Bulgaria

Health Care & Long-Term Care Systems

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Health care systems

1.3. BULGARIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

Bulgarian GDP per capita is currently one of the lowest in the EU with 12,800 PPS in 2014. The global financial and economic crisis has had a strong impact on the Bulgarian economy that resulted in a strong contraction of the economic growth. The recovery has been slow over 2010-13, reflecting partially global economic headwinds. Population was estimated at 7.3 million 2013. It has been decreasing in past years mainly to due emigration. According to Eurostat projections, total population is projected to decrease from around 7.2 million in 2015 to 5.5 million in 2060.

Total and public expenditure on health as % of GDP

Total expenditure ([53]) on health as a percentage of GDP (7.6% in 2013, latest available data) has remained stable over the last decade (from 7.6% in 2003) and is below the EU-average ([54]) of 10.1% in 2013. Throughout the last decade, public expenditure has decreased as % of GDP: from 4.7% in 2003 to 4.2% of GDP in 2011 (EU: 7.7% in 2013). Public spending as a share of GDP is one of the lowest in the EU.

When expressed in per capita terms, also total spending on health at 990 PPS in Bulgaria in 2013 was far below the EU average of 2,988 in 2013. So was public spending on health care: 587 PPS in 2013 vs. an average of 2,208 PPS in 2013. Overall, Bulgaria devotes relatively few resources to health care.

Expenditure projections and fiscal sustainability

As a consequence of population ageing, health care expenditure is projected to increase by 0.4 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 1.1 pps of GDP from now until 2060 (EU: 1.6) ([55]).

Despite the deficit in the structural primary balance and the debt to GDP ratio being on an increasing trend, no sustainability risks appear over the medium-term thanks to the very low starting level of the debt ratio. In the long-term, Bulgaria appears to be at medium risk because of the unfavourable initial budgetary position slightly compounded by the age-related expenditures on health care and long term care ([56]).

Health status

Life expectancy at birth (78.0 years for women and 71.1 years for men in 2014) is one of the lowest in the EU, while healthy life years (66.6 years for women and 62.4 years for men in 2013) are above the respective EU averages (83.6 and 78.1 years of life expectancy in 2014, 61.5 and 61.4 in 2013 for the healthy life years). Mortality rates, which are thought amenable if appropriate and timely care is delivered, are also high (391 in Bulgaria vs. 128 deaths in the EU per 100 000 inhabitants). The infant mortality rate of 7.3‰ is very high compared to the EU average of 3.7‰ in 2013, having gradually fallen over the last decade (from 12.3‰ in 2003).

As for the lifestyle of the Bulgarian population, the data indicates a high proportion of regular smokers (29.2% in 2008), being above the EU average of 22.0%. The proportion of the obese population is below EU level of 13.4% (EU: 15.5%), while the alcohol consumption is at EU level.

System characteristics

Overall description of the system

The health system is a system of compulsory health insurance with contributions from

([53]) 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 + HC.R.1.

([54]) 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.

([55]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([56]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

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 having 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 provides 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), while the structure of insured is as follows: 45% insured by the employer, 4% self-insured and approximately 44% insured by the state. 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.

The 2015 amendments to the Health Insurance Act (State Gazette, Vol. 72/18.09. 2015, Vol. 79/13.10.2015, Vol. 98/15.12.2015) led to recovery of the health insurance rights of 195,726 Bulgarian citizens for the second half of 2015.

All children aged 0-18 and all retired people have their health coverage provided by the state. 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 mln 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.

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 2013, public expenditure accounted for only 59.3% of total health expenditure (EU: 77.4%) and out-of-pocket expenditure was at the very high level of 39.6% 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 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 ([57]). Cost-sharing also applies to outpatient medicines, except for treatment of chronic diseases. A large number of patients report making informal payments ([58]).

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 hospitals to ask additional payments from mothers with 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.

A patient has the right for an elective hospital admission within two months. Patients who wish to pay for faster admission may do so, but this should not change the order of already planned admissions. The admission list of patients is published on the web site of the NHIF and monitored by the interested persons. Admissions are registered electronically vie eHealth tools by the NHIF and can be verified by the respective patient.

The ordinance 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 and after 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 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 subfields; health 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 2013, there were 398 practising physicians per 100 000 inhabitants, compared to 344 in EU. However, Bulgaria has a low number of general practitioners (63 per 100 000 inhabitants vs. 78 in 2013 in the EU). The number of nurses per 100 000 inhabitants (447 in 2013) is much below the EU average of 837. 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 profit from traveling to cities where access to care is easier.

Hospital care in Bulgaria is provided by public and private health establishments.

Similarly to the number of physicians, hospital capacity exceeds EU averages. In 2013, the number of acute care beds was 524 compared to 356 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.

([57]) According to the new text in the Health Social Insurance Act, Ar. 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.

([58]) 'Study on corruption in the healthcare sector', HOME/2011/ISEC/PR/047-A2, October 2013.

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 MoH 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, shall be defined in the National Framework Agreement for Medical Activities. In case such an agreement is not concluded the decision should be taken by the NHIF Supervisory Board.

A disproportionally high share of public health care spending is spent on inpatient curative and rehabilitative care (61% in Bulgaria in 2008 versus 35% in the EU in 2009 and 34% in the EU in 2013), while a low share of spending is allocated to outpatient care (12% in Bulgaria in 2008 versus 22% in the EU in 2009).

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 with 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

Medicines to be reimbursed by the NHIF are listed on the Positive Drug List, grouped under the anatomical-therapeutic-chemical code. The products included in the list are both trade names and international non-proprietary names (INN) by dosage forms and are reimbursed in 25-100%. Medicines on the list are reimbursed based on reference pricing (maximum value per unit of substance). An independent National Council for prices and Reimbursement decides on reimbursement. This body is under direct supervision of the Council of Ministers.

Bulgaria has no explicit legislation regarding generics, but has a policy to promote them. GPs may prescribe pharmaceuticals covered by the National Health Insurance Fund.

In 2015 the Ministry of Health adopted changes in the regulations on the pricing of medicines. The

new provisions are intended to limit the co-payment by patients to not more than 60% of the cost per package, based on the reference value of the medicinal product, which is the lowest value for the defined daily dose for a therapeutic course of treatment. This ensures that even if the patient is prescribed the most expensive product in the group, he/she will not pay more than 60% than he/she would have paid for the cheapest product (reference product).

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 for medicinal products. Health technology assessment is already a tool for decision-making. The 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. The HTA is carried out also in the event of inclusion in the positive drug list of new innovative medicinal products.

eHealth, Electronic Health Record

A system of accreditation of medical facilities is being 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 being established by an executive agency, responsible for developing uniform criteria for assessing the efficiency and effectiveness of health care services. 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 EU citizens who possess a European Health Insurance Card ([59]).

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 impatient 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 2014 the national assembly endorsed the National Health Strategy 2014-2020 (http://dv.parliament.bg/) and an action plan for its implementation. According to the strategy the main direction of government's policy is to increase the part of spending devoted to prevention. In early 2015 the government adopted the "Objectives for Health 2020". The document formulates national goals in the field of improving health status of 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 reduction of child mortality, the improvement of health status among economically active groups and an increase in life expectancy.

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.

([59]) Users may access this electronic service through the home page, located at: 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.

Recently legislated and/or planned policy reforms

As far as future strategic objectives are concerned, according to the National Health Care Strategy (2014-2020) there are eight basic priority areas guiding future health system change. These address the following areas: 1) Ensuring a reliable system of health provision and access to quality medical care and health services through better medical standards and life-long learning for health care personnel; 2) Introducing a single integrated information system through the development of eHealth; 3) Streamlining of financial management by integrating e-system of financial and non-financial reporting in real time is adopted by NHIF and all health providers contracted with NHIF; 4) Strengthening and modernising the system for emergency medical care, e.g. via raising salaries of the personnel, easy access to medical specialisation and establishing medical standards for good practices; 5) Regional policy with particular emphasis on supporting the medical facilities in remote and small regions of the country; 6) Effective functioning of the mother, child and school health. A special emphasis is laid on the health education at school and to the prevention services performed by the GPs; 7) Sustainable development of human resources with a focus on medical specialisation staff and continuous training; 8) Reorientation of the health system towards prevention and the prevention of socially significant diseases.

Recent reforms in the healthcare system envisage the splitting of the current coverage package into three packages — basic, additional and emergency. The reform officially establishes waiting lists and introduces the possibility for voluntary health insurance for those who do not want to wait for services provided under the additional package.

With the latest amendments to the law on medical treatment facilities from December 2015, the National Assembly adopted the National Health Map, which will determine and plan the needs of the population for health services access to outpatient and hospital care on geographical principles. The changes also provides for the formation of complex multidisciplinary centres for children with disabilities and chronic illnesses and people with rare diseases. Thus in the hospitals with active care these patients will be serviced in one place.

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

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 spreading coverage rights to the social groups previously excluded; improve regulation of the health services market to limit the size of informal health care payments and reduce the role of out-of-pocket payments in total expenditure as a highly regressive method of financing. These would contribute to reduce the inequalities in access to and quality of health care among social groups and regions.

- 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 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 1.3.1: **Statistical Annex – Bulgaria**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	19	21	24	27	33	37	37	38	41	42	42	9289	9800	9934
GDP per capita PPS (thousands)	10.7	11.1	11.4	11.8	12.1	12.1	11.1	11.3	11.0	11.2	11.3	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	6.4	7.3	6.9	6.8	7.0	6.7	-5.0	1.1	4.4	1.2	1.4	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	9.0	3.5	6.9	0.7	5.8	9.2	-1.5	6.0	6.3	-2.7	4.3	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	7.6	7.3	7.3	6.9	6.8	7.0	7.2	7.6	7.7	7.4	7.6	10.4	10.1	10.1
Total current as % of GDP	7.4	7.1	7.1	6.8	6.5	6.6	7.1	7.5	7.7	:	:	9.8	9.6	9.7
Total capital investment as % of GDP	0.2	0.2	0.2	0.1	0.3	0.4	0.2	0.0	0.1	:	:	0.6	0.5	0.5
Total per capita PPS	412	447	515	557	663	781	813	869	968	952	990	2828	2911	2995
Public as % of GDP	4.7	4.4	4.5	3.9	4.0	4.1	4.0	4.2	4.2	4.2	4.5	8.1	7.8	7.8
Public current as % of GDP	4.5	4.3	4.3	3.8	3.7	3.7	3.8	4.2	4.2	:	:	7.9	7.7	7.7
Public per capita PPS	240	253	291	296	334	457	405	457	529	536	587	2079	2218	2208
Public capital investment as % of GDP	0.2	0.2	0.2	0.1	0.3	0.4	0.2	0.0	0.1	:	:	0.2	0.2	0.1
Public as % total expenditure on health	62.1	60.7	60.9	57.0	58.3	58.5	55.3	55.7	54.7	56.3	59.3	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	13.6	13.5	12.9	11.6	10.5	11.7	10.1	12.6	12.6	12.9	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	:	:	77.0	77.0	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	38.1	39.2	38.9	42.7	42.6	42.6	44.4	43.1	44.5	42.5	39.6	14.1	14.4	14.1

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												**2009**	**2011**	**2013**
Population, current (millions)	7.7	7.7	7.7	7.6	7.6	7.5	7.5	7.4	7.4	7.3	7.3	502.1	504.5	506.6
Life expectancy at birth for females	75.9	76.2	76.2	76.3	76.6	77.0	77.4	77.4	77.8	77.9	78.6	82.6	83.1	83.3
Life expectancy at birth for males	68.9	69.0	69.0	69.2	69.5	69.8	70.2	70.3	70.7	70.9	71.3	76.6	77.3	77.8
Healthy life years at birth females	:	:	:	71.9	73.9	65.7	65.9	67.1	65.9	65.7	66.6	:	62.1	61.5
Healthy life years at birth males	:	:	:	66.2	67.1	62.1	62.1	63.0	62.1	62.1	62.4	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	204	194	210	210	209	201	189	191	364	391	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	12.3	11.6	10.4	9.7	9.2	8.6	9.0	9.4	8.5	7.8	7.3	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	2.70	2.66	2.87	2.64	2.54	2.72	:	:	:	:	:	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	0.00	0.00	0.00	0.00	0.00	:	:	:	:	:	0.18	0.18	0.19
Out-patient curative and rehabilitative care	1.07	1.00	0.97	0.87	0.84	0.82	:	:	:	:	:	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	2.73	2.54	2.44	2.49	2.29	2.33	:	:	:	:	:	1.60	1.55	1.44
Therapeutic appliances and other medical durables	0.11	0.13	0.08	0.11	0.17	0.10	:	:	:	:	:	0.31	0.31	0.32
Prevention and public health services	0.26	0.28	0.22	0.24	0.26	0.29	0.25	0.32	0.29	:	:	0.25	0.25	0.24
Health administration and health insurance	0.10	0.09	0.10	0.10	0.08	0.07	0.10	0.10	0.15	:	:	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	2.49	2.38	2.51	2.23	2.15	2.27	:	:	:	:	:	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	:	0.00	0.00	0.00	0.00	:	:	:	:	:	0.16	0.16	0.18
Out-patient curative and rehabilitative care	0.59	0.59	0.56	0.49	0.47	0.46	:	:	:	:	:	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	0.74	0.60	0.54	0.52	0.47	0.43	:	:	:	:	:	0.79	1.07	0.96
Therapeutic appliances and other medical durables	0.02	0.01	0.00	0.00	0.00	0.00	:	:	:	:	:	0.13	0.12	0.13
Prevention and public health services	0.26	0.26	0.20	0.21	0.24	0.27	0.23	0.28	0.27	:	:	0.25	0.20	0.19
Health administration and health insurance	0.10	0.10	0.11	0.10	0.07	0.07	0.09	0.09	0.14	:	:	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.3.2: **Statistical Annex - continued – Bulgaria**

												EU- latest national data		
Composition of total as % of total current health expenditure	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	36.6%	37.3%	40.3%	39.1%	39.1%	41.2%	:	:	:	:	:	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	0.0%	0.0%	0.0%	0.0%	0.0%	:	:	:	:	:	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	14.5%	14.0%	13.6%	12.9%	12.9%	12.4%	:	:	:	:	:	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	37.0%	35.6%	34.3%	36.8%	35.2%	35.3%	:	:	:	:	:	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	1.5%	1.8%	1.1%	1.6%	2.6%	1.5%	:	:	:	:	:	3.2%	3.3%	3.3%
Prevention and public health services	3.5%	3.9%	3.1%	3.6%	4.0%	4.4%	3.5%	4.2%	3.8%	:	:	2.6%	2.6%	2.5%
Health administration and health insurance	1.4%	1.3%	1.4%	1.5%	1.2%	1.1%	1.4%	1.3%	2.0%	:	:	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	55.5%	55.9%	58.8%	58.8%	58.9%	61.2%	:	:	:	:	:	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	:	0.0%	0.0%	0.0%	0.0%	:	:	:	:	:	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	13.1%	13.8%	13.1%	12.9%	12.9%	12.4%	:	:	:	:	:	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	16.5%	14.1%	12.6%	13.7%	12.9%	11.6%	:	:	:	:	:	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	0.4%	0.2%	0.0%	0.0%	0.0%	0.0%	:	:	:	:	:	1.6%	1.6%	1.6%
Prevention and public health services	5.8%	6.1%	4.7%	5.5%	6.6%	7.3%	6.0%	6.7%	6.5%	:	:	3.2%	2.7%	2.5%
Health administration and health insurance	2.3%	2.4%	2.6%	2.6%	1.9%	1.8%	2.4%	2.2%	3.4%	:	:	1.4%	3.5%	3.5%

												EU- latest national data		
Expenditure drivers (technology, life style)	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
MRI units per 100 000 inhabitants	:	:	0.27	0.31	0.31	0.31	0.40	0.42	0.63	0.74	0.73	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	0.6	0.6	0.7	0.7	:	:	1.0	1.0	1.1	0.9	0.9	0.8
CTS per 100 000 inhabitants	:	:	1.6	1.7	1.9	2.2	2.7	3.0	2.9	3.2	3.4	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	:	:	:	:	:	:	:	:	0.0	0.0	0.0	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	:	11.5	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	:	:	:	39.7	29.2	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	10.6	10.6	10.1	10.0	10.2	10.5	10.2	10.2	9.7	:	:	10.3	10.0	9.8

Providers	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Practising physicians per 100 000 inhabitants	360	352	364	365	364	360	369	375	386	391	398	329	335	344
Practising nurses per 100 000 inhabitants	379	383	404	410	421	424	421	426	430	439	447	840	812	837
General practitioners per 100 000 inhabitants	69	69	68	67	65	63	65	64	64	67	63	:	78	78.3
Acute hospital beds per 100 000 inhabitants	483	470	491	475	489	499	508	508	499	511	524	373	360	356

Outputs	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Doctors consultations per capita	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	:	:	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	:	:	19.9	20.0	20.9	21.7	23.4	25.0	26.1	27.3	30.0	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	:	:	:	:	:	:	:	:	:	:	:	6368	6530	7031
Acute care bed occupancy rates	:	:	:	:	:	:	70.1	:	:	:	:	72.0	73.1	70.2
Hospital curative average length of stay	:	:	:	:	:	:	:	:	:	:	:	6.5	6.3	6.3
Day cases as % of all hospital discharges	:	:	:	:	:	:	:	:	:	:	:	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060**	**EU Change 2013 - 2060**
AWG reference scenario	4.0	4.2	4.4	4.5	4.5	4.4	0.4	0.9
AWG risk scenario	4.0	4.5	4.9	5.2	5.3	5.2	1.1	1.6

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

Population projections	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**Change 2013 - 2060, in %**	**EU - Change 2013 - 2060, in %**
Population projections until 2060 (millions)	7.3	7.0	6.5	6.1	5.8	5.5	-24.8	3.1

Sources: EUROSTAT, OECD and WHO

Bulgaria

Long-term care systems

2.3. BULGARIA

General context: expenditure, fiscal sustainability and demographic trends

GDP per capita in PPS is at 12,800 and around half of the EU average of 27,500 in 2014. Bulgaria has a population of 7.3 million inhabitants. During the coming decennia the population will steadily decrease, from 7.3 million inhabitants in 2015 to 5.5 million inhabitants in 2060. Thus, in Bulgaria the population is expected to decrease by 25%, while it is expected to increase at the EU level by 3%.

Health status

Life expectancy at birth (78.0 years for women and 71.1 years for men in 2014) are one of the lowest in the EU, while healthy life years (66.6 years for women and 62.4 years for men in 2013) are above the respective EU-averages (83.6 and 78.1 years of life expectancy in 2014, 61.5 and 61.4 in 2013 for the healthy life years). The percentage of the Bulgarian population having a long-standing illness or health problem is considerably lower than in the Union (21.2% in Bulgaria versus 36.4% in the EU in 2014). In 2014 the percentage of the population indicating a self-perceived severe limitation in its daily activities stands at 4.0%, which is lower than the EU-average of 8.6%.

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 strong limitations due to health problems in 2013, an increase of 16% is envisaged until 2060 to 320 thousand. That is a less steep increase than in the EU as a whole (40%). However, due to the population decline, as a share of the population, in the period 2013-2060, the dependents are becoming a bigger group, from 3.9% to 5.9%, an increase of 54%. This is more than the EU-average increase of 36%.

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 0.2 pps of GDP in Bulgaria by 2060.([352]) 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 2.5 pps of GDP in Bulgaria by 2060. 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.

In the long-term, Bulgaria has some fiscal sustainability risks because of the unfavourable initial budgetary position slightly compounded by the age-related expenditures on health care and long term care. ([353])

System Characteristics

Currently, medical and social services are regulated by different bodies and legislation. Depending on the specific case, LTC is provided by the state, the municipal authorities and private providers via social insurance and social welfare. In order to address the challenge for more integrated health-social services ([354]), in September 2015 the National Assembly adopted amendments to the Health Law, which regulate the integrated approach there. The regulatory framework to settle their provision is currently under preparation. The types of services and the conditions and procedure for their provision, as well as the criteria and standards concerning their quality and the procedure of controlling their observance, shall be regulated by an Ordinance adopted by the Council of Ministers upon a

([352]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf

([353]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf

([354]) 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.

proposal by the Minister of Health and the Minister of Labour and Social Policy.

As mentioned above LTC is provided under different legislative acts. Cash benefits are provided to children with disabilities under the Law on Family Allowance - monthly benefit for raising a child with permanent disabilities (paid until the child reaches the age of 2 years), monthly benefit for a child with a permanent disability until graduation from high school, but not after the age of 20, and monthly supplement for children up to 18 years of age with permanent disability. In addition, all family allowances are provided to children with disabilities regardless of the family income. People with disabilities are supported financially under the law on the integration of persons with disabilities and the law on social assistance. They are entitled to a monthly social integration supplements and monthly social benefits.

Organisationally, many LTC services are also provided in acute hospitals, which may be cost-inefficient. Because of lacking data, the involvement of the health care sector proper in providing LTC services is difficult to delineate.

The financial resources for LTC services are provided from the state budget, the local budgets, by registered private providers, as well as under various projects on national and international programmes. In recent years, the system for LTC has 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.

In 2010, legislation for organising care in homes for medical and social care has been adopted. The aim is 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.

Once placed in residential institutions, the recipients of care must pay a fee for their stay. In most cases, the amount of this fee is 70% of the monthly income received, but not higher than the actual monthly expenditure for the service provided. The amount of the fees for community-based social services, including services of residential type is significantly lower. Persons with no income and bank savings do not pay fee.

Public spending on LTC was at the level of 0.4% of GDP in 2013 in Bulgaria, much below EU average of 1.6% of GDP. According to the 2015 Ageing Report, in 2013 100% of this expenditure was spent on in-kind benefits (EU: 80%), while 0% was provided via cash-benefits (EU: 20%).

Private co-payments for formal in-kind LTC services can be significant. For example a person that is enrolled in a public facility for elderly care needs to transfer it 70% of his/her retirement income, but not higher than the actual monthly expenditure for the service provided.

In the EU, 30% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 43% higher in Bulgaria. Overall, in 2013 1.7% of Bulgarian population receives formal LTC in-kind and/or cash benefits (EU: 4.2%). 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 2013 the expenditure for institutional (in-kind) services makes up 31.3% of public in-kind expenditure (EU: 60%). Thus, relative to other Member States Bulgaria has a very strong focus on institutional care, which may be cost-inefficient. Taking this into account, developing of community-based social services to prevent institutionalisation and to meet the growing needs for long-term care services is among the key policy priorities. As part of the efforts to prevent institutionalisation of elderly people and people with disabilities, social services in specialised institutions are provided only if all other options prove inadequate for providing social services in the community. The following data clearly shows that: as of the end of 2014 the number of community-based social services for elderly people and people with disabilities was 440 while at the end of 2015 it reaches 482 with total capacity of 9,205 places. The number of

specialised institutions remains the same, but the trend is related to significant reduction of their capacity.

Regarding the financial support for provision of social services, the funds provided by the State for community-based social services for children and adults, as activities delegated by the State (approximately BGN 113.6 million), are significantly higher than those provided by the specialised institutions (BGN 86.9 million). In addition, since 1 of 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.

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.

In 2016, besides the clinical pathway “palliative care”, three clinical pathways (CPs) for long term care will be included in the scope of the activities for hospital care paid by the NHIF, namely: CP "Continuous treatment and early rehabilitation after acute stage of ischemic and haemorrhagic stroke with residual health problems", CP "Continuous treatment and early rehabilitation after myocardial infarction and after cardiac interventions" and CP "Continuous treatment and early rehabilitation after surgery with large and very large volume and complexity of residual health problems".

These CPs cover the traditionally existing need to carry out this activity in the relevant conditions and its payment with public funds. Health care activities are included as a specific activity across all clinical pathways and clinical procedures and provided by health care professionals during the hospital treatment. They are included as part of the overall complex of medical activities, including those related to diagnostics, treatment and rehabilitation.

Types of care

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+). 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.

As part of the implementation of the "Concept of Deinstitutionalisation and Prevention of Social Exclusion of People Living in Institutions", the Agency for Social Assistance has developed a plan for reforming the specialised institutions for elderly people and people with disabilities 2010-2011, which outlines concrete measures and activities for the reform of 14 specialised institutions for adults with disabilities. In 2011, 12 specialised institutions were abandoned and 28 new community based services of residential type were established. 150 people were deinstitutionalised and accommodated in community based social services of residential type. As of July 2012, the number of specialised institutions is 163 with a capacity of 11,326 places. As of December 2015 the number of the specialised institutions is 160, with total capacity of 10 990 places. To ensure that the government is continuing its efforts toward implementation of deinstitutionalisation process an action plan for the implementation of the national strategy for long-term care is to be developed.

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 Integration Centres, Protected Housing), as well as the further development of the model for services provided at home (personal assistants, social assistants, domestic assistants, domestic social patronage, public canteens). In July 2012, the number of community based social services for elderly people was 370 with a capacity of 8,043 places. As of December 2015 the number of community-based social services for elderly and people with disabilities reaches 482 with total capacity of 9 205 places.

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

Eligibility is based on a needs' assessment which is performed by the local authority together with the

"Agency for Social Assistance". According to the latest amendments to the law on social assistance (adopted by the National Assembly in January 2015) social services are provided on the basis of an individual support needs assessment and an individual support plan developed by a multi-disciplinary team. The purpose of the introduction of the multi-disciplinary assessment teams is to allow involvement of various professionals with specific knowledge and experience. 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 and they are nation-wide and binding. These may include the applicant's income, property status, family status, potential care providers (friends or relatives), type and severity of disability, etc.

The family physician is 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 family doctor. 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 to be mentioned. The responsible partners for the prevention of the long-term conditions and diseases are general practitioners. The National Health Insurance Fund pays the medical rehabilitation of all persons no matter whether are of working age or above, as long as there are medical indications. 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, and some of them have contracts with the National Social Security Institute (NSSI). A significant part of the funds for rehabilitation are provided by the healthcare system.

Another source for prevention and rehabilitation is the National Social Security Institute (NSSI). The funds that are provided for this initiative are defined in the law on social security budget and for 2015 amount to BGN 14.2 million (EUR 7.3 million). It is envisaged that 40 000 persons can use grants for prevention and rehabilitation.

The program has a maximum duration of 10 days as NSSI assumes the cost of accommodation and partially supports for food expenses up to BGN 5 (EUR 2.56) per day-stay. Any person that is socially insured has the right to obtain up to four basic diagnostic and therapeutic procedures daily. The NSSI signed contracts with 14 entities for a total of 43 institutions implementing this program. 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

There is no established information system collecting data on formal carers providing long-term care. There is even less information about the number of people providing informal care. But there is little doubt that the overwhelming bulk of LTC is provided by informal carers in families.

The cultural traditions in Bulgaria encourage 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. The provision of LTC is considered to be a family matter. It should be noted that since 2012 up to now trainings for professionalisation of care have been conducted under various schemes under OP "Human Resources Development" (OP HRD).

Though informal care thus is of outmost importance it has so far neither been legally

recognised or financially encouraged within the system of LTC services. The informal carers can be supported financially under the National Programme "Assistants to people with disabilities" which provides home-based care (the service "Personal assistant") to people with disabilities and seriously diseased lonely people by ensuring employment for unemployed people as personal and social assistants (the responsible body is the Agency for Social Assistance).

Home-based services are provided also by private providers, as well as under the OP HRD projects. 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 project "New Opportunities for Care" will be upgraded through the "Independent Living" scheme which has already been launched under OP HRD 2014-2020. Under the scheme, all municipalities on the territory of the Republic of Bulgaria can apply with projects aimed at facilitating access to healthcare services and development of community-based social services for social inclusion of people with disabilities, as well as facilitating their access to employment. A total of 16 000 persons with disabilities and persons over 65 years in inability to self-service are expected to be supported under the scheme.

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 models of integrated health-social services to meet more adequately the needs of vulnerable persons. In the context of the current reform a law on social services is being developed. 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 and effectiveness of the social services.

Beginning 2014, the Council of Ministers has adopted a National Strategy on long-term care. 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.

Key measures for the realisation of the objectives in the field of long-term care policy are:

1. Expanding access to social services, improvement of their quality and interaction between health, social and educational services: This includes the construction of an adequate network of social services in the communities and in home environment (new services in the community and at home, including provision hourly services to support social inclusion) and uniform distribution throughout the country; the development of innovative cross-cutting services for the elderly and people with disabilities, including rehabilitation, occupational therapy and lifelong learning; the development and maintenance of a map of long term care services in Bulgaria; the development and improvement of standards for the provision of long term care services; the construction of structures for integrated home care for the elderly.

2. Regarding the deinstitutionalisation of the elderly and people with disabilities placed in institutions: An assessment of the needs of each person and determination of the need for support, by applying an individual approach; Preventing the risk of institutionalisation by providing alternative services in the community and to ensure the active participation of the person in this process; Restructuring and phased closure of institutions.

3. Regarding the promotion process of long-term care: 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.).

4. Regarding support for individuals and professionals who care for the elderly and people with disabilities several measures are in consideration: The provision of adequate training and supervision of personnel providing long term care services depending on the specific needs of the target groups, creating a system of independent monitoring; The development of forms of social support services for dependent family members - Increase in the number of professionals providing long-term care for sick elderly and disabled people in the home and community.

5. Regarding the increase in efficiency and improvement in funding mechanisms for LTC services: Encouraging providers to create services with their own funds; Application of the principle "money follows the client"; Analysis and assessment of the role of the social security system for funding and ensuring sustainability of long term care system for the elderly and people with disabilities; Increasing the capacity of local organisations to provide services for long term care and promote public-private partnerships; Promotion of entrepreneurship in the social sector and the involvement of all stakeholders, including businesses and service providers from the private sector in the development and delivery of innovative and alternative services.

Financing from the state and municipal budgets shall to achieve the goals objectives of the strategy, as well as funds from the European Social Fund and European Regional Development Fund. Additionally, some new arrangements, will be approved in the parameters of the medium-term forecast of the state budget and the budgets of municipalities.

For the implementation of the National Strategy on long-term care an action plan is about to be developed, containing all measures and concrete projects in order to reform and modernise the system of long-term care.

Furthermore, in the context of the ongoing social services reform the efforts are directed toward providing entirely new models of integrated health-social services to meet more adequately the needs of vulnerable persons. In this context the latest amendments to the Health Law, adopted by the National Assembly in September 2015, regulates the integrated health-social services. The regulatory framework to settle their provision is currently under preparation. In addition, as mentioned above, amendments to the Law on Social Assistance were adopted by the National Assembly in January 2016 in order to provide better access, individual approach and efficiency of the social services. A special Law on Social Services is currently being developed with the participation of all stakeholders in order to address adequately all challenges in this sector. 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 and effectiveness of the social services.

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 flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and 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 2.3.1: **Statistical Annex – Bulgaria**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	19	21	24	27	33	37	37	38	41	42	42	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	10.7	11.1	11.4	11.8	12.1	12.1	11.1	11.3	11.0	11.2	11.3	26.8	27.6	28.0	28.1	27.9
Population, in millions	7.8	7.7	7.7	7.6	7.6	7.5	7.5	7.4	7.4	7.3	7.3	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	0.0	0.1	0.2	0.0	0.0	:	:	:	:	:	:	1.0	1.0	1.0	1.0	:
Per capita PPS	1.0	8.3	12.4	1.3	1.5	0.0	:	:	:	:	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	0.3	0.4	0.1	0.1	:	:	:	:	:	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	75.9	76.2	76.2	76.3	76.6	77.0	77.4	77.4	77.8	77.9	78.6	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	68.9	69.0	69.0	69.2	69.5	69.8	70.2	70.3	70.7	70.9	71.3	76.6	76.9	77.3	77.4	77.8
Healthy life years at birth for females	:	:	:	71.9	73.9	65.7	65.9	67.1	65.9	65.7	66.6	:	62.6	62.1	62.1	61.5
Healthy life years at birth for males	:	:	:	66.2	67.1	62.1	62.1	63.0	62.1	62.1	62.4	:	61.8	61.7	61.5	61.4
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	:	31.4	31.8	31.5	32.5
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	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	15	24	33	42	43	43	15	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	33	22	11	:	:	:	106	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	0.6	0.6	0.6	0.6	0.6	0.6	1.7	2.0	2.2	2.2	2.3	2.1
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 2.3.2: **Statistical Annex - continued – Bulgaria**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	7.3	7.0	6.5	6.1	5.8	5.5	-25%	3%
Dependency								
Number of dependents in millions	0.28	0.29	0.30	0.31	0.32	0.32	16%	40%
Share of dependents, in %	3.9	4.2	4.7	5.2	5.6	5.9	54%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	0.4	0.4	0.4	0.5	0.5	0.6	42%	40%
AWG risk scenario	0.4	0.5	0.7	1.0	1.7	2.9	622%	149%
Coverage								
Number of people receiving care in an institution	15,224	16,264	16,470	17,426	18,206	19,009	25%	79%
Number of people receiving care at home	106,284	108,536	111,471	112,115	112,470	113,813	7%	78%
Number of people receiving cash benefits	0	0	0	0	0	0	:	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	1.7	1.8	2.0	2.1	2.3	2.4	45%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	43.4	43.0	42.5	41.3	40.8	41.1	-5%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	100.0	100.0	100.0	100.0	100.0	100.0	0%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	0.0	0.0	0.0	0.0	0.0	0.0	:	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	31.3	31.1	29.4	28.7	28.0	26.1	-16%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	68.8	68.9	70.6	71.3	72.0	73.9	7%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	60.3	54.5	51.0	48.5	47.9	43.1	-28%	-2%
Unit costs of home care per recipient, as % of GDP per capita	19.0	18.1	18.1	18.7	20.0	20.4	7%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	:	:	:	:	:	:	:	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)".