child-survival/under-five-mortality/ and Country profiles: Bulgaria. Available at: https://data.unicef.org/country/bgr/

3. Legal Introduction of the System

Name and type of legal act	Temporary rules for the structure of the medical administration in Bulgaria (a normative act) – considered as the beginning of the Bulgarian health system
Date the law was passed	February 1, 1879
Date of *de jure* implementation	1879 (exact date not available)
Brief summary of content	The Rules established the Supreme Medical Council (SMC) under the Department of Internal Affairs (later Ministry of Interior), responsible for all scientific and administrative issues in the field of health care, the structure of the initial health administration with its functions and procedures. The rules consisted of three parts (Bojilova, 2013): 1. Rules for medical governance in Bulgaria 2. Statute for the medical establishments in Bulgaria (hospital statute) 3. Rules for the structure of pharmacies in Bulgaria.
Socio-political context of introduction	The Russo-Turkish Liberation War, 1877-1878, led to the liberation of Bulgaria from Turkish slavery and establishment of the Third Bulgarian Kingdom on 3 March 1878. During the Provisional Russian Administration from June 1877 to June 1879, a large number of normative acts (temporary rules) were adopted (for example: the organization of the army, courts, schools, police, medical departments and the postal service; introduction of compulsory primary education, compulsory military service for men aged 20-30; establishment of the Bulgarian National Bank). The Provisional Russian Administration handed over power to the Bulgarian Prince Alexander I Battenberg in June 1879. Bulgaria had been divided, by the Congress of Berlin in 1878, into the Kingdom of Bulgaria and Eastern Rumelia (still under the control of the Ottoman Empire). Unification was proclaimed in September 1885. In 1912-1913 Bulgaria participated in the Balkan Wars (the first against the Ottoman Empire, 1912-1913; the second, inter-allied war in 1913).

4. Characteristics of the System at Introduction

a. Organizational structure

- Centralization of HCS system: Centralization began with the establishment of the Supreme Medical Council (SMC) assigned by the government. Subordinated to the SMC were the Hospital Councils. The system developed with the establishment of a new position – the Inspector General with ministerial rank, and a new structure under the Ministry of Interior – known as the Civil Medical Governance through the Civil Medical Laws from 1882. The SMC continued to exist as a central institution but its rights were limited. In 1888, the Sanitary Law, the first submitted and considered under the constitutional order in the National Assembly, changed and expanded the administrative structure of the Bulgarian health care system and regulated the centralization of sanitary management in one higher sanitary authority – the Civil Sanitary Directorate at the Ministry of Interior.
- Regional allocation of responsibilities for health care: The local sanitary services were the main cell of the health care system, most of which was organized and financed by the central state. However, there was a tendency for such services to continue to be organized and financed by the regional and local self-governing authorities as they had been since the beginning of the system.
- Health insurance coverage: The Law on Disability and Illness Insurance for State Workers and Their Family Members introduced social health insurance in Bulgaria for the first time in 1906. In 1918, through the Act on Worker Insurances for Illness and Injury, the number of people entitled to compulsory health insurance increased significantly through the inclusion of all workers in the public and private sectors. Health insurance contributions, which also covered maternity and perinatal care, were paid for by the insured individual, their employer and the state, with each of them contributing 1 % of the worker's wage. The health insurance system was further developed with the passing of the 1924 Law on Social Insurance, which, along with compulsory insurance, introduced voluntary insurance for self-employed craftsmen, tradesmen and farmers. Coverage was extended to include situations such as accident, illness, maternity, disability and old age. A Social Insurance Fund was established, based on a tripartite system: the workers and employers paid equal, fixed contributions, depending on the worker's wage, and the state's contribution was equal to one half of

the amount collected. The fund also financed the building of hospitals, nursing homes, dispensaries, community facilities and worker homes. The number of insured people gradually increased from 34,720 in 1919 to 1.5 million by the end of 1951 (Popov, 2005; Popov, 2009; Konstantinov, 2017; Balabanova, 2001).

» Eligibility/entitlements for health insurance were defined by occupational status. The public system established under the regulations of 1879 and the Public Health Law of 1888 provided entitlements to very basic health care for the whole population.

b. Provision

Indicator	Number
Physicians (1878)	71
Dentists (1903)	27
Pharmacists (1912)	247
Nurses (1912)	39
Midwives (1898)	52
Hospitals (1898)	65
Hospital beds (1898)	2,900
Private hospitals (1905)	5
Share of people treated in hospital (% of total population) (1889)	0.56 %
Share of people treated in ambulatory settings (% of total population) (1889)	1.63 %

Source: Konstantinov, 2017

c. Financing

Sources of financing included direct payments, the state, regional and municipal budgets and charity and insurance contributions after 1918. The Social Insurance Fund established in 1924 financed the building of hospitals, nursing homes, dispensaries, community facilities and worker homes. The health budget was 4.7 % of the state budget in 1880-1884 and around 2-3 % afterwards until 1914 (Konstantinov, 2017).

d. Regulation

» Actors responsible for regulation: Prince Alexander I Battenberg issued decrees and the National Assembly passed laws. The Chairman of the Supreme Medical Council was delegated to review at least once a year the activities of all hospitals. Hospital councils managed hospitals and could exempt the socially disadvantaged from fees. The Civil Sanitary Directorate at the Ministry of Interior (1888) controlled all sanitary services in the country, took measures against epidemic diseases, inspected public and private hospitals and authorized the opening of new ones, controlled pharmacies, monitored the legal practice of medicine and the proper application of sanitary legislation; the SMC had consultative functions.

» Regulations of providers: The SMC registered doctors in the civil service and those allowed to practice independently.

» Public service package: hospital care, outpatient services and – in some cases – medicines.

5. Subsequent Historical Development of Public Policy on Health Care

a. Major reform I

Name and type of legal act	Set of laws and government decisions
Date the laws were passed	1948-1951
Date of *de jure* implementation	1948-1951
Brief summary of content	Restructuring of the Bulgarian health care system from a Bismarckian-type insurance model to a centralized government system based on the principles of socialist health care. The Social Insurance Institute (Fund until 1941) was transformed into the State Institute for Social Insurance in 1948, and its budget was consolidated into the state budget in 1950. In 1951, the insurance system and its assets (of over BGN 40 billion) were nationalized (Popov, 2005). Nationwide free medical care was introduced in 1951. Private hospitals and pharmacies were nationalized. Physicians' and chemists' cooperatives, as well as private medical practices, were prohibited in 1972.
Socio-political context of introduction	In 1946 the monarchy was abolished and Bulgaria became a people's republic with a provisional government until 1947 and a new Constitution at the end of 1947, followed by a total nationalization of private property (with a few exceptions, such as homes), state monopoly and non-market (planned) economy.

b. Major reform II

Name and type of legal act	Law on Health Insurance
Date the law was passed	June 19, 1998
Date of *de jure* implementation	July 1, 2000
Brief summary of content	The adoption of the 1998 Law on Health Insurance marked the beginning of a one-year transition period for the establishment of the National Health Insurance Fund (NHIF), the single institution responsible for compulsory social health insurance (SHI). The levying of health insurance contributions, set at 6% of income, started on 1 July 1999, one year after the establishment of the NHIF. Initially, from July 2000, the Fund covered only outpatient services. Coverage was extended to inpatient care from July 2001. The reform aimed to introduce market principles, decentralization and pluralism both in financing and ownership of the health providers.
Socio-political context of introduction	The political changes in Bulgaria started in 1989 with the development of a multiparty system and adoption of a new Constitution in 1991. From 1990-1997 the political environment underwent rapid change, accompanied by severe economic crisis. The debate over the need to restructure the health system into a social insurance system started in parallel with the transformation from a centrally planned economy to a market economy (Dimova, Popov, Rohova, 2007). In 1997, after the establishment of a new government with a strong parliamentarian majority, the political and economic situation was stabilized and the reform implemented.

6. Description of the current health care system

a. Organizational structure

» Centralization of HCS system: Despite the decentralization reforms in 1990s, the system is still highly centralized and authority is concentrated in the Council of Ministers (CoMs), the Ministry of Health (MoH) and the National Health Insurance Fund (NHIF). The MoH is responsible for the overall organization and functioning of the health system, while its regional branches – the Regional Health Inspectorates (RHIs) – have only

administrative functions. The NHIF is a single payer responsible for social health insurance with substantial governmental control over its functioning. Contractual relations between the NHIF's regional branches and health care providers are based on a centralized negotiation process between the NHIF and professional organizations of physicians and dentists, and all services and prices are specified at national level. The state is the owner of a significant share of hospital care providers; however, their management is decentralized.

» Regional allocation of responsibilities for health care: Municipalities are owners of a considerable share of health care providers for specialized outpatient care and some hospitals. Their responsibilities are predominantly to supervise the activities of their own establishments.
» Segmentation by population group: although social health insurance, which is the primary scheme, is compulsory for all citizens, there is a large segment of uninsured people, for a variety of reasons. At the end of 2019, more than 15 % of the population lacked health insurance (NHIF, 2020; NSI, 2020), a large proportion of whom were uninsured due to their low socio-economic status. Voluntary health insurance (VHI) covers only around 10 % of the population, mostly through corporate group polices (EAMA, 2017).
» Eligibility/entitlement: citizens and legal residents of the country (Law on Health Insurance, 1998). Social health insurance contributions are paid by employers and employees, or by the self-employed. The state pays contributions for children, pensioners, the poor, and some other groups.

b. Coverage

Indicator	%	Source
Percentage of population covered by social insurance schemes	85	NHIF, 2020; NSI 2020
Percentage of population covered by private schemes	10	EAMO, 2017
Percentage of population uncovered	15	NHIF, 2020; NSI 2020

c. Provision

Indicator	Value (2019)
Physicians (per 1,000 inhabitants)	4.26
Nurses and midwives (per 1,000 inhabitants)	6.69
Hospital beds (per 1,000 inhabitants)	7.45
Hospital beds in public hospitals (number)	38,390
Hospital beds in private hospitals (number)	13,386

Source: NCPHA, 2020 (National Centre of Public Health and Analyses (2020). Public Health Statistics, Bulgaria 2020, Annual)

» Importance of inpatient and outpatient sectors: Inpatient care is the dominant sector with high admission rates (319 per 1000 in 2019; NCHPA, 2020; NSI, 2020) and a high share of total health expenditure (35 % in 2018; WHO GHED, 2021).

d. Financing

Indicator	Value (2018)
Total expenditure on health in % of GDP	7.3
Domestic general government health expenditure in % of current health expenditure	57.6
Private expenditure on health in % of current health expenditure	42.4
Out-of-pocket expenditure in % of current health expenditure	40.5
External health expenditure in % of current health expenditure	0

Source: WHO Global Health Expenditure Database, 2021

e. Regulation of dominant system

- Actors responsible for regulation: The main national actors responsible for regulation are the National Assembly, the Council of Ministers (CoMs) and the Ministry of Health. At local level, municipalities have limited regulative functions. Based on the laws passed by the National Assembly, the CoM adopts legislation regulating various aspects of health care such as structural changes in the system, access to medical care, prices of medicinal products. The MoH is responsible for the overall functioning of the system, protection of public health and the state health control. It regulates and controls different aspects of health and pharmaceutical care through designated agencies and councils (Executive Agency for Medical Supervision, Bulgarian Drug Agency, National Council on Prices and Reimbursement of Medicinal Products) and Regional Health Inspectorates (RHIs). Municipal councils adopt decisions, based on which mayors issue orders concerning health care initiatives and activities at municipal level (Dimova et al, 2018).
- Regulation of providers: Physicians, dentists, pharmacists and the other health professionals must be registered with their respective professional organization to be allowed to practice. All health care establishments, including pharmacies, drugstores and alternative medicine providers, are registered with the MoH or RHIs. New hospitals can be established only upon the CoMs' approval. The BDA maintains registers of drug manufacturers, importers, wholesalers, retailers, intermediates, parallel exports, authorizes and registers medicinal products and clinical trials.
- Public service package: The SHI system covers a broad range of health services and goods, which form the basic NHIF benefit package, including primary outpatient medical care, specialized outpatient medical care, outpatient diagnostic services, outpatient dental care, inpatient services. Medicines paid fully or partially by the NHIF are listed in the Positive Drug List (PDL), which defines exact patient co-payments and reimbursement levels covered by the NHIF.

The NHIF's benefit package and the PDL are established on the basis of regulations issued by the MoH. Emergency care, inpatient mental health care, transfusion haematology, in vitro fertilization and transplantations are covered by the state.

7. Co-existing systems

The role of voluntary health insurance (VHI) is insignificant at 0.7 % of the current health expenditure in 2018 (WHO GHED, 2021) and covers only approx. 10 % of the population, mostly through group polices. VHI is intended to cover complementary services and goods not covered by the NHIF (such as specific lab tests, dental services and drugs) and supplementary services (for example, better service and free choice of a hospital physician or team). However, VHI in Bulgaria largely covers services that are also included in the NHIF benefit package (visits to specialists, hospital treatment, prophylaxis, etc.). VHI is provided by commercial joint-stock companies for general or life insurance, supervised by the Financial Supervisory Commission.

8. Role of global actors

As a member of the European Union, Bulgaria benefits from the EU Structural Funds which include the field of health care. Various programmes and projects are financed through the World Bank, the European Economic Area and Norway Grants programme and the Swiss Agency for Development and Cooperation.

9. List of additional relevant legal acts

- Law on Health. State Gazette No. 70, 10 August 2004.
- Law on Healthcare Establishments Act. State Gazette No. 62, 9 July 1999.
- Law on Medical Devices. State Gazette No. 46, 12 June 2007.
- Law on Medicinal Products in Human Medicine. State Gazette No. 31, 13 April 2007.
- Law on Professional Organizations of Physicians and Dentists. State Gazette No 83, 21 July 1998.

» Law on Professional Organizations of Pharmacists. State Gazette No 75, 12 September 2006.
» Law on Professional Organizations of Nurses, Midwives and Associated Medical Specialists, Dental Technicians and Assistant Pharmacists. State Gazette No 46, 3 June 2005.

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