Bulgaria

Health Care & Long-Term Care Systems

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Health care systems

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2.3. BULGARIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

GDP per capita in PPS is at 12,500 and around half of the EU average of 29,600 in 2015. Bulgaria has a population of 7.1 million inhabitants. During the coming decennia the population will steadily decrease, from 7.1 million inhabitants in 2016 to 4.9 million inhabitants in 2070. Thus, in Bulgaria the population is expected to decrease by 32%, while it is expected to increase at the EU level by 2%.

Total and public expenditure on health as % of GDP

Total expenditure ([71]) on health as a percentage of GDP (8.9% in 2015, latest available data) has increased over the last decade (from 7.3% in 2005) but remains below the EU-average ([72]) of 10.2% in 2015. Throughout the last decade, total public expenditure has first decreased as % of GDP but has recently recovered from 4.6% in 2005 to 4.9% of GDP in 2015 (EU: 8.0% in 2015). Public spending as a share of GDP is one of the lowest in the EU. Looking at health care without long-term care ([73]) reveals a similar picture with public spending below the EU average (4.9% vs. 6.8% in 2015). When expressed in per capita terms, also total spending on health at 1,232 PPS in Bulgaria in 2015 was far below the EU average of 3,305 in 2015 ([74]). So was public spending on health care: 675 PPS in 2015 vs. an average of 2,609 PPS in 2015. Overall, Bulgaria devotes relatively few resources to health care.

([71]) Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + capital formation on health care from COFOG.

([72]) The EU-averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU-average for each year is based on all the available information in each year.

([73]) To derive this figure, the SHA aggregate HC.3 for LTC (health) is subtracted from total health spending.

([74]) Note that these PPS figures reflect current plus capital health expenditure in contrast to EUROSTAT data series, which reflect current expenditure only.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.3 pps of GDP, below the average growth expected for the EU of 0.9 pps of GDP, according to the "AWG reference scenario". When taking into account the impact of non-demographic drivers on future spending growth ("AWG risk scenario"), health care expenditure is expected to increase by 1.3 pps of GDP from now until 2070 (EU: 1.6) ([75]).

Bulgaria does not appear to face fiscal sustainability risks. In the short and medium-term risks are low. Also in the long term, Bulgaria faces low fiscal sustainability risks, due to a favourable initial budgetary position, which counterbalances the risks associated with the projected ageing costs (incl. pensions and health care) ([76]).

Health status

Life expectancy at birth (78.2 years for women and 71.2 years for men in 2015) is one of the lowest in the EU, while healthy life years (65.0 years for women and 61.5 years for men in 2015) are above the respective EU averages (63.3 and 62.6 in 2015). Mortality rates, which are thought amenable if appropriate and timely care is delivered, are also high (282 in Bulgaria vs. 127 deaths in the EU per 100,000 inhabitants). The infant mortality rate of 6.6‰ is very high compared to the EU average of 3.6‰ in 2015, having gradually fallen over the last decade (from 10.4‰ in 2005).

As for the lifestyle of the Bulgarian population, the data indicates a high proportion of regular smokers (27.3% in 2014), being above the EU average of 21.8%. The proportion of the obese population is below EU level of 14.4% (EU: 15.5%), while the alcohol consumption is above the EU level.

([75]) The 2018 Ageing Report: https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([76]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

System characteristics

Overall description of the system

The health system is a system of compulsory health insurance with contributions from employees and contractual relationship between the National Health Insurance Fund (NHIF) as purchaser of services and healthcare providers. NHIF acts as a single buyer of health services and runs the mandatory health insurance for the Bulgarian citizens. NHIF is separated from the structure of the public healthcare system and has its own governing bodies. The mission of the NHIF is to provide free and equal access for the insured persons to medical care for a defined package of health services and the free choice of a contracted provider.

Coverage

A system of mandatory social health insurance is designed to provide coverage for the residing population.

The majority of the population takes part in the health insurance system. The share of the people without health insurance payments for 2014 amounts to approximately 7 % (516 753 people). The 2015 amendments to the Health Insurance Act ([77]) led to recovery of the health insurance rights of 195 726 Bulgarian citizens for the second half of 2015.

According to the data of the "Civil Registration and Administrative Service Directorate General" (GRAO) until the end of 2014 approximately 1,630,000 people who have their permanent address in Bulgaria had foreign residence and are not legally obliged to take part in the obligatory health insurance system ([78]).

Health The structure of insured is as follows: 45% insured by the employer, 4% self-insured and approximately 44% insured by the state. coverage is provided by the state for the following population groups: any person who has not attained the age of 18 years, if attending school as a full-time pupil until completion of secondary education, but not later than the attainment of the age of 22 years; any full-time student enrolled in a higher school until attainment of the age of 26 years, and any full-time doctoral candidate enrolled within the state quota, as well as all retired people. People without incomes receive social assistance from the Social Assistance Agency. Long-term unemployed people without incomes and real estate have the right to get their hospital treatment paid for by the Fund of the Ministry of Labour and Social Policy on the basis of their property status proven. This fund amounts to BGN 5 million per year.

All women in Bulgaria have the right to receive free of charge health services for giving birth, regardless of their health insurance status. Similarly, all pregnant women have access to free health care services, regardless of their health insurance status. The access to emergency medical care is free for all, regardless of health insurance status.

Administrative organisation and revenue collection mechanism

The National Health Insurance Fund (NHIF) pools the compulsory social health insurance wage-related contributions of employed individuals and the general tax revenue allocated by the government, which covers for the contributions of the non-working population (pensioners, unemployed, people taking care of disabled members of the family, people with right to social welfare, etc). The NHIF carries out the financing of the healthcare network through its 28 regional authorities (regional health insurance funds). The NHIF contracts health services from general practitioners (GPs), specialists in outpatient departments, medical laboratories, dentists and hospitals for the insured population and provides for medication and medical devices.

A system of accreditation of medical facilities is organised by the Ministry of Health with the participation of the NHIF, the Bulgarian physicians', dentists' and patients' associations. In addition, a system for medical audits and monitoring is established by an executive agency, responsible for developing uniform criteria for assessing the efficiency and effectiveness of health care services.

([77]) State Gazette, Vol. 72/18.09. 2015, Vol. 79/13.10.2015, Vol. 98/15.12.2015.

([78]) There is no official information on the number of people residing in Bulgaria without social health insurance coverage.

Bulgaria has a mixed system of health care financing. The Bulgarian health care system is financed from three main sources: compulsory health insurance contributions, general taxation, and household private expenditure.

Role of private insurance and out of pocket co-payments

While the state provides free, universal access to emergency health care, private expenditure plays an important role in financing health care in Bulgaria. In 2015, public expenditure accounted for only 54.8% of total health expenditure (EU: 78.4%) and out-of-pocket expenditure was at the very high level of 47.7% of total health expenditure. The role of private insurance is very limited.

Out-of-pocket payments take three main forms: direct payments, cost-sharing and informal payments. Direct payments in Bulgaria include payments for specialist services without a GP referral, payments to the providers without a contract with the NHIF, or payments not covered within the benefit package. Cost-sharing applies as a flat mandatory fee for visits to a GP, a specialist or a health diagnostic laboratory covered by the NHIF and for hospital stay ([79]). Cost-sharing also applies to outpatient medicines, except for treatment of chronic diseases.

In mid-March 2016 the Council of Ministers adopted amendments to the ordinance on the implementation of the right of access to medical care. It defines the terms and conditions under which the insured persons will be reimbursed by NHIF services It forbids e.g. hospitals to ask additional payments from accompanying persons of children up to seven years of age, in case they stay in the hospital with their child. If the case requires extra care that the hospital cannot provide, children up to 18 years of age will be accompanied free of charge. In case of a need of hospitalisation, companions of disabled people who cannot be self-served will have the right for free of charge stay in the hospital.

([79]) According to the new text in the Health Social Insurance Act, Art. 37, the amount of cost-sharing is not connected already to the minimum wage, but on yearly basis is defined by a Decree of the Council of Ministers.

In case of emergency, all patients have the right to be immediately admitted in hospital. Elective hospital admissions for the health insured are to be performed within two months. This period can only be prolonged on request of the patient or due to medical indications. The ordinance furthermore prohibits hospitals to require patients or their relatives to make any donations, i.e. informal payments, during the hospitalisation, as well as one month before it. The ordinance does not allow patients to pay extra for activities funded by the NHIF.

Types of providers, referral systems and patient choice

Primary care is provided by GPs working in private practices, group practices and in outpatient hospital departments. The citizens have free choice of GPs, whom they can change once every six months. GPs are being legally assigned the function of gatekeepers, referring patients to the specialists and hospitals. Facilities which provide specialised ambulatory care include individual or group practices for specialised medical care within: separate medical specialists; health care centres; diagnostic consultation centres (containing at least 10 physicians in various specialities); laboratory and image diagnosis centres; or individual medical and diagnostic or technical laboratories.

The density of physicians in Bulgaria exceeds the average density in the EU. In 2015, there were 405 practising physicians per 100,000 inhabitants, compared to 344 in EU. However, Bulgaria has a low number of general practitioners (62 per 100,000 inhabitants vs. 78 in 2015 in the EU). The number of nurses per 100,000 inhabitants (437 in 2015) is almost half the EU average of 833. The availability and quality of health services varies across the country and needs substantial improvements in non-urban areas. The ill-defined skill-mix together with an unequal distribution of physicians across the regions affects the provision and use of primary care, resulting in bottlenecks and limiting the effectiveness of the system and leading to strong inequities in access to health care, although patients can travel to nearby cities where access to care is easier.

Hospital care in Bulgaria is provided by public and private hospitals.

Similarly, to the number of physicians, hospital capacity exceeds EU averages. In 2015, the number of acute care beds was 601 compared to 402 per 100,000 inhabitants in the EU. The number of acute care beds is also increasing contrary to the general trend in the EU. The number for all hospital beds (incl. long-term care beds) in Bulgaria is also higher than the EU average (Bulgaria: 681; EU: 526 per 100,000 inhabitants). Further reducing hospital capacity, optimising bed occupancy rates and bed turnover rates, increasing the number of day case surgery and outpatient cases, and concentrating high-tech complex care in a few facilities (centres of excellence) are perhaps areas where further improvements can be made.

Treatment options, covered health services

There is a defined basket of services that has to be delivered to the whole population covered. An ordinance adopted by the Ministry of Health regulates the scope of the specific medical activities in the package paid with funds from NHIF. The outpatient care is included entirely in the basic package. For primary care the basic package includes provision of health information, promotion, prevention, diagnostics and therapeutic activities. They aim at completing the provision of necessary medical care and services and to protect and improve the health of patients and their families. The focus is put on health education about risk factors regarding socially significant illnesses and damages from unhealthy habits as well as on promoting positive health habits.

Price of healthcare services, purchasing, contracting and remuneration mechanisms

Health care providers are mainly reimbursed retrospectively on a per-case and per-capita basis. Actual payment rates are agreed in the contract with the NHIF beforehand.

Primary health care providers are reimbursed by the NHIF on a contractual basis according to the National Framework Contract. The contracts are based on monthly per-capita payments per insured person on the patient list. They also may include additional payments for additional procedures, such as preventive health, immunisation, regular medical check-up, dispensary treatment and observation. Moreover, those working in sparsely populated and remote areas receive an additional per-capita remuneration combined with periodic balancing. Outpatient specialists are paid on a fee-for-service basis with different rates depending on the service provided.

Hospitals receive funding mainly through case-based payments (or payments per clinical pathway), based on a single flat rate per pathway combined with global budgets. The flat rate is calculated according to the cost of medical activities, auxiliary services provided to patients and up to two outpatient examinations following the patient's discharge. The terms, conditions and the procedure for monitoring, analysis and control on the implementation of medical care providers, as well as of the volumes and the total value of the services provided, have to be defined in the National Framework Agreement for Medical Activities. In case such an agreement is not concluded the decision is be taken by the NHIF Supervisory Board.

A high share of public health care spending is spent on inpatient curative and rehabilitative care (48.5% in Bulgaria in 2015 versus 32% in the EU in 2015), while a low share of spending is allocated to outpatient care (12.4% in Bulgaria in 2015 versus 22.5% in the EU in 2015).

The institutions which are financed from the state budget (mainly state psychiatric hospitals and health and social care children's homes) follow different procedures and are paid per diem by the Ministry of Health.

The mechanisms for paying staff employed in inpatient care institutions vary according to the type of the institution and, generally, combinations of various payment methods are used. In the public inpatient sector, health personnel are mostly salaried and receive additional performance-related bonuses. In private hospitals, payment mechanisms are directly negotiable between the employer and the employees under labour contracts for different personnel categories.

The market for pharmaceutical products

Medicinal products subject to medical prescription and fully or partially paid by public funds are included in the Positive Drug List and their prices are formed using external and internal reference

prices. For external reference purposes, producer prices from 10 EU reference countries are used. If there are producer prices in those 10 reference countries, the rule is to set the price at the lowest price for the same medicinal product as listed in one of 7 additional EU reference countries.

According to the National Health Strategy 2014-2020, one of the key challenges in delivering quality, effective and affordable medicinal products is the design of mechanisms to stimulate rational use of medicinal products and the implementation of generic drug policy.

Use of Health Technology Assessments and cost-benefit analysis

The adopted amendments to the health insurance law in June 2015 initiated the following reforms. An obligatory centralised negotiation of the discounts paid by NHIF for innovative medicines and products for cancer treatment is introduced, as well as a mechanism for health technology assessment (HTA) for medicinal products.

The HTA process started in 2016 with the establishment of a special commission at the National Centre of Public Health and Analyses (NCPHA), a subordinate body of the Ministry of Health. HTA is to be carried out in the event of inclusion in the positive drug list of new innovative medicinal products. HTA aims to provide information about the safety, clinical effectiveness and efficiency, as well as on the budgetary, social, legal and ethical impacts of the application of medicinal products in healthcare.

However, an amendment of the Ordinance on the conditions, rules and procedure for regulation and registration of the prices of medicinal products, adopted by a Council of Ministers' Decree in January 2017, allows the inclusion of medicines with no evidence on clinical efficacy or cost-efficiency in the positive drug list. A decision to reimburse such medicines can be taken by the National Council on Prices and Reimbursement of Medicinal Products.

eHealth, Electronic Health Record

The use of information and communication technologies (ICT) is growing in the Bulgarian health system. The health portal of the National Health Insurance Fund enables the insured persons to review their e-medical record online. The electronic service for reviewing the medical record is available to all citizens of the Republic of Bulgaria, who are (or were) health insured, as well as citizens of countries with which there are acting bilateral agreements can access the portal ([80]).

Some other e-services provided by NHIF include checking for GPs that have contracted with NHIF and medicines paid by NHIF. Additionally, there are electronic submissions of reports from the inpatient care sector to NHIF, electronic daily registers of hospitalised and discharged patients, electronic checks of validity of health insurance cards, verification of health insurance status, etc.

Health promotion and disease prevention policies

Resources directed to prevention and health promotion policy are low due to the overall low level of health spending.

In early 2015, the government adopted a national response "Objectives for Health 2020" for implementation of the WHO strategic framework "Health 2020". This document formulates national goals in the field of improving the health status of the population as a factor for sustainable growth and defines long-term priorities of the country in the health sector. Based on the analysis of the health status of the population in Bulgaria, the concept defines several national health goals by 2020, including a reduction of child mortality, an improvement of the health status among the economically active groups and an increase in life expectancy. By the end of the same year ([81]), the National Health Strategy 2014-2020 that sets out the main goals of the health system until 2020 was adopted. The strategy and its action plan for implementation contain the priority policies and measures for addressing the increasing health challenges. Among these are equal treatment, the impact of the social determinants on public health

([80]) Users may access this electronic service through https://pis.nhif.bg/main/. In order to access his/her e-medical record online the insured person should possess Qualified Electronic Signature or should obtain an Unique Access Code from his/her Regional Health Insurance Fund.

([81]) The National Health Strategy 2014-2020 was adopted by the National Assembly in December 2015 (publ. SG No. 101 from 2015).

and the main prerequisites for the functioning of the health system.

Bulgaria still has untapped potential to achieve better health of the population and prevent most of the diseases and premature mortality, respectively. There is a potential to increase the high levels of premature mortality by a stronger focus on health promotion and disease prevention policies, e.g. by changing unfavourable life styles.

Recently legislated and/or planned policy reforms

The strategic goals set out in the National Health Strategy 2014-2020 are based on the analysis of the health and demographic situation of the Bulgarian population. There are five national health priorities that focus the health policy on the sustainable improvement of the health of Bulgarian citizens in all age groups: 1) decrease of children's mortality at age 0-1 year to 6.8 per 1,000 live born; 2) decrease of children's mortality at age 1-9 up to 0.24 per 1,000; 3) decreasing of mortality of young and teenagers 10-19 years of age up to 0.28 per 1,000; 4) decreasing of mortality of economically active population – age 20-65 years to 4.19 per 1,000; 5) increasing of average length of life of people above 65 with 16.4 years.

With the latest amendments to the law on medical treatment facilities from December 2015, the National Assembly adopted the National Health Map, which allows determining and planning the needs of the population for health services access to outpatient and hospital care on geographical principles. The changes also provide for the formation of complex multidisciplinary centres for children with disabilities and chronic illnesses and people with rare diseases.

Since 2016, in accordance with the changes in the law on health insurance adopted in December 2015, NHIF applies new mechanisms for the implementation of control activities, to reduce opportunities for fraud and abuse in the health insurance system. NHIF employees together with controllers carry out unexpected controls over the execution of contracts with medical and / or dental care providers, pre-payment control of the provided medical and / or dental care services and ex-post control.

As many of the state-owned hospitals struggle with continuously persisting debts, in April 2018, the Ministry of Health enacted a compulsory tool to report and monitor financial management of state-owned hospitals. The tool is based on a set of requirements to the planning and accountability, investment policy, human resource management and public procurements; and on key performance indicators such as average length of stay, bed turnover, occupancy rate, liquidity ratios, net operating capital, debt to equity ratio, etc.

Challenges

The analysis above shows that a range of reforms have been implemented over the years to increase the efficiency in the sector while trying to improve the access to care. However, there may be room for improvements in a number of areas. The main challenges for the Bulgarian health care system are as follows:

- To guarantee the universality of health care coverage by implementing the mandatory health insurance subscription for permanent residents; to limit the size of out-of-pocket payments in total expenditure. This would contribute to reduce inequalities in access to and quality of health care.

- To improve the basis for more sustainable and efficient financing of health care in the future (e.g. considering additional sources of general budget funds), aiming at a better balance between resources and spending, as well as between the number of contributors and the number of beneficiaries. This can reduce the size of private payments and reduce inequalities in the access and quality of care and its distribution between population groups and regional areas.

- To continue to enhance and better distribute primary health care services to improve the effectiveness and efficiency of health care delivery. In the future, the effective implementation and usage of the recently deployed eHealth tools, including electronic patient records, can help ensuring effective referral systems from primary to specialist care and improving care coordination between types of care.

- To increase the primary care staff supply by implementing a comprehensive human resources strategy that adjusts the training of doctors to ensure a balanced skill-mix, that avoids staff shortages and that motivates and retains staff to the sector, especially in view of migration. In addition, consider enhancing financial and institutional incentives for GPs to provide adequate levels of services to patients based on quality indicators, performance-based reporting and payment bonuses.

- To increase health system efficiency by the shifting excessive capacity and activity of acute inpatient care towards ambulatory and outpatient care services, and strategically directing more resources towards providers of lower levels of care.

- To consider additional measures to improve the rational prescribing and usage of medicines, such as information and education campaigns, the monitoring of prescription of medicines and a more explicit policy on incentivising the uptake of generics. The policies could help improving population health, reducing the high level of out-of-pocket payments and improving access to cost-effective new medicines by generating savings to the public payer.

- To continue improving the systems for data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted. Promote the use of ICT in the gathering, storage, use and exchange of health information.

- To gradually increase the use of cost-effectiveness information in determining the basket of goods and the extent of cost-sharing.

- To foster public action in the area of health promotion and disease prevention on the basis of the defined public health priorities (diet, smoking, alcohol, lack of exercise) and given the recent pattern of risk factors.

- To operationalise, implement and adapt as needed the National Health Care Strategy (2014-2020), with a view of increasing ownership of the strategy by all stakeholders of the health system.

Table 2.3.1: **Statistical Annex – Bulgaria**

General context												EU- latest national data			
GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
GDP, in billion Euro, current prices	24	27	32	37	37	38	41	42	42	43	45	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	11.6	11.7	11.8	11.7	10.7	11.2	11.2	11.4	11.4	12.0	12.5	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	7.7	7.4	7.9	6.5	-3.1	2.0	4.5	0.6	1.4	1.9	4.3	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	1.2	6.6	9.0	0.5	6.9	6.4	-4.8	12.0	14.6	1.7	3.7	0.2	0.2	4.1

Expenditure on health*	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Total as % of GDP	7.3	6.9	6.8	7.0	7.2	7.6	7.7	7.3	8.1	9.1	8.9	10.2	10.1	10.1	10.2
Total current as % of GDP	7.1	6.8	6.5	6.6	7.1	7.5	7.7	7.1	7.9	8.5	8.2	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.2	0.1	0.3	0.4	0.2	0.0	0.1	0.2	0.2	0.6	0.7	0.9	0.6	0.2	0.3
Total per capita PPS	501	543	645	762	799	863	956	925	1,030	1,185	1,232	2,745	2,895	2,975	3,305
Public total as % of GDP	4.6	3.9	4.0	4.1	3.9	4.4	4.3	4.2	4.3	5.1	4.9	8.0	7.8	7.8	8.0
Public current as % of GDP	4.3	3.8	3.7	3.7	3.8	4.2	4.2	4.0	4.1	4.5	4.2	7.7	7.6	7.6	7.8
Public total per capita PPS	312	311	375	450	433	499	530	531	545	664	675	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.28	0.15	0.31	0.41	0.08	0.20	0.12	0.20	0.23	0.58	0.66	0.2	0.2	0.2	0.2
Public as % total expenditure on health	62.3	57.2	58.1	59.1	54.2	57.8	55.5	57.4	52.9	56.0	54.8	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	11.8	14.2	13.4	10.7	11.5	12.4	13.2	13.1	14.8	13.0	13.4	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	77.0	77.0	88.2	:	:	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	38.9	42.7	42.6	42.6	44.4	43.1	44.5	47.7	47.2	45.8	47.7	14.6	14.9	15.9	15.9

Note: *Including also expenditure on medical long-term care component, as reported in standard internation databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Population, current (millions)	7.7	7.6	7.6	7.5	7.5	7.4	7.4	7.3	7.3	7.2	7.2	502.1	503.0	505.2	508.5
Life expectancy at birth for females	76.2	76.3	76.6	77.0	77.4	77.4	77.8	77.9	78.6	78.0	78.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	69.0	69.2	69.5	69.8	70.2	70.3	70.7	70.9	71.3	71.1	71.2	76.6	77.3	77.7	77.9
Healthy life years at birth females	:	71.9	73.9	65.7	65.9	67.1	65.9	65.7	66.6	66.1	65.0	62.0	62.1	61.5	63.3
Healthy life years at birth males	:	66.2	67.1	62.1	62.1	63.0	62.1	62.1	62.4	62.0	61.5	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	210	210	209	201	189	191	280	300	275	289	282	64	138	131	127
Infant mortality rate per 1 000 live births	10.4	9.7	9.2	8.6	9.0	9.4	8.5	7.8	7.3	7.6	6.6	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	2.9	2.6	2.5	2.7	:	:	:	:	2.5	2.6	2.4	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	0.3	0.4	0.4	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.0	0.9	0.8	0.8	:	:	:	:	1.1	1.1	1.1	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	2.4	2.5	2.3	2.3	:	:	:	:	3.3	3.4	3.3	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.1	0.1	0.2	0.1	:	:	:	:	0.0	0.2	0.2	0.3	0.3	0.4	0.4
Prevention and public health services	0.2	0.2	0.3	0.3	0.3	0.3	0.3	:	0.2	0.2	0.2	0.3	0.2	0.3	0.3
Health administration and health insurance	0.1	0.1	0.1	0.1	0.1	0.1	0.2	:	0.1	0.1	0.1	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	2.5	2.2	2.2	2.3	:	:	:	:	2.1	2.2	2.1	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.0	0.0	0.0	0.0	:	:	:	:	0.3	0.4	0.4	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.6	0.5	0.5	0.5	:	:	:	:	0.5	0.5	0.5	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.5	0.5	0.5	0.4	:	:	:	:	0.7	0.8	0.7	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.0	0.0	0.0	0.0	:	:	:	:	0.0	:	:	0.1	0.1	0.2	0.2
Prevention and public health services	0.2	0.2	0.2	0.3	0.2	0.3	0.3	:	0.2	0.2	0.2	0.2	0.2	0.2	0.3
Health administration and health insurance	0.1	0.1	0.1	0.1	0.1	0.1	0.2	:	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.3.2: **Statistical Annex - continued – Bulgaria**

												EU- latest national data			
Composition of total as % of total current health expenditure	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Inpatient curative and rehabilitative care	40.3%	39.1%	39.1%	41.2%	:	:	:	:	31.7%	30.7%	29.4%	29.1%	27.9%	27.1%	27.0%
Day cases curative and rehabilitative care	:	:	:	:	:	:	:	:	3.3%	4.8%	4.6%	1.7%	1.7%	3.0%	3.1%
Out-patient curative and rehabilitative care	13.6%	12.9%	12.9%	12.4%	:	:	:	:	13.6%	13.2%	13.5%	26.8%	26.3%	23.7%	24.0%
Pharmaceuticals and other medical non-durables	34.3%	36.8%	35.2%	35.3%	:	:	:	:	42.4%	40.2%	40.7%	13.1%	12.8%	14.7%	14.6%
Therapeutic appliances and other medical durables	1.1%	1.6%	2.6%	1.5%	:	:	:	:	0.0%	2.5%	2.8%	3.6%	3.6%	4.1%	4.1%
Prevention and public health services	3.1%	3.6%	4.0%	4.4%	3.5%	4.2%	3.8%	:	2.7%	2.6%	2.6%	2.8%	2.5%	3.0%	3.1%
Health administration and health insurance	1.4%	1.5%	1.2%	1.1%	1.4%	1.3%	2.0%	:	1.4%	1.4%	1.3%	4.5%	4.3%	3.9%	3.8%
Composition of public as % of public current health expenditure															
Inpatient curative and rehabilitative care	58.8%	58.8%	58.9%	61.2%	:	:	:	:	51.1%	49.2%	48.9%	33.9%	33.6%	32.1%	31.9%
Day cases curative and rehabilitative care	0.0%	0.0%	0.0%	0.0%	:	:	:	:	6.4%	9.1%	9.1%	1.9%	2.0%	3.4%	3.5%
Out-patient curative and rehabilitative care	13.3%	12.9%	12.9%	12.4%	:	:	:	:	12.8%	12.0%	12.4%	22.9%	23.5%	22.2%	22.5%
Pharmaceuticals and other medical non-durables	12.6%	13.7%	12.9%	11.6%	:	:	:	:	16.5%	17.3%	16.2%	11.8%	11.9%	12.6%	12.7%
Therapeutic appliances and other medical durables	0.0%	0.0%	0.0%	0.0%	:	:	:	:	0.0%	:	:	1.8%	1.9%	2.0%	2.1%
Prevention and public health services	4.7%	5.5%	6.6%	7.3%	6.0%	6.7%	6.5%	:	4.4%	4.2%	4.5%	2.9%	2.5%	3.2%	3.2%
Health administration and health insurance	2.6%	2.6%	2.2%	1.9%	2.6%	2.4%	3.6%	:	2.7%	2.7%	2.6%	4.1%	4.0%	3.6%	3.4%

												EU- latest national data			
Expenditure drivers (technology, life style)	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
MRI units per 100 000 inhabitants	0.27	0.31	0.31	0.31	0.40	0.42	0.63	0.74	0.73	0.71	0.71	1.0	1.4	1.5	1.9
Angiography units per 100 000 inhabitants	0.6	0.6	0.7	0.7	:	:	1.0	1.0	1.1	1.1	1.1	0.9	0.9	0.9	1.0
CTS per 100 000 inhabitants	1.6	1.7	1.9	2.2	2.7	3.0	2.9	3.2	3.4	3.4	3.4	2.1	1.9	2.1	2.3
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.2
Proportion of the population that is obese	:	:	:	11.5	:	:	:	:	:	14.4	:	15.0	15.1	15.5	15.4
Proportion of the population that is a regular smoker	:	:	39.7	29.2	:	:	:	:	:	27.3	:	23.2	22.3	21.8	20.9
Alcohol consumption litres per capita	10.5	10.4	10.9	11.0	10.9	10.8	10.7	11.0	12.1	12.0	:	10.4	10.3	10.1	10.2
Providers	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Practising physicians per 100 000 inhabitants	364	365	364	360	369	375	386	391	398	399	405	324	330	338	344
Practising nurses per 100 000 inhabitants	404	410	421	424	421	426	430	439	447	442	437	837	835	825	833
General practitioners per 100 000 inhabitants	68	67	65	63	65	64	64	67	63	63	62	77	78	78	78
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402
Outputs	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2009**	**2011**	**2013**	**2015**
Doctors consultations per capita	5.4	5.4	5.4	5.4	5.4	5.4	5.4	:	:	5.9	5.9	6.2	6.2	6.2	6.3
Hospital inpatient discharges per 100 inhabitants	20	20	21	22	23	25	26	27	30	32	31	17	16	16	16
Day cases discharges per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	6,362	6,584	7,143	7,635
Acute care bed occupancy rates	:	:	:	:	:	:	:	:	:	:	:	77.1	76.4	76.5	76.8
Hospital average length of stay	:	:	7.2	6.8	6.5	6.1	6.0	5.8	5.6	5.4	5.3	8.0	7.8	7.7	7.6
Day cases as % of all hospital discharges	:	:	:	:	:	:	:	:	:	:	:	28.0	29.1	30.9	32.3

Population and Expenditure projections

												Change 2016-2070, in pps.	
Projected public expenditure on healthcare as % of GDP*	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Bulgaria**	**EU**
AWG reference scenario	5.0	5.1	5.2	5.3	5.4	5.5	5.6	5.6	5.6	5.5	5.4	5.2	0.3	0.9
AWG risk scenario	5.0	5.3	5.6	5.9	6.1	6.3	6.5	6.6	6.6	6.5	6.4	6.3	1.3	1.6

Note: *Excluding expenditure on medical long-term care component.

												Change 2016-2070, in %	
Population projections	**2016**	**2020**	**2025**	**2030**	**2035**	**2040**	**2045**	**2050**	**2055**	**2060**	**2065**	**2070**	**Bulgaria**	**EU**
Population projections until 2070 (millions)	7.2	7.0	6.7	6.4	6.2	5.9	5.7	5.6	5.4	5.2	5.0	4.9	-31.9	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

Bulgaria

Long-term care systems

3.3. BULGARIA

General context: expenditure, fiscal sustainability and demographic trends

GDP per capita in Bulgaria in PPS is at 12,500 and around half of the EU average of 29,600 in 2015. Bulgaria has a population of 7.1 million inhabitants. During the coming decennia the population will steadily decrease, from 7.1 million inhabitants in 2016 to 4.9 million inhabitants in 2070. Thus, in Bulgaria the population is expected to decrease by 32%, while it is expected to increase at the EU level by 2%.

Health status

Life expectancy at birth (78.2 years for women and 71.2 years for men in 2015) are one of the lowest in the EU. In contrast, healthy life years, an indicator with a self-reported component, with 65 years for women and 61.5 years for men in 2015 are above the respective EU averages of 63.3 and 62.6. The percentage of the Bulgarian population having a self-reported long-standing illness or health problem is considerably lower than in the Union (21.6% in Bulgaria versus 34.2% in the EU in 2015). In 2014, the percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 4.6%, which is lower than the EU-average of 8.1%.

Dependency trends

The number of people depending on others to carry out activities of daily living increases over the coming 50 years. From 280 thousand residents living with self-reported strong limitations due to health problems in 2016, a decrease of 3% is envisaged until 2070 to 270 thousand, which is in contrast to the steep increase expected in the EU as a whole (25%). However, due to the population decline, as a share of the population, in the period 2016-2070, the dependents are becoming a bigger group, from 3.9% to 5.6%, an increase of 43%. This is more than the EU average increase of 21%.

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. In the "AWG reference scenario", public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors is a projected increase in spending of about 0.1 pps of GDP in Bulgaria by 2070 ([442]). The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 1.0 pp of GDP in Bulgaria by 2070. This reflects, that coverage and unit costs of care are comparatively low in Bulgaria, and may experience an upward trend in future, driven by demand side factors.

Bulgaria does not appear to face fiscal sustainability risks in the short run. The medium and long-term risks are low as well ([443]).

System Characteristics

There is no well-defined long-term care (LTC) system in Bulgaria. Instead, LTC health and LTC social services are regulated by different bodies and legislation. Depending on the specific case, LTC is provided by the state, the municipal authorities or private providers or social welfare.

The organisation and the provision of social services, including long-term care services, are regulated by the Law on Social Assistance and the Regulations on its Implementation ([444]). Social services in Bulgaria are decentralised and are managed by the mayors of the respective municipalities. The mayors are also responsible for fulfilling the criteria and the standards for provision of social services. Municipalities are authorised to initiate the establishment of new social services in line with the national priorities and to develop these services according to the local community needs.

([442]) The 2018 Ageing Report, https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf.

([443]) European Commission, Fiscal Sustainability Report (2018), https://ec.europa.eu/info/sites/info/files/economy-finance/ip094_en_vol_2.pdf.

([444]) According to the Law, social services are activities assisting persons for social inclusion and independent living, which are based on social work and these services are provided in the community and in specialised institutions.

Social services are provided upon request of the potential beneficiary and after undergoing individual need's assessment and the establishment of an individual plan for support. Social services in specialised institutions are provided only after exhaustion of the opportunities for providing social services in the community.

In 2015, municipalities provided long-term care social services at the amount of BGN 206 million (€105 million), accounting for 67% of overall spending on long-term care social services. The most of the services were targeted to persons with disabilities. They included in-kind benefits for accommodation, rehabilitation, assistance in carrying out daily tasks and home help provided to sick or injured people to assist them with their daily tasks ([445]) .

People with disabilities are supported financially under the Law on the Integration of Persons with Disabilities and the Regulations on its implementation, the new Law on Persons with Disabilities in force since January 2019 and under other legislative acts. They receive in-kind rehabilitation services accounting for 0.5% of public expenditure on LTC social services.

In addition, under the Law on Family Allowances all family allowances are provided to children with disabilities regardless of the family income. In 2015, families were paid cash benefits amounting at BGN 9.3 million (€4.7 million).

As of January 2017 a new monthly allowance for raising a child with a permanent disability was introduced with amendments to the Law on Family Allowances, affecting more than 26,000 disabled children. The allowance is differentiated according to the degree of the disability or the degree of the reduced capacity of the child and according to its purpose, ranging from BGN 350 (€178.5) to BGN 930 (€474) ([446]). It is not means-tested and is available for all children with permanent disabilities to cover for their basic and specific needs due to disability. The aim is to ensure the provision of care and support at home and in family environment.

Furthermore, according to the Law on Family Allowances, if permanent disabilities of 50% or more are established by the time the child reaches the age of 2, the mother shall be paid an additional one-off benefit upon childbirth to an amount fixed annually with the State Budget of the Republic of Bulgaria Act for the respective year, but not smaller than in the previous year. In case the child has permanent disabilities, the monthly allowances for raising a child under one year of age shall be paid until the child reaches the age of 2, regardless of the income of the family.

Cash benefits are provided to pensioners with permanently reduced working capacity and degree of disability exceeding 90%, who constantly need attendance. They can receive a supplement to their pension amounting at 75% of the social old-age pension (BGN 94.19 in July 2018) as regulated by the Social Security Code. They are covered by the pensions fund and the pensions not related to labour activity fund, and in 2015 accounted for 27% of all LTC benefits provided in the country.

The financial resources for LTC services are provided from the state budget, the local budgets, by registered private providers such as non-governmental organisations, as well as under various projects of national and international programmes. In recent years, LTC social services have been considerably expanded as a result of actions aimed at deinstitutionalisation and providing more community-based and family-friendly services. However, there are challenges in this area, and a more extensive network of community services and suppliers across the country is needed to meet the demand for care.

Currently, more than 90% of the long-term care social services are public. Institutional care is almost entirely public, while non-governmental organisations and charities are increasingly involved in day care for the elderly. Home care is

([445]) Data based on selected expenditure categories of the following ESSPROS functions: Old age, Disability and Sickness, Eurostat, ESSPROS data by scheme https://ec.europa.eu/eurostat/web/social-protection/data/data-by-scheme.

([446]) The focus in the allowances' differentiation is directed to the higher types and degrees of disability. In order to ensure fairness and guarantees for making a decent and independent choice to use the opportunities provided by the state to support children with permanent disabilities and their families, an opportunity is given to their parents, at their discretion, to manage these funds and to choose whether to take care personally for their children or to hire an assistant.

provided by individuals contracted by the state or municipalities, depending on the type of service.

Public spending on LTC ([447]) was at the level of 0.4% of GDP in 2016 in Bulgaria, much below EU average of 1.6% of GDP. According to the 2018 Ageing Report, in 2016 73.4% of this expenditure was spent on in-kind benefits (EU: 84.4%), while 26.6% was provided via cash-benefits (EU: 15.6%).

The amount of the fees for formal institutional LTC services can be significant. For example, a person that is enrolled in a public facility for institutionalised elderly care needs to transfer up to 80% of his/her retirement income, but not higher than the actual monthly expenditure for the service provided.

Social services are provided in consideration of fees paid by the beneficiaries or on a negotiated basis. Fees for social services which are financed by the state budget are fixed by a Tariff of Social Services Fees endorsed by the Council of Ministers. According to the Tariff, the amount of the social service fee is determined as a percentage of the person's income, depending on the type of social service. The fees should not exceed the actual monthly income of the recipient of care. People with no incomes or deposits, persons accommodated in shelters and in crisis centers as well as the persons who have transferred real estate property to the state or to a municipality with the purpose of developing social services are exempted from paying fees for social services. Fees for social services financed by municipal budgets are paid under the Local Taxes and Fees Act. The payment for social services provided by private providers is made on a negotiated basis when the social services do not constitute activities delegated by the State.

In Bulgaria, similar to the EU average, 49% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. Overall, in 2015 1.9% of the Bulgarian population received formal LTC in-kind and/or cash benefits (EU: 4.6%). On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

In 2015, the expenditure for institutional (in-kind) services makes up 33.3% of public in-kind expenditure (EU: 66.3%). Thus, relative to other Member States Bulgaria has a less strong focus on institutional care. Typically, as institutional care is relatively costly, Member States with shares well above the EU levels may benefit from efficiency gains by shifting some coverage (and thus expenditure) from institutional to other types of care.

Regarding financial support for provision of social services, in 2016 the state provided approximately BGN 113.6 million for community-based social services for children and adults, as activities delegated by the state to the municipalities. These are significantly higher than the funds provided for specialised institutions (BGN 86.9 million). In addition, since January 2016 the sustainability of 9 centres for family-type accommodation for children/youth with disabilities with constant medical care has been financially ensured by the state budget.

Types of care

LTC services are provided in specialised institutions, community-based social services of residential type close to family environment, and also as daily and consultative community-based social services, as well as home-based social services. Bulgaria is in the process of deinstitutionalising the LTC system, aiming at a higher provision of home and community care services. The main target groups of LTC are people with impairments (disability) and elderly people (65+).

The number of specialised institutions remains the same, but the trend is showing significant reduction of their capacity. As of December 2017, the number of specialised institutions is 161 with a capacity of 10 881 places.

The transition from traditional institutional care to community and family-based services is mainly realised through an expansion of the range of services (day care centres, social rehabilitation and

([447]) Long-term care benefits can be disaggregated into health related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

integration centres, protected housing, family-type accommodation centres), as well as further development of the model for services provided at home (personal assistants, social assistants, domestic assistants, domestic social patronage, public canteens). By June 2018, the number community-based social services for elderly and people with disabilities was 530 with total capacity of 16,206 places. This is a marked increase since 2012, when 370 community-based social services for elderly and disabled people were available with a total capacity of 9,205 places.

Eligibility criteria and user choices: dependency, care needs, income

According to the latest amendments to the Law on Social Assistance (adopted by the National Assembly in January 2016) eligibility for social services is based on a needs' assessment and an individual support plan developed by a multi-disciplinary team within the respective social service. Assessment of LTC needs is individual and normally based on an application to the respective welfare service. Generally, the minimum eligibility criteria are defined in the legislation. They are nation-wide and binding and may include the applicant's income, property status, family status, potential care providers (friends or relatives), type and severity of disability, etc.

General practitioners acting as family doctors are responsible for the initial examination and monitoring of the health status of the elderly. In case of impaired health and the need for LTC, the elderly patient is referred to the relevant health institutions and medical nursing care is arranged, if needed. The arrangements for any medical services, medical nursing care included, are made by the general practitioner. Where necessary, the doctor alerts the social services. Upon receiving an application from the elderly patient or his/her family physician, friends or relatives, the social assistance directorate makes an initial assessment of the situation and decides on the LTC measures and programme to be applied in each specific case.

Prevention and rehabilitation measures

There are a couple of mechanisms for prevention and rehabilitation to be mentioned. The responsible partners for the prevention of long-term conditions and diseases are the general practitioners. A significant part of the funds for rehabilitation are provided by the healthcare system. As long as there are medical indications for rehabilitation, it is paid by the National Health Insurance Fund (NHIF). Determining the need for rehabilitation is not only the competence of general practitioners, but also of all other medical specialists in the outpatient and inpatient care. There are departments of physical medicine and rehabilitation in all major hospitals and in over 20 specialised rehabilitation hospitals, funded by the NHIF.

Another source for prevention and rehabilitation is the National Social Security Institute (NSSI). The funds provided are defined in the Law on State Social Security Budget and in 2017 amounted to BGN 20.1 million (€10.3 million). It was envisaged for around 47,500 persons to use grants for prevention and rehabilitation. The rehabilitation programme has a maximum duration of 10 days as NSSI assumes the cost of accommodation and partial support for food expenses up to BGN 7 (€3.58) per day-stay. The NSSI signed contracts with 18 entities for a total of 49 institutions implementing this programme. Entitled to this benefits are the socially insured for sickness, maternity and/or accident and occupational disease persons. They must have paid contributions for a period of six consecutive calendar months preceding the month before the start of rehabilitation. The persons should have a specified diagnosis by a certified physician, indicating the need for rehabilitation. Another eligible group is recipients of personal disability pension. The only condition for them is that their age is below the age of entitlement to old-age pension.

Formal/informal caregiving

Traditionally, long-term care for the elderly is provided as informal care by family members. There is little information about the number of people providing informal care, however, there is little doubt that the overwhelming bulk of long-term care is provided by informal carers in families.

As to formal care, in line with the national legislation, the Social Assistance Agency has established a public register of the private

providers of social services who are entitled to provide services on the territory of the Republic of Bulgaria. The information about all social services financed by the state budget is published on the official web page of the Social Assistance Agency and it is regularly updated.

The provision of LTC is still broadly considered to be a family matter. The cultural tradition in Bulgaria encourages care for elderly people to be provided by family members, who are not trained professionally, but accept that responsibility out of a sense of family duty. However, since 2012 trainings for professionalisation of care have been conducted under various schemes under the Operational Programme "Human Resources Development" (OP HRD), co-financed by EU and state funds.

Though informal care thus is of outmost importance, for a long time it has neither been legally recognised nor financially encouraged. Since 2003, informal carers can be financially supported under the National Programme "Assistants to people with disabilities" which provides home-based care (the service "personal assistant") to people with disabilities and lonely people with serious diseases. Under this Programme, managed by the Agency for Social Assistance, in 2017 the funding reached BGN 8.9 million and it provided employment for 2,450 previously unemployed persons.

Home-based services are provided also by private providers, as well as under EU co-funded projects of the Operational Programme "Human Resources and Development" (OP HRD). From the start of the OP HRD in 2007 the amount of funding for providing home-based social services exceeds BGN 458 million in total. In this regard, it should be noted that the service "personal assistant" was provided under the "New Opportunities for Care" project under the "New Alternatives" operation. The project was implemented by the Agency for Social Assistance in partnership with 264 municipalities and its implementation ended in February 2016. Project services were provided to: people with disabilities in difficulty or inability to self-service; people over 65 years in difficulty or inability to self-service; families of children with disabilities; lonely seriously ill persons. The project covered more than 15,600 service users supported by approximately 14,700 personal assistants.

The Operation "Independent living" supplements and upgrades measures financed under OP HRD (2007-2013) and OP HRD (2014-2020), through the implementation of an all-embracing approach at municipal level to provide hourly services to disabled people and the elderly who have difficulties for self-care. The implementation takes place in 260 municipalities and 33 districts (in Sofia Municipality, Varna Municipality and Plovdiv Municipality) for nearly 24,800 disabled persons, including children and persons over 65 who are unable to self-service, from 16,500 appointed personal assistants, social assistants and home helpers by the end of 2016.

Taking into account the real needs and significant contribution of social services to the home environment for the support of disabled and elderly people, the Council of Ministers adopted a Decree № 137 of 05.07.2017 approving changes in the 2017 budget programmes of the Ministry of Labour and Social Policies. The decree envisages additional funds for the provision of the social services "Personal assistant", "Social Assistant" and "Home Assistant", for more than 15,000 disabled persons and persons over 65 who are unable to self-care.

Recently legislated and/or planned policy reforms

A comprehensive reform in the area of social services sector is underway as part of the efforts to provide entirely new model of providing accessible, qualitative, effective and integrated social services to meet more adequately the needs of vulnerable persons. In the context of the current reform in March 2019 a Law on Social Services (the Social Services Act) was adopted by the National Assembly. It will partly enter in force in 2020 and fully in 2021. The relevant sub-legislative acts, which are necessary for its implementation will also be prepared. The main objective is to improve the regulatory framework in the field of social services with a view to improve the planning, management, financing, quality, effectiveness and monitoring of the social services.

Beginning of 2014, the Council of Ministers has adopted a National Strategy on long-term care. The current Plan for the Implementation of the National Strategy for Long-term Care refers to the period 2018-2021 ([448]). The main objective of the Strategy is to create conditions for independent and decent living of elderly and people with disabilities by providing quality, accessible and sustainable long-term care services according to their individual needs and achieving a better balance between the quality of the services and their effective and efficient delivery. A strong emphasis in the Strategy is also placed on the deinstitutionalisation of care for the disabled and the elderly, the development of home-based services and the support of families with increased responsibility for the care of dependent family members. The promotion of interaction between social and health services, including the development of innovative cross-sectoral services, as well as the implementation of an integrated approach are also among the priorities of the Strategy.

The strategy has the following objectives: 1) Developing a network for social services in the communities, tailored to the needs of the elderly and disabled people. Provision of both stationary and non-stationary social services close to and in home environment; 2) Adoption of a regulatory framework for a wide range of social services targeting vulnerable groups; 3) Ensuring sustainable financing of LTC services; 4) Improving coordination between the line institutions for LTC; 5) Phased restructuring of the system for inpatient treatment and active deinstitutionalisation.

In 2010, legislation for organising care in homes for medical and social care has been adopted. The aim was to implement continuous medical monitoring and specific care for individuals with chronic diseases, disabilities and social problems. However, so far there is no budget for financing these homes, such that for now these homes have not yet been established.

In order to address the challenge for more integrated health care and social services ([449]), in September 2015 the National Assembly adopted amendments to the Health Law to regulate the integrated approach. However, the regulatory framework of these amendments is not yet devised, and therefore their implementation has been considerably delayed. It is envisaged that the types of services, the conditions and the order for their provision, the criteria and the standards for the quality of these services and the procedures for implementation of the control over their compliance shall be regulated by an ordinance adopted by the Council of Ministers upon a proposal of the Minister of Health and the Minister of Labour and Social Policy.

Key measures for the realisation of the objectives of the national long-term care strategy, to be financed by the state and municipal budgets, as well as EU funds from the European Social Fund and European Regional Development Fund, are:

- Expanding access to social services, improvement of their quality and interaction between health, social and educational services.

- Deinstitutionalisation of the elderly and people with disabilities placed in institutions.

- The continued implementation of best practices for long-term care for mentally ill patients after their active psychiatric treatment and provision of adequate living conditions in the community through appropriate services and integrated cross-sectorial reintegration programs; The development and validation of a model for provision of long-term treatment and palliative care; The provision of home care for people with chronic diseases resulting in damage to critical functions (respiratory, neuromuscular, renal failure, etc.).

([448]) Plan for the Implementation of the National Strategy for Long-term Care (2018-2021), www.mlsp.government.bg/index.php?section=POLICIESI&lang=&I=280.

([449]) Integrated health and social services are activities through which medical and social service specialists provide healthcare and medical supervision and perform social work, including in home environments, to support children, pregnant women, people with disabilities and chronic conditions and aged people who need assistance in the performance of their daily activities. The services may be provided by municipalities, medical treatment facilities and the persons under Article 18(2) of the Law on Social Assistance.

- Provision of adequate training and supervision of personnel providing long term care services, creating a system of independent monitoring; developing social support services for dependent people; increase in the number of professionals providing long-term care for dependent elderly and disabled people at home and in the community.

- Increase in efficiency mechanisms for LTC services.

An Action Plan for the period 2018-2021 for the implementation of the National Long-Term Care Strategy has also been adopted by the Council of Ministers in January 2018. The Plan addresses the deinstitutionalisation of the care for elderly people and people with disabilities. The aim is to improve the conditions for independent and decent life of the elderly people and people with disabilities in the community by extending and improving the social services system, including services for social inclusion.

The main groups of measures in the Action Plan are as follows: providing support in home environment and in the community for people with disabilities and elderly people dependent on care; providing quality community-based social services for persons living in specialised institutions with poor living conditions and quality of care and closing of institutions; enhancing the effectiveness of the long-term care system; building the necessary infrastructure for providing social and integrated health and social services for people with disabilities and elderly people dependent on care.

The financing of the Action Plan will be implemented with funds from the state budget and EU funds from the Operational Programme "Regions in Growth" 2014-2020 and the Operational Programme "Human Resources Development" 2014-2020. The Plan envisages the set up of 100 new community-based social services for 2,140 users. Patronage care for disabled and elderly people dependent on care will be developed. It will provide mobile integrated health and social services on hourly basis. The provision of home-based social services will also continue with funds from the state budget. Over 30,000 people will be supported through patronage care and assistant services.

With regard to the quality of long-term care in January 2016 the National Assembly adopted amendments to the Social Assistance Act in order to guarantee better access to social services, including access to long-term care services; applying an individual approach and comprehensive needs' assessment; prevent permanent institutionalisation of vulnerable persons; higher efficiency of the social services; introducing judicial control during the process of placement of persons under full guardianship in community-based social services of residential type and in specialised institutions; facilitate the registration and licensing regimes for the providers of social services; and others.

The social services' reform, including the long-term care, is also supported by the implementation of the project "New Standards for Social Services". The project aims at improving the accessibility, effectiveness and the quality of social services as well as the deinstitutionalisation of the care for children and adults, including disabled people, by developing up-to-date quality standards and financing in line with the needs of the recipients. Within the project financial models for pricing the provision of social services are being developed, including for the long-term care services, as well as a model for financing the integrated cross-sectoral services. An important activity is the development of quality standards with objective and measurable criteria and indicators and a monitoring and control system of the services. Among the activities of the project is also the development of a model for planning of a minimum package of services at regional and municipal level, objective criteria for developing a needs' map and a map of services at the national level, as well as the development of the maps themselves. The implementation of the project activities will also assist the overall reform in the social services sector. The project should be completed by the end of 2019.

Challenges

Bulgaria has adopted a strategy for strengthening its long-term care system, and the implementation of the project has to be duly monitored. The main challenges of the system appear to be:

- **Improving the governance framework:** to set the public and private financing mix and organise formal workforce supply to face the growing number of dependents, and provide a strategy to deliver high-performing long-term care services to face the growing demand for LTC services; to strategically integrate medical and social services via such a legal framework; To define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to establish good information platforms for LTC users and providers; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; To deal with cost-shifting incentives across health and care.

- **Improving financing arrangements:** to face the increased LTC costs in the future e.g. to foster pre-funding elements, which implies setting aside some funds to pay for future obligations; to explore the potential of private LTC insurance as a supplementary financing tool.

- **Providing adequate levels of care to those in need of care:** to adapt and improve LTC coverage schemes, and the scope of coverage, that is, setting the types of services included into the coverage. To provide targeted benefits to those with highest LTC needs; to reduce the risk of impoverishment of recipients and informal carers.

- **Encouraging independent living:** to provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.

- **Ensuring availability of formal carers:** to determine current and future needs for qualified human resources and facilities for long-term care; to improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers.

- **Supporting family carers:** to establish policies for supporting informal carers, such as through, respite care, cash benefits paid to the care recipients, while ensuring that women are not encouraged to withdraw from the labour market for caring reasons.

- **Ensuring coordination and continuity of care:** to establish better co-ordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care co-ordination and the integration of health and care to facilitate care co-ordination.

- **To facilitate appropriate utilisation across health and long-term care:** to arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; to steer LTC users towards appropriate settings.

- **Improving value for money:** to invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; to invest in ICT as an important source of information, care management and coordination.

- **Prevention:** to promote healthy ageing and preventing physical and mental deterioration of people with chronic care; to employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.3.1: **Statistical Annex – Bulgaria**

GENERAL CONTEXT

GDP and Population	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
GDP, in billion euro, current prices	24	27	32	37	37	38	41	42	42	43	45	12,451	13,213	13,559	14,447
GDP per capita, PPS	11.6	11.7	11.8	11.7	10.7	11.2	11.2	11.4	11.4	12.0	12.5	26.8	28.1	28.0	29.6
Population, in millions	7.7	7.6	7.6	7.5	7.5	7.4	7.4	7.3	7.3	7.2	7.2	502	503	505	509
Public expenditure on long-term care (health)															
As % of GDP	0.1	0.0	0.0	:	:	:	:	:	0.0	0.0	:	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	:	:	:	:	0.2	0.2	0.2	264.1	283.2	352.1	373.6
As % of total government expenditure	0.2	0.1	0.1	:	:	:	:	:	0.0	0.0	:	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
Health status															
Life expectancy at birth for females	76.2	76.3	76.6	77.0	77.4	77.4	77.8	77.9	78.6	78.0	78.2	82.6	83.1	83.3	83.3
Life expectancy at birth for males	69.0	69.2	69.5	69.8	70.2	70.3	70.7	70.9	71.3	71.1	71.2	76.6	77.3	77.7	77.9
Healthy life years at birth for females	:	71.9	73.9	65.7	65.9	67.1	65.9	65.7	66.6	66.1	65.0	62.0	62.1	61.5	63.3
Healthy life years at birth for males	:	66.2	67.1	62.1	62.1	63.0	62.1	62.1	62.4	62.0	61.5	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	32.1	29.0	24.4	21.4	19.2	18.2	18.6	19.1	20.5	21.6	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	2.5	2.5	4.7	4.5	3.8	4.1	3.9	3.8	4.0	4.6	8.3	8.3	8.7	8.1

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	15	24	33	42	43	43	15	15	15	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	33	22	11	:	:	:	106	106	106	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	0.6	0.6	0.6	0.6	0.6	0.6	1.7	1.7	1.7	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
Providers															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.

Table 3.3.2: **Statistical Annex - continued – Bulgaria**

PROJECTIONS

Population	**2016**	**2020**	**2030**	**2040**	**2050**	**2060**	**2070**	**MS Change 2016-2070**	**EU Change 2016-2070**
Population projection in millions	7.1	6.9	6.4	5.9	5.5	5.2	4.9	-32%	2%
Dependency									
Number of dependents in millions	0.28	0.28	0.29	0.29	0.29	0.29	0.27	-3%	25%
Share of dependents, in %	3.9	4.1	4.5	4.9	5.2	5.5	5.6	43%	21%
Projected public expenditure on LTC as % of GDP									
AWG reference scenario	0.4	0.4	0.5	0.5	0.5	0.6	0.5	37%	73%
AWG risk scenario	0.4	0.4	0.5	0.7	0.8	1.1	1.4	244%	170%
Coverage									
Number of people receiving care in an institution	12,530	12,575	12,859	12,836	12,791	12,787	12,072	-4%	72%
Number of people receiving care at home	21,689	21,733	20,737	19,326	18,879	18,436	17,340	-20%	86%
Number of people receiving cash benefits	101,818	102,983	108,431	109,433	110,159	111,930	107,777	6%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	1.9	2.0	2.2	2.4	2.6	2.7	2.8	48%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	48.6	48.9	49.2	49.0	49.2	49.7	50.4	4%	33%
Composition of public expenditure and unit costs									
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	75.0	74.3	73.6	73.8	74.6	74.3	73.4	-2%	5%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	25.0	25.7	26.4	26.2	25.4	25.7	26.6	6%	-27%
Public spending on institutional care (% of tot. publ. spending LTC in-kind)	33.3	33.7	35.4	36.6	37.2	37.5	36.4	9%	0%
Public spending on home care (% of tot. publ. spending LTC in-kind)	66.7	66.3	64.6	63.4	62.8	62.5	63.6	-5%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	56.9	56.1	59.6	61.8	65.6	64.6	59.0	4%	10%
Unit costs of home care per recipient, as % of GDP per capita	65.8	63.9	67.4	70.9	74.9	74.7	72.0	9%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	7.0	7.0	7.2	7.0	7.0	6.8	6.6	-6%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).