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Management Aspects of the Bulgarian Health Care Reform

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1. INTRODUCTION

1.1 Background

Since the recent political changes, most countries in Central and Eastern Europe are in a transition period towards new societal structures including a new approach to health care. The problems and opportunities of this transition have been described in many publications and will not be repeated here. Multilateral and bilateral international aid has become available to the countries in Central and Eastern Europe for the reform process.

The Republic of Bulgaria and the PHARE programme of the European Union have agreed to implement a number of projects in the field of health care reform. The PHARE project of which one activity is presented in this report is called the 'Support to the creation and introduction of a health insurance system in Bulgaria'. Other PHARE projects are for example concerned with the training of general practitioners and with the modernization of hospital management.

During the first phase of the health insurance project, methodologies have been developed to determine the costs of detailed activities of hospital care, and to relate these costs to an information system providing data on the duration, intensity and outcome of treatment for specific medical diagnoses. Also a Law on Health Insurance has been drafted and presented to Parliament.

The five objectives of the second phase of this project (1995-1996) are:

1 the testing and implementing of various payment systems (also in ambulatory care) in the two pilot districts of Smolyan and Gabrovo;
2 the testing and implementing of the new information methodology in the two pilot districts;
3 proposing options for health care management on the basis of an analysis of the existing situation;
4 training staff for new activities in health care management including information systems and financial management;
5 polling a sample of the Bulgarian people and the Bulgarian health care professionals about their ideas concerning the above-mentioned health care reform.

The Dutch public health research and consultancy organisation 'TNO Prevention & Health' has been selected to provide technical assistance for objectives 3-5.

Since June 1995, the project has been overseen by a Steering Committee chaired by the Minister of Health, Dr. M. Vitkova. Bulgarian organisations charged with the implementation of the project are the Centre for Financial and Managerial Technologies of Health Care (director: Dr. D. Iliev) and

the National Centre of Health Informatics (director: Mr. C. Griva). The leader of the project is Prof. J. Jantschulev.

For political reasons the choice for social health insurance or another financing system (or indeed management system) for Bulgarian health care has not yet been made. Up to a certain point, phase two of this PHARE project can continue its activities, but at some stage in the near future the policy decisions concerning health management and health financing should become clear before the project can be completed. This is exactly what is covered by the third objective of the project. The authors of this report hope that this report can help in preparing and taking these policy decisions. One could consider changing the name of the project into the more general 'Bulgarian health management and financing project'.
We realise that this PHARE project is only one of several involved in health care reform in Bulgaria. The Ministry of Health is pursuing its own course in the preparation of the health care reform, in cooperation with the European Union, the World Health Organisation, the World Bank and other agencies and countries. We have tried as much as possible to be well-informed about the progress in this field. We have consulted numerous Bulgarian and foreign counterparts and other experts, too many to mention them here by name. We want to thank them for their cooperation and patience. Obviously, the responsibility for the report is ours alone.

An important simultaneous development is the preparation of a strategy document called 'Health for the nation' by the Ministry of Health. A first unedited draft of this document became available on the 31st of August 1995. We have made use of it while writing this report. Although the emphasis of 'Health for the nation' is on health policy (see § 1.2), it also contains chapters on health care management and data on the size and activities of the health care infrastructure.

1.2 Objectives of this report

The general objective of this report is to assist Bulgarian policy makers in their decision-making concerning health care reform, especially the management and financing aspects of this reform. In this framework, the report is the background document for a workshop to be organised in Sofia in November 1995. The aim of this workshop is to discuss the various options available to the Bulgarian authorities to reorganise a number of aspects of the health care system. The options are based on the analysis of the existing Bulgarian health care system. The analysis puts the emphasis

on management and financing aspects and not on epidemiological or statistical data. When we do use statistical data - e.g. on the number of health care facilities - these data are the most recent ones we could find, usually 1993 or 1994. The 1994 data are sometimes still provisional.
The report barely touches on *health policy*, i.e. the endeavour to improve the health status of the Bulgarian people by modifying the so-called health determinants such as life style and the physical and psychosocial environment. The presence of high-quality health services is also a health determinant, but further improvement of these health services will have less influence on the future health status of the Bulgarian people than for example curbing the smoking epidemic. Health policy is undoubtedly the other pillar of the Bulgarian health care reform, but as such is the subject neither of this report nor of the project which both are primarily concerned with health services management and financing. However, the discussion of the management of preventive health care is included, covering health education as an important aspect of health policy.

It should be clear what is meant by management and system in this report. Literature about management could fill a whole library and even the specialty of health care management has been described extensively. In its simplest form, management is the methodology by which the managers assure that others do what is expected from them in order to reach a common objective. 'Organisation' is sometimes used more or less as an equivalent of 'management', also by us, although this is not entirely correct. In fact, the term management puts the emphasis more on the steering process, whereas the term organisation is used less in connection with the objectives to be reached and more on the relations between the various parties involved. We prefer not to put too much emphasis on these semantic differences.
In health care management, those in the position of managers must make sure that the health care professionals (physicians, nurses, laboratory technicians, etc.) and the supporting staff (administrative personnel, engineers, drivers, cooks, etc.) achieve what is commonly regarded as the goal of good health care: affordable and accessible health care services of good quality, i.e. with a proven effectiveness for promoting and restoring health and appreciated by the population.
A system consists of various parts that are related to each other, with varying degrees of hierarchy and autonomy. It is obvious that the health care system is a real system: it consists of many parts that cannot function without each other. Different types of professionals and different types of facilities have to cooperate for the common goal. In order to manage such a complicated system, health care managers are needed at various levels, e.g. the national level, the local level and the level of the health care facility. Those managers use a number of management tools, such as planning techniques, directives (laws, orders, guidelines), the movement of personnel and the

control of funds. For planning and evaluation, managers need data that must be supplied by reliable management information systems. Without always giving details about these managerial tools when describing the system, the reader will find them throughout the text.
In this report, the Bulgarian health care system will be described, with the (mostly hierarchical) relations that exist between the various parts of the system, the management methods that are used to keep the system going, the bottlenecks that thereby arise and possible ways to improve the organisation of the system.

1.3 Description of the report

After this introductory chapter, chapters 2 and 3 of the report describe health care management at national and local level as it exists today. The description is given without comment as to the appropriateness of the present structures. Our conclusions arising from the analysis are presented in chapter 4, the link between the analysis and the description of alternative policy options available to the Bulgarian authorities and especially the Ministry of Health.
The presentation of different policy options in chapter 6 and chapter 7 is preceded by chapter 5 which explains the methodology used in the next two chapters and connects this exercise to the effort of the Ministry of Health to formulate a strategy document called 'Health for the nation'.

Important remark:
In section 5.4, we make suggestions for the use of this report. Those who are familiar with the Bulgarian health care system can skip chapters 2 and 3 and go directly to chapter 4. The options presented in chapters 6 and 7 cannot be discussed completely during one workshop. For the workshop in November 1995, we therefore have chosen two key areas of health care reform from chapter 7 only and the options available for these areas. The description of the other subjects and options can be used in the regular process of policy development by the Ministry of Health.

In chapter 6 and chapter 7 we present the options for the Bulgarian health care reform with their implications, advantages and disadvantages. Some choices seem rather obvious, other options are real alternatives. There are usually several options for each aspect of the health care system and health care management discussed in this report, including the option *not* to change the present situation or even the option *not* to take a decision.

The options are divided in two areas: the nature (type, content) of health care will be discussed in chapter 6 and the organisation (management) of health care in chapter 7. These two areas are related but also to a large extent independent of each other, which can be illustrated with an example. The introduction of strong general practice with a scientific basis as it exists in some western countries will thoroughly modify the nature of Bulgarian health care. General practice could, however, be equally well organised in two totally different management situations: in a budget-controlled state system such as exists in Bulgaria today or in a system of private practices financed by insurance payments.

To improve readability, the information in this report has been kept to the essentials and references are not presented in the text. The literature that we have used is mentioned at the end of the main text.

2. PRESENT HEALTH CARE MANAGEMENT AT THE NATIONAL LEVEL

2.1 Legal framework

2.1.1 Introduction

In this section, we present a short description of the most important laws governing Bulgarian health care. These are the Constitution, the Public Health Law (which has been amended in the last few years and will be amended again later in 1995), the Law on Self Government and Local Administration and the annual Budget Laws. We also give a synopsis of the recent Law on Pharmaceutical Products and Pharmacies. For more information than presented here the reader should consult the official legal texts.

We also describe the key elements of two draft laws relevant for our project. The first one is the Draft Law on Health Insurance, although it is not sure if this law will be passed. The second one is the Draft Law for the Social Insurance Fund which was proposed more recently. Other draft legislation in the field of or related to health care will not be described here. It would be useful, however, if an overview of such draft legislation would be available in the Ministry of Health.

2.1.2 Constitution

According to article 52 of the Constitution of 1991, 'Citizens are entitled to health care which shall guarantee accessible medical aid and to free medical care in accordance with provisions and procedures defined by law. The health care of the citizens shall be financed from the state budget, employers, personal or joint insurance payments and other sources in accordance with provisions and procedures defined by law.'

2.1.3 Public Health Law

The Public Health Law lays down the main principles of the Bulgarian health care system. Seen from the point of view of the management of the system, the following principles are relevant.

Every citizen is entitled to health care, free of charge, to be provided by the public institutions. The State guarantees the quality of health care and for this purpose the necessary institutions will be created by the Ministry of Health, the Medical Faculties, the municipal councils and the Ministries of the Interior, Transport and Defence (the latter including the so-called Building Troops).

The Ministry of Health, advised by the Higher Medical Council, sets the organisational, methodological and scientific policy for the health care institutions on the national and municipal levels, especially concerning the planning, organisation and coordination of the health care to be delivered, the volume of the activities of the health care institutions and the number, specialty and qualification of the medical and other personnel. The Ministry of Health is not responsible for the management of the health care establishments belonging to other ministries; it plays, however, a certain role concerning the policy and technical aspects of these establishments.

The institutions at the municipal level are placed under the double supervision of the municipal council and the Ministry of Health. The municipal councils are responsible for the management of the institutions at the municipal level and for the development of health care and its physical infrastructure on their territories, State establishments excepted.

The Public Health Law establishes within the Ministry of Health the Higher Medical Council. This advisory body is composed of 20 representatives of the Ministry, the medical associations and the medical faculties.

The Ministry of Health, in cooperation with the Ministry of Labour and the trade unions, elaborates the principles and criteria of the human resources needed in the health care sector.

The Ministry of Health, in cooperation with the other actors in the field of health care including the population itself, is responsible for the development of health policy, e.g. concerning the control of infectious diseases and other health promotion and health protection activities. Special programmes are concerned with mother and child care, occupational health care, AIDS, sports, alcohol and drugs, etc.

The Ministry of Health is responsible for the public health situation and the quality of health care. The Chief State Sanitary Inspector is charged with the implementation of direct inspection. The

State Inspectorate has an advisory role via an obligatory representation in several expert committees at national and local level.

In 1991 the Public Health Law was amended to allow the establishment of private practice. The law sets the conditions of required professional qualifications, a permit by the State sanitary control organisation, positive advice by the professional organisation and registration with the municipal authorities.
The establishment of a private facility needs the approval of the Minister of Health. There are several conditions for obtaining this approval, one of them being positive advice by the Higher Medical Council and the Bulgarian Medical Association.
A private facility can be ordered closed by the Minister of Health, on a proposal of the Higher Medical Council. The local professional organisations must be asked to give an opinion. The legal title for closure is the non-fulfilment of the conditions set with the approval and the obvious fact that the facility cannot guarantee adequate quality of care.
The legal regulation of the prices to be charged to the patients concerns the Minister of Health, on the basis of a proposal by the medical professional organisations.

The conditions for and the way of production, storage, usage and selling of pharmaceutical products and medical appliances are defined by the Pharmaceutical Council, established in the Ministry of Health. The Council is composed of representatives of the Ministry of Health, the professional organisations and the higher pharmaceutical institutions, among which is the National Drug Institute. In 1995, a new law further restricted the provision of pharmaceutical products and changed some of the pharmaceutical aspects of the Public Health Law (see § 2.1.6).
As far as the establishment and closure of private pharmacies and laboratories is concerned, a similar regulation is in force as for the private medical institutions.

2.1.4 Budget Law

The so-called Budget Law is established every fiscal year by the Council of Ministers and must be accepted by Parliament. This annual law determines the revenues and expenditures under the State budget. Total expenditures under the State budget for 1995 are 218 billion leva, i.e. approximately $ 3.2 billion according to the exchange rate in July 1995. The major items on the expenditure side are payments for interest (114 billion leva), defence and security (35 billion leva) and transfers to

municipalities (31 billion leva). Calculated in another way, 85 billion leva is destined for social security.

The Law determines the allocation of financial resources to all Bulgarian health care. The Ministry of Finance allocates these resources to the Ministry of Health, to the other ministries involved in health care, and directly to the teaching hospitals and some tertiary hospitals and to the municipalities for the municipal health care facilities. The municipalities augment this transfer with their income from local taxes.

Details about the financing of health care at the national and municipal level are discussed in § 2.8 and § 3.2, respectively.

2.1.5 Law on Local Self Government and Local Administration

The Law on Local Self Government, which came into force at the end of 1992, determines the role of local and regional authorities in policy making and financing in various fields including health care. The Law recognises the following levels of the governmental organisation:

municipalities (in Bulgarian: obshtina)

The municipality is the principal administrative and territorial unit where local self-government is exercised. The tasks of the municipalities are described in the law and include health care, sanitation and environmental control. Each municipality has an elected mayor and an elected municipal council. At the moment there are 255 municipalities in Bulgaria, but this number may change in the near future. The municipality is the most important type of local government as far as health care is concerned.

According to the Law on Local Self Government, the municipal council sets the policy of the municipality regarding health care. The municipal council compiles an autonomous health care budget on the basis of its own sources of revenue (local taxes) and the subsidies that the State allocates to the municipalities according to criteria determined by law (see § 3.2). The municipal budget finances the running costs and the investment costs of the municipal health care activities. The municipality has no right to borrow for costs of a general nature such as wages and running expenses.

The law also stipulates that the state property in the health care sector shall be transferred to the ownership of the municipalities at the moment that the law comes into force.
Although the law mentions the possibility of voluntary association of administrative and territorial units, there is at present no association of municipalities that could function as a coordinating body.

districts (in Bulgarian: okrag)

The district used to be an administrative and territorial unit comprising several municipalities. It combined the functions of self-government through delegated representation of municipalities (activities of supra-municipal importance) and the functions of the central government authorities. The district council consisted of two delegated representatives for each municipality. The district governor was a representative of the central government, appointed by the regional governor.
Officially, the districts have ceased to be a level in local government. In health care management, however, the district area has retained a certain role, although not clearly demarcated from the municipal and national level. Two examples: All former districts have a so-called district integrated hospital which serves as a referral hospital for the municipalities of the district (see § 3.3.1). Also, the local branches of the National Centre of Health Informatics and the District Institutes of Hygiene and Epidemiology are organised at former district level.
There used to be 28 districts in Bulgaria.
A decree of 17 July 1995 signed by the Prime Minister has established 28 District Centres for Health Care which will serve the same area as the former districts. These District Centres will be based on the district health information centres (see § 3.4), with some additional staff and a new director to be appointed by the Minister of Health. Their role in the management of local health affairs remains to be settled, but in the future these District Centres will have to carry out state policy, monitor and control public health care institutions, provide methodological help to these institutions, elaborate the proposals for funding them, and organise health services in case of emergencies and disasters.
In Bulgarian, the word 'okrag' is not used for the area covered by these new District Centres, but 'rayon'.
In translations from Bulgarian into foreign languages, there is often confusion as to the meaning of districts of regions. In our English text, we have chosen the translation of the Bulgarian terms as presented here: district = okrag/rayon, region = oblast. For familiar terms such as 'district integrated hospital', we use the term district without the prefix 'former' in this report.

regions (in Bulgarian: oblast)

The region has an administrative purpose and no elected bodies of local self-government are instituted in it. It is an administrative and territorial unit, where state authority is decentralised for the purpose of pursuing an effective regional policy. The regional governor is appointed by the Council of Ministers.
The regions play until now almost no role in the management of health care in Bulgaria and at present are also not equipped to do so.
At present there are 9 regions; the city of Sofia is one of them and the region of Sofia is another.

The boundaries of the regions and (former) districts are shown in Figure 2.1.

Figure 2.1 Map of Bulgaria with districts and regions

The nine regions are indicated with the first letter of the regional 'capital': Burgas, Haskovo, Lovetch, Montana, Plovdiv, Russe, Sofia (2x: city region and surrounding region) and Varna.

Greater Sofia Municipality

The Greater Sofia Municipality is a municipality and also one of the regions. It is, however, also a specific administrative and territorial unit, combining the self-government of the community with the implementation of government policies for the development of the capital.
The subdivisions and structure of the Greater Sofia Municipality are specified by a separate law.
As far as the organisation of health care is concerned, there are some differences between Greater Sofia (and other major cities) and most other municipalities. This will be described in § 3.5.

2.1.6 Law on Pharmaceutical Products and Pharmacies

This recent law (1995) governs the terms and conditions for the licensing and control of producing pharmaceuticals, their registration, laboratory testing, application, import and export, wholesale and retail trade, in view of ensuring quality, efficiency and safety. The Ministry of Health is responsible for the national pharmaceutical policy. It is the task of the National Drug Institute to provide scientific advice. The Pharmaceutical Council within the Ministry of Health advises the Minister of Health on the organisational aspects of the pharmaceutical policy, including advice on the opening and closing of pharmacies. Supervision and control of the implementation of the pharmaceutical policy is entrusted to the Chief Sanitary Inspector, aided by the National Drug Institute and the District Centres for Hygiene and Epidemiology. The coordination between the latter two organisations is specified in the act.
Only licensed drugs may be sold to the public. The Ministry of Health determines who is qualified to prescribe drugs and which drugs may be sold without a prescription. The prices of pharmaceutical products are regulated by the government.
Pharmacies may be opened by pharmacists, hospitals and municipalities; manufacturers and wholesalers of drugs are not allowed to be involved in the operation of pharmacies. Pharmacists who are employed in public-owned pharmacies are not allowed to work in private pharmacies. In case no pharmacy is operational in a municipality with at least 5000 inhabitants, the municipality is obliged to open one.

2.1.7 Draft Health Insurance Law

In 1993, a draft Health Insurance Law was formulated after proposals and discussions between various interested parties, especially the Ministry of Health, the Bulgarian Socialist Party, the Bulgarian Medical Association and the institutes and consultants in charge of the implementation of phase I of the PHARE Health Insurance Project. The main principles of the draft law are the introduction of compulsory social health insurance for all Bulgarian citizens with a single independent Insurance Fund. A National Health Insurance Council would supervise the proper functioning of the insurance system. Premiums would be paid by employers and employees, and by the State for the unemployed, retired, etc. The Fund would make contracts with health care providers for the provision of a specific package of benefits.

This draft law has been presented to Parliament, debated there but neither accepted nor rejected. At the moment, the draft law is not on the agenda of Parliament any more. It should be mentioned that the financial consequences of accepting the law are not yet clear.

2.1.8 Draft Law for the Social Insurance Fund

Recently, a new Law for the Social Insurance Fund was drafted. The draft law separates the funds for social insurance from the state budget. The social insurance funds are transferred to a National Insurance Institute with independent management, where they are protected against seizure for other purposes. The members of the tripartite governing board of the Institute are appointed by the Council of Ministers and organisations of employers and employees. The managerial council of the Institute will be formed by the general manager and the heads of the departments. Overall control and appointment of the general manager of the Institute of the Institute is in the hands of the National Assembly, while the Chamber of Audits will be responsible for financial control. The Institute will have territorial branches in the country, but the density of this network is not specified in the draft law. If passed, the draft law will change the organisation of social insurance in Bulgaria, but the present rights and duties of the insured will remain the same.

This draft law may have consequences for the introduction of social health insurance as well, although health insurance is not mentioned as such. One could imagine expansion of the activities of the Institute into the field of health insurance, albeit with separation of the funds for social insurance and health insurance.

2.2 Role of the Ministry of Health

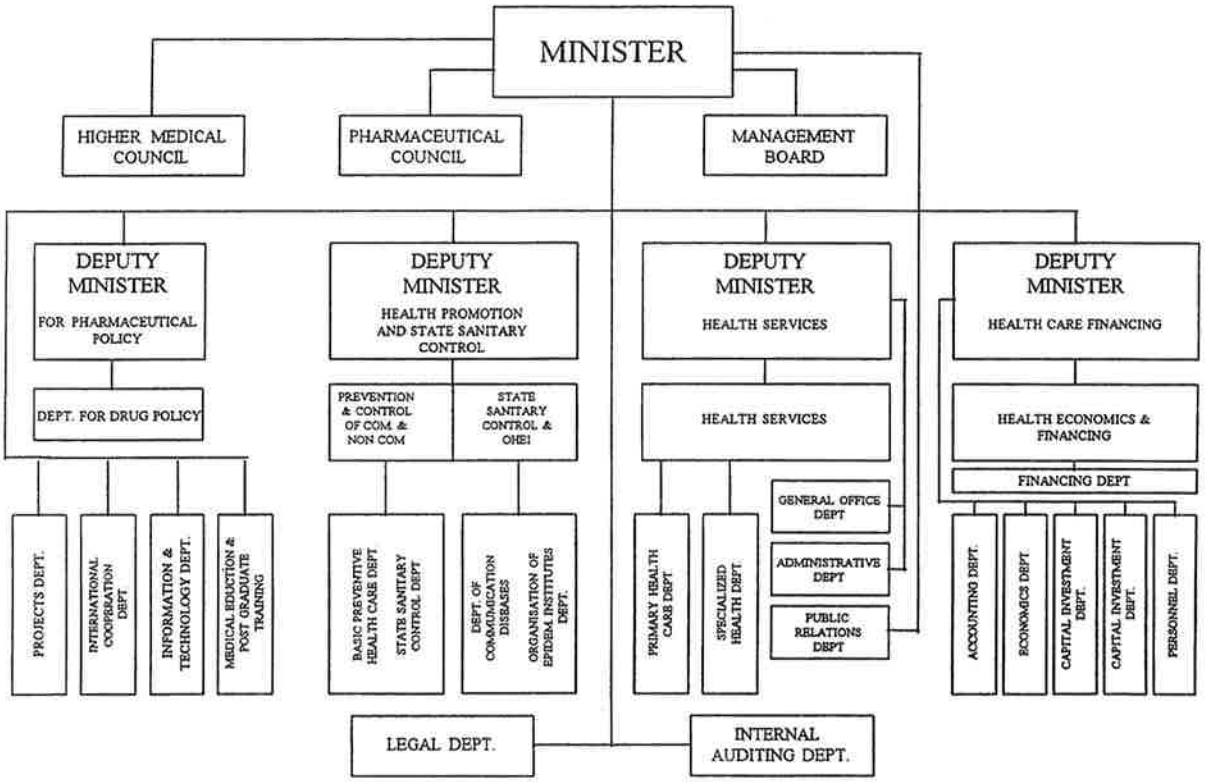
Bulgarian health care is organised as a hierarchical and territorial state system in which several administrative levels can be recognised.

The Ministry of Health is the top of the management pyramid. As already described in § 2.1.3, the Ministry is responsible for the guidelines concerning the administration of the health services (including financial administration), the macro-planning of physical and human resources, legislation concerning health and health care, quality norms and quality control.

The functions and tasks of the Ministry of Health are further specified in decree nr. 250 of the Council of Ministers of the 30th of December 1991. The Ministry of Health, as a specialised branch of the central executive power, implements State policy concerning preventive and curative health care. It is the organisation for expertise and control in this field, responsible for methodological developments, coordination and legislation. Practical examples of responsibilities of the Ministry of Health mentioned in this decree are the control of infectious diseases, the development of a pharmaceutical policy, and the regulation of an equitable supply of health services according to the needs of the population.

The administrative structure of the Ministry of Health is shown in Figure 2.2, including the position of the major advisory councils.

Figure 2.2 Organization chart of the Ministry of Health



Each deputy minister heads a division in charge of a group of activities. Each division has a number of departments. The management board of the Ministry of Health (called 'Collegium' in Bulgarian) is composed of the deputy ministers, the heads of divisions and the heads of departments. Altogether, the Ministry of Health has 160 employees, including administrative and cleaning staff.

The Ministry of Health regulates the mandate and activities of health care institutions by issuing 'naredby' (orders) and 'ukazanija' (guidelines). In practice, the Ministry of Health has limited management power, because large sectors are managed by other ministries, by medical faculties and by municipalities. The recent decree establishing District Centres for Health Care may be an attempt to increase control of health care facilities by the Ministry of Health.

The Ministry of Health is responsible for a number of health care institutions, mainly hospitals with a high degree of specialization or sophistication. The more important ones are mentioned in Table 2.1.

Table 2.1 National health care establishments

* 38 specialized hospitals:
  - 14 psychiatric hospitals
  - 11 'institutional' hospitals (see Table 2.3)
  - 10 hospitals for lung diseases
  - 1 paediatric hospital
  - 1 experimental clinical hospital
  - 1 hospital for emergency medicine
* 5 Higher Medical Institutes (university hospital complexes) in Sofia, Plovdiv, Varna, Pleven and Stara Zagora
* two Faculties of Dentistry in Sofia and Plovdiv
* nation-wide emergency services
* 72 sanatorium and balneological institutions

However, some of these national health care establishments - e.g. institutional hospitals and Higher Medical Institutes - receive their budget directly from the Ministry of Finance, which in practice makes them quite independent from the Ministry of Health.

The Ministry also governs a number of national institutes for data collection and research. The more important ones are mentioned in Table 2.2.

Table 2.2 National institutes of the Ministry of Health

* Institute of Hygiene
* District Centres for Hygiene and Epidemiology
* Centre for Financial and Managerial Technologies of Health Care
* National Centre of Health Informatics
* District Centres of Health Informatics (to be transformed into District Centres for Health Care)
* National Drug Institute
* Institute of Public Health (planned)
* National Centre for Health Education (planned)

These national health care establishments and institutes will be described in § 2.4.

2.3 Role of other ministries

The Ministries of the Interior, Transport and Defence (including the so-called Building Troops) are quite substantially involved in the provision of health care for their employees and their families. These ministries operate hospitals, polyclinics, health centres and health posts in Sofia and elsewhere in the country.

The Military Medical Academy (MMA) is a complex of three military hospitals with functions in the fields of comprehensive in-patient and outpatient treatment (except gynaecology and paediatrics), training and research. The army and air force institutions are in Sofia, the navy institute in Varna. With 2000 beds the MMA is the biggest hospital complex in Bulgaria and probably one of the best equipped. The MMA is involved in hospital information systems and cost accounting procedures. Apart from the military and their families, 40% of all patients are civilians. The MMA also treats members of the government, Parliament and diplomatic corps, employees of certain companies and referred patients from the health services of the Ministries of the Interior and Transport. It is one of the designated centres for emergency and disaster medicine in Sofia. The MMA is financed directly by the Ministry of Finance (783 million leva in 1995).
The Ministry of Defence also operates a network of hospitals, polyclinics and sanatoria throughout the country, but it has not been possible to obtain figures about its size for this report. The total budget for military health care is also not known.

The Ministry of the Interior also has a network of health care services in all 28 (former) districts, but smaller than that of the Ministry of Defence. It provides services mainly to active and retired policemen and their families, but also other employees of the Ministry of the Interior, border guards from the Ministry of Defence, people who have been arrested but not yet tried (other

prisoners fall under the Ministry of Justice), some government officials, and a substantial number of patients not connected to the Ministry of the Interior but attracted by its services. At peripheral level, the network consists of health centres (without beds) with general physicians, dentists, pharmacists and nurses. These health centres are separate from the existing municipal structures, but can refer patients to them (or to the hospital in Sofia, see below). The Ministry has two polyclinics with specialists (in Sofia and Plovdiv), 3 sanatoria for long-term care and rehabilitation, and one hospital with 400 beds in Sofia. The hospital has secondary and tertiary functions and is also a research centre. All services are completely free.

The health services of the Ministry of the Interior are the responsibility of a Deputy minister and financed from the budget of this Ministry. It has not been possible to determine the total size of the network in terms of money and personnel. The hospital has a computerised management information system and a balanced budget.

The Ministry of the Interior also operates district Inspectorates of Hygiene and Epidemiology for activities in the interest of the Ministry of the Interior, separate from the District Offices of Hygiene and Epidemiology of the Ministry of Health.

The Ministry of Transport has its own system of health services for approximately 200,000 employees of this ministry: railway workers, drivers, sailors and airways personnel. To this number should be added the families of the railway workers and sailors and the pensioners of these two branches. Approximately 25% of the patients of the health services of the Ministry of Transport are not at all connected to this ministry, but receive free treatment there. Moreover, the network is concluding contracts with private and State companies for treatment of their employees and sponsoring with equipment. The network consists of the Transport Medical Institute in Sofia including a hospital of 405 beds. Other Transport hospitals are in Plovdiv, Varna, Burgas, Ruse, Gorna Orjahovica and Stara Zagora; these 6 peripheral hospitals have altogether 1060 beds. All hospitals have a polyclinic; there are also some other polyclinics that are not integrated in hospitals. The whole network employs 2600 medical and non-medical staff. The hospital in Sofia functions also as a tertiary centre for the peripheral hospitals. Consultants from the hospital in Sofia travel regularly to the peripheral hospitals, and the hospital sometimes invites consultants from other Sofia hospitals on a contract basis or refers patients to them.

Approximately 30% of the work of the network is concerned with an intensive system of medical and dental check-ups related to the profession and destination of the patients. For these check-ups, specialised laboratories are available, e.g. in the fields of psychophysiology, ophthalmology and cardiology. It is felt that this system of check-ups saves money through prevention of morbidity

(also abroad) and that only the specialised health services of the Ministry of Transport are able to provide this expertise.
The health services receive their budget (402 million leva for 1995) from their own Ministry of Transport. For this, the Ministry of Health is consulted on a voluntary basis. The budget of the Transport health services is balanced.

2.4 National hospitals and institutes

2.4.1 National hospitals

According to the Public Health Law, the five Higher Medical Institutes (university hospital complexes) are under the aegis of the Ministry of Health. They figure, however, as a separate budget item in the republican budget and their main income comes therefore directly from the Ministry of Finance. This makes them quite independent from the Ministry of Health. There are also two Faculties of Dentistry in Bulgaria.

The top level hospital complex in Sofia that also has research and training roles used to be called the Medical Academy. Since 1991, the Medical Academy has been separated into the Sofia Higher Medical Institute (Faculty and university hospital complex) and the 12 National Centres. The National Centres have a research and teaching function; 11 of them are also top-level specialised (tertiary) hospitals. Their hospital function is described in statistics as 'institutional hospital', their scientific and teaching function as 'national centre'. The national centres are also financed directly by the Ministry of Finance, making them as independent from the Ministry of Health as the Higher Medical Institutes are. The specialization of the national centres is presented in Table 2.3.

Table 2.3 Specialisations of tertiary institutional hospitals (national centres).

- cardiovascular diseases
- clinical and transfusional haematology
- drug abuse
- emergency medicine
- endocrinology
- infectious diseases
- oncology
- orthopaedic and reconstructive surgery
- physical treatment and rehabilitation
- phytotherapy and popular medicine
- radiology
- sport medicine

Of all these tertiary establishments, only the oncological centre will be shortly described as an example. The National Oncological Centre in Sofia is the scientific institute for cancer control in Bulgaria. It has 239 beds. Is also keeps the National Cancer Registry that registers cancer morbidity and mortality since 1952. The National Oncological Centre supervises the 13 oncological dispensaries in the country which are, however, administered by the municipalities in which they are located.

Methodologically and technically, cancer control in Bulgaria could be called a vertical programme for a specific type of disease, but this is not true from the point of view of the management of the network. This is also the case for the other vertical programmes which operate a network of dispensaries (see § 3.3.2). The regional cancer centres cover an average population of 600,000 people and have their own regional registration units. Screening programmes for breast and cervical cancer have been started, but do not function well. Primary prevention of cancer in the form of health education activities is the responsibility of the Health Promotion Centre within the Centre for Hygiene (see § 2.4.2); however, implementation is also not very successful.

Apart from the university hospitals and the national centres, there are a number of specialised hospitals at national level, such as psychiatric hospitals (see Table 2.1). In contrast to the university hospitals and national centres, these specialised hospitals are directly controlled and financed by the Ministry of Health. These specialised hospitals cannot only be found in Sofia, but also in other parts of the country. There are, however, also a number of specialised hospitals that belong to the municipal health services (see § 3.3.1). The specialised hospitals have their own polyclinics for outpatient care.

2.4.2 National institutes

Of the national institutes, we describe only the following.

The National Centre of Health Informatics has branch offices in all 28 districts. These District Health Information Offices supply data to the municipalities and to the National Centre. Their officials are state employees. By the decree described in § 2.1.5, the District Health Information Centres will be transformed into District Centres for Health Care with a much enlarged task.

The Centre for Financial and Managerial Technologies of Health Care is a research and development institute belonging to the Ministry of Health. Together with the National Centre of Health Informatics, the CFMTHC is responsible for the PHARE project which is the subject of this report. At present there are discussions whether the CFMTHC is to be incorporated into an Institute of Public Health. Such an Institute of Public Health has existed in the past, but was closed in 1992.

The Centre for Hygiene is a national scientific institute under the Ministry of Health, doing research in the field of hygiene and epidemiology and advising the Ministry of Health concerning methodological issues and legislation. A Centre for Health Promotion is integrated into the Centre for Hygiene. This Centre for Health Promotion develops health promotion programmes, advises the District Centres for Hygiene and Epidemiology (see below), organises training courses, publishes materials and a journal and participates in international projects. It is, however, in a difficult organisational and financial position.
The 28 District Centres for Hygiene and Epidemiology are not under this national Centre for Hygiene, but directly under one of the Deputy ministers of Health who is also the Chief State Sanitary Inspector. This Deputy minister is assisted in her tasks by the Department of State Sanitary Control within the Ministry. The Ministry of Health appoints the directors and deputy-directors of the District Centres for Hygiene and Epidemiology; all staff are state employees. Until 1992, these District Centres were the joint responsibility of the Ministry of Health and the municipalities, but since then the role of the municipalities has been discontinued. The District Centres are responsible for health protection activities: sanitary control (e.g. in schools, factories and tourist facilities), control of drinking water and food, environmental control and radiological hygiene. Furthermore, they are monitoring the immunisation programme, supplying the vaccines, implementing the control of infectious diseases, supervising health education activities and controlling the compliance with various legal rules and regulations (see also § 3.3.4). The 28

centres have microbiological laboratories that also work for the hospitals in the district. The whole network employs approximately 4500 staff including more than 1000 physicians.
The Department of State Sanitary Control of the Ministry of Health is engaged in work on the modernisation of the various rules and guidelines in this field.

2.4.3 Emergency services

The Bulgarian emergency services have recently been reorganised, partly as the result of a PHARE project. Emergency care is a responsibility of the State, i.e. of the Ministry of Health and managed and financed as a national system. In the future, the emergency services may be part of the same management structure as the fire brigade and the police. All collaborators of the emergency services throughout the country are State employees: physicians, nurses, feldshers, drivers, and so on. A special department of the Ministry of Health is in charge of the emergency services. There are coordination centres for emergency care in the capitals of all (former) districts (except Sofia, see below), with outposts in some smaller municipalities. The directors of the coordination centres are appointed by the Minister of Health. Full emergency services according to the new model now exist in 10 districts. In 4 districts, the new model is being implemented and in the remaining districts will follow later.
The coordination centres for emergency care are situated in the district integrated hospitals (see § 3.3.1), where they have a few rooms for the intake and observation of patients. A consultant physician of the hospital decides about eventual admission to the hospital. However, the management and financing of the coordination centres is completely independent of the hospital, which at times creates some tension between those in charge of municipal care and emergency care. The emergency services possess a fleet of ambulances and emergency equipment; some of the material is new, other equipment needs replacement. Two types of teams can be sent to emergency cases: resuscitation teams with higher (medical) expertise, and smaller first aid teams of lower qualification. Ambulances can be ordered by dialling a single telephone number (nr. 150) throughout Bulgaria. Within the system of emergency services, there is radio and telephone communication within districts, from districts to regions and from regions to the highest level in Sofia. There is, however, no such thing as a national coordination centre in Sofia. The coordination centre for emergency services in Sofia municipality does not belong to the Ministry of Health but to the municipality. The situation in Sofia is further complicated by the facts that many hospitals operate their own fleet of ambulances, that these hospitals belong to different owners (Ministries of

Health, Internal Affairs, Transport and Defence; Faculty of Medicine; municipality of Sofia), and that some of these hospitals operate their own emergency departments although not in the sense of the above-mentioned coordination centres with specific staff for emergency care. The need is felt for 3 or 4 standardised coordination centres for emergency care in Sofia, but this has not yet been possible due to the fragmented management structure.

2.4.4 Sanatorium facilities

The Ministry of Health owns and manages a number of sanatorium establishments throughout the country. Other sanatorium establishments belong to other ministries and to municipalities. 'Sanatorium' has a rather wide meaning in Bulgaria, comprising establishments with a more medical (non-acute and rehabilitation) role and other establishments with a more recreational character. Among the former are sanatoria for patients with cardiovascular disease or tuberculosis and for children with chronic diseases. Among the latter are balneological institutions and the so-called prophylactoria (see § 2.5). There seems to be lack of clarity as to the need for and the role of sanatorium facilities.

2.5 Social tasks of the Ministry of Health

Apart from the Ministry of Social Affairs, the Ministry of Health is also involved in the running of institutions for social care such as nurseries (jointly with the Ministry of Education and Sciences), homes for the elderly and homes for physically and mentally disabled people. Many of the institutions for social care under the Ministry of Health are administered and financed by the municipalities, especially 442 nurseries (including a food programme), 31 mother and child homes and 23 'prophylactoria'. A prophylactorium is a kind of preventive sanatorium for workers in high-risk professions. One could also consider the provision of services in the 33 balneological establishments as a form of social care or even as a form of cheap holiday.
The social tasks of the Ministry of Health will not further be considered in this report.

2.6 Organisations of health professionals and patients

Health care professionals in Bulgaria are organised in several associations some of which will be shortly described here.

Bulgarian Medical Association

The BMA is an independent non-governmental and non-political organisation, member of the World Medical Association.
Approximately half of Bulgarian physicians are members of the BMA. The board of the BMA consists of elected volunteers. They are assisted by a paid secretary-general and a small office staff. The BMA has various sections, e.g. for private practitioners, ophthalmologists, etc.
The BMA is interested in the development of private practice in Bulgaria. It would like to develop into a representative of all physicians when health care will be contracted in the future. The BMA also has an interest in under-graduate and post-graduate education, quality control and registration of physicians.
The BMA is actively lobbying members of Parliament and others to achieve its goals. It also issues a bi-weekly journal.

Apart from the BMA, there is also a Stomatological Association and an Association of Private Pharmacists.

Trade unions

In Bulgaria, there are three unions of health care workers. The first two are the Medical Federation of the Podkrepa Labour Confederation and a section within the Confederation of Independent Syndicates in Bulgaria (KNSB). Although both unions are officially independent and not allied to existing political parties, Podkrepa explicitly excludes members of the former communist regime from its leadership and is more critical of the policies of the present government than the KNSB. The majority of the members of both unions are nurses and other intermediate staff, but medical doctors have important functions in them. It seems that more physicians are trying to defend their financial and other interests through the Bulgarian Medical Association. The third union is the Independent Syndicate of Medical Professionals.

Organisations of hospital directors

There is an Association of Hospital Directors, a comparatively large organisation that tries to defend the interests of hospitals of very different size and functions. There is also an active 'Medical Directors Club', the members of which are the medical directors of the district integrated hospitals in the 28 districts. Within a reformed health care system in Bulgaria, these hospitals may face some difficulties because several issues are not well regulated by law. For example: although an integrated hospital is administered and financed by one municipality only, it attracts the more complicated cases from surrounding municipalities as well. Through the pressure of the Medical Directors Club, the Council of Ministers has already adapted the formula that regulates the financial flow to the municipalities (see § 3.2). The president of the Club is also a member of the Higher Medical Council. The Ministry of Health is invited to the meetings of the Club. The Club comments on draft legislation. Apart from financing, the programme of the Club also mentions an independent legal status of the hospitals and a limitation of the patients' flow to their own municipal health services only (or equalization of financing for treatment in other municipalities).

Nurses Association

The major goal of the Nurses Association is to upgrade the education of nurses. At present, nurses receive two years of training after secondary school. This initial training, which is considered as a middle level education, can be followed by additional courses lasting between one month and one year. It is planned to start courses for the higher education of head nurses in September 1995.

Consumers Organisations

A real Patients' Organisation, representing the interests of (future) patients in the triangle providers-purchasers-consumers, does not yet exist in Bulgaria. There are, however, associations of patients with specific diseases and handicaps, e.g. diabetes, colostomy, renal failure (haemodialysis) and blindness. There is also a general consumers' organisation in Bulgaria.

2.7 Financing of health care at the national level

The planned State and municipal expenditures for health care in 1995 are presented in Table 2.4.

Table 2.4 Bulgarian budget for health care in 1995

to be spent by:	millions of leva
Ministry of Health	5,816
State and teaching hospitals	4,909
30% of transfer to municipalities*	9,364
Military Medical Academy	783
other health care by Ministry of Defence	n.a.
health care by Ministry of the Interior	n.a.
health care by Ministry of Transport	402
local budget added by the municipalities*	10,000
total Bulgarian budget for health care (excluding private payments)**	(approx.) 31,000

* assumption
** excluding other health care by the Ministry of Defence and health care by the Ministry of the Interior
n.a. not available

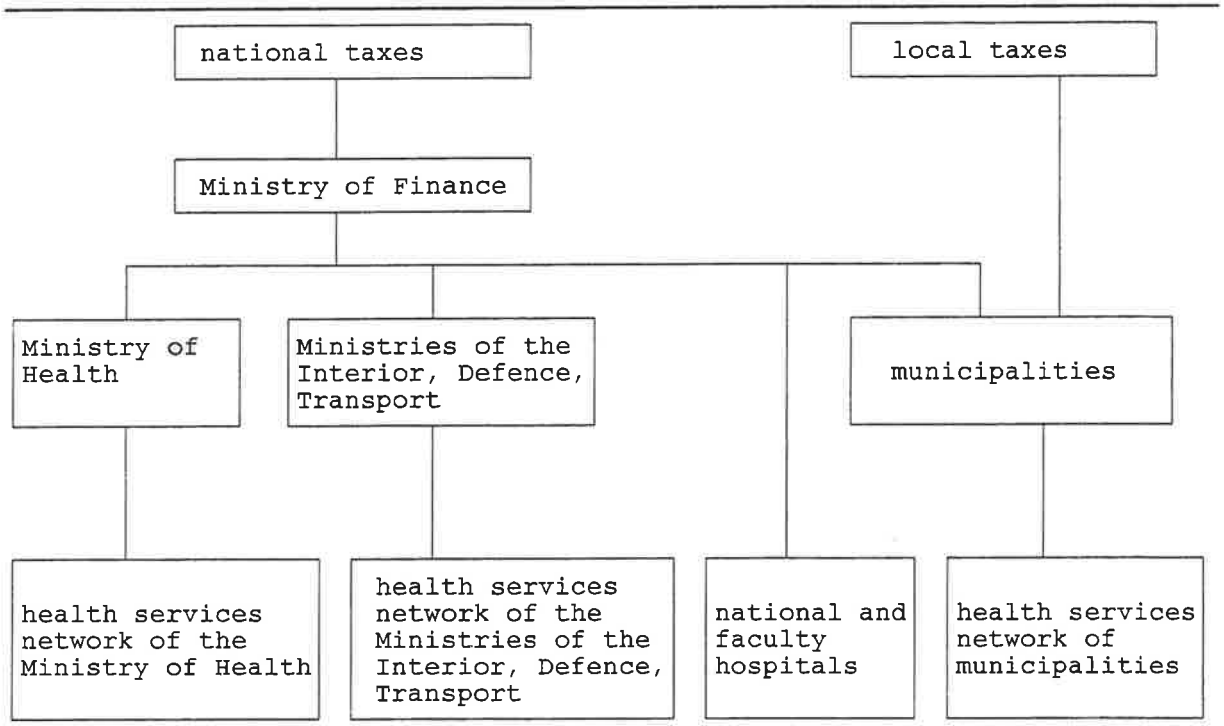
We would very much have liked to complete this table with real figures for the municipalities and the missing values for the Ministries of Defence and the Interior, but were unable to obtain them. The combined 1995 health budgets of the Ministries of Defence and the Interior could be assumed to be a few billion leva. The sum of the municipal expenditures for health care is much more important and it will be possible to calculate it from regular accounting documents next year. In Table 2.1, we have assumed that approximately 30% of the total budgets of the 255 municipalities of Bulgaria is spent on health care, but we do not really know. We conclude that the total amount budgeted for Bulgarian health care (except private payments but including the Ministries of Defence and the Interior) must be roughly 35 billion leva or 4000 leva per person per year. The health care expenditures in 1994 were 21,343 million leva (excluding private payment, the Ministry of the Interior and other health care by the Ministry of Defence), i.e. approximately 4% of GNP. If private payments and both ministries would be included, one would arrive at approximately 5% of GNP. This is low, even by Eastern European standards.

It will be difficult to discuss seriously about health care financing in Bulgaria if no more precise data become available.

Apart from a relatively small amount for co-payment, the expenditures for health care are financed by central and local taxation and are determined by the financial capacity of the State and the municipalities. The annual republican budget is allocated by the Ministry of Finance according to the Budget Law. As described in § 2.1.4, financial resources to the health care sector are allocated via three main groups (see Figure 2.3):

* A direct subsidy to specific health care institutions, for example to the teaching hospitals, but also to pharmacies for drugs for certain diagnostic groups and certain categories of patients (see below).
* Several Ministries own and manage health care institutions, especially the Ministry of Health but also others, e.g. the Ministry of Defence. The financial flows run via the budgets of these Ministries to the health care institutions for which they are responsible.
* A subsidy from the State budget to the municipalities for their integrated hospitals and other municipal health care facilities.

Figure 2.3 Financial flows (excluding private payments)



Calculated with a specific formula the municipalities receive a general subsidy. The criteria used in this formula are mainly related to the size of the health care facilities owned by a municipality rather than to the real cost of health care for its inhabitants. The subsidy has to cover a part of the

expenditures for health care, welfare and the other activities for which the municipalities are responsible. This subsidy includes the running costs as well as the investment costs.

As described in § 2.1.6, the government regulates the prices of drugs. The Council of Ministers stipulates the maximum profit margins in this sector. In the year 1994 an amount of 3,759 million leva was spent on drugs which in that year meant 17.6% of the total expenditures in health care (excluding private payments).
Drugs in ambulatory care have always been paid for by the patients. By law, various population groups and diagnostic categories have been defined for which drugs will be subsidised, usually between 75 and 100%. The pharmacies get reimbursed directly by the Ministry of Health.
Apart from the subsidies for the above-mentioned diagnostic categories, medication for pregnant women, mothers of children up to 3 years of age and their children is free.

Besides the official aspects described in this section, it should be mentioned that corruption is expressed by many as an important problem in Bulgarian health care.

3. PRESENT HEALTH CARE MANAGEMENT AT THE MUNICIPAL LEVEL

3.1 Organisational structure

Apart from the health care facilities themselves, the municipalities are the lowest level in the management pyramid of Bulgarian health care. They own most of the physical infrastructure of the health services on their territory and they employ the health care professionals and other staff working in them. Exceptions have been discussed in chapter 2.

There used to be 28 health care districts in Bulgaria which were situated between the national and municipal levels of the management pyramid. For national administrative purposes, the district system has been replaced by a division into nine regions, but some health services continue to be provided for use at the district level, e.g. the so-called district integrated hospitals of an intermediate level of sophistication between national hospitals and municipal hospitals. This, however, is an intermediate level of technology and *not* an intermediate level of management. District hospitals are providing services to a (former) district - i.e. a group of municipalities - but they are governed and financed by the single municipality where they are located.

Technically speaking, the elected mayor and the councillors' health care committee of a municipality are in charge of the health care services in their municipality. The municipality owns all health care buildings on its territory (except national services if any), employs all personnel in them and pays for all costs incurred by prevention and treatment of the inhabitants of the municipality. However, there usually is no staff with knowledge about health care in the municipal office. Therefore, in practice, the director of the (district or municipal) hospital in a municipality is the main authority for health care, but he or she depends on the mayor for the funding of the hospital. The hospitals and other health care establishments are not independent legal entities but ordinary municipal offices.

3.2 Financing of municipal health services

Municipal health care is mostly financed by the municipalities. To a small extent, patients cover the expenses by direct payment, e.g. for part of drugs and dental treatment.

The municipal budget (for all expenditures, including health care) is obtained from the Ministry of Finance and local taxes. The elected mayor and councillors are free to adjust the percentage of its budget that goes to health care; we have assumed that on average this is approximately 30%, but percentages vary widely between municipalities. The possibilities for raising additional local taxes are limited.

According to the Law on Local Self Government, the municipal council sets its policy on health care. The council must compile a budget on the basis of its own sources of revenue (local taxes) and subsidies from the State. Out of this budget the municipality finances health care, welfare and other activities. The allocation to the health care sector is an autonomous responsibility for the municipality. The Law on the 1995 State Budget gives one general guideline for the allocation: the relative shares of funds for health care, education and welfare may not be smaller than the relative shares during the preceding years. We assume that the municipalities spend on average 30% of their total budget on health care, but we do not really know. Health is considered a priority and health professionals feel relatively confident that they really receive the planned amount of money, although especially in the district integrated hospitals the planned amount is insufficient to cover the expenses.

The directors of hospitals have to submit an annual application for the budget of their establishments according to the number of inhabitants covered by the hospital and (since the 1st of January, 1995) the number of hospitalised patients. Until last year, the number of beds was used instead of the number of hospitalised patients. The new criterion leads to an increase in the hospitalization rate. Because all staff are municipal employees, salaries are automatically guaranteed and indexed.
Although district hospitals treat more complicated cases than the smaller municipal hospitals, they are funded according to the same criteria. Also, the district hospitals treat patients referred to them from the smaller hospitals without clear rules for reimbursement and often no reimbursement at all.

The health care establishments usually obtain the first instalment of their funds long after the beginning of the year. Even more serious is that for a number of years the funds have often been insufficient to cover the expenses of a whole year; many hospitals are running up increasing debts, although this is explicitly forbidden by the Law on Local Self Government. It is not clear how these debts shall ever be paid. It is not known how the shortage of funds affects the quality and outcome of health care.

There is no major privatization in health care establishments at the moment except for a number of dental cabinets and pharmacies, but thousands of physicians operate private offices after official working hours, sometimes even in government facilities.

At present there is only a weak correlation between provision of health care services and the resource allocation. Much more needs to be known about the actual flows of funds to health care facilities. As an example, there are large but unexplained differences in the cost of a similar patient treated in different polyclinics in Bulgaria, possibly partly due to different ways of calculating costs for laboratory tests and X-rays.

3.3 Types of municipal health services

The major types of municipal health care establishments one can find in a municipality are presented in Table 3.1. National establishments which necessarily are located on the territory of a municipality are not mentioned in this Table.

Table 3.1 Types of municipal health care establishments

* district integrated hospitals
* municipal hospitals
* workers' hospitals
* specialised hospitals
* dispensaries
* other polyclinics
* rural health services
* dental polyclinics
* sanatoria of which are for tuberculosis
* pharmacies and pharmaceutical units
* balneological centres prophylactoria and resort polyclinics

The terminology used can be quite confusing for an outsider. The types of health care will be explained and elaborated upon in the following paragraphs.

3.3.1 Hospital care

As shown in Table 3.1, the two more important types of hospitals in municipalities are: district integrated hospitals and municipal (or community) hospitals. An integrated hospital has on average 950 beds, a municipal hospital 267.

All hospital buildings are owned by the municipality and all personnel in them are employed by the municipality.
All hospitals are governed by a medical director, assisted by a deputy director for economical affairs.

A district integrated hospital offers comprehensive and rather sophisticated health care, both in-patient care and ambulatory care in a polyclinic. Most medical specialties can be found here, although specific health problems are sometimes treated in specialised hospitals (see § 2.4 and below) and so-called dispensaries (see § 3.3.2). Health professionals rotate between the hospital and the polyclinic. Laboratories are shared between in- and out-patient care. The polyclinic also offers dental care and physiotherapy and theoretically also primary care (see § 3.3.2 and 3.3.3).

One usually finds one district integrated hospital in each district, serving the population of its own municipality for all cases and the population of the other municipalities for the more complicated cases that cannot be treated in the municipal hospitals. The district integrated hospitals in Shumen and Pleven are not called by that name because of their teaching functions. The six municipal hospitals of Sofia are included in their number, however, explaining the total number of 31.

A municipal hospital offers in-patient and ambulatory care, but usually only for the basic medical specialties: paediatrics, obstetrics-gynaecology, internal medicine and surgery. Less than half of Bulgarian municipalities possess a municipal hospital.

A so-called workers' hospital is a general hospital originally connected to an enterprise and providing services to its employees and their families. Out-patient services are provided by general polyclinics called workers' polyclinics. It is not clear at the moment to what extent workers' hospitals and workers' polyclinics have become ordinary municipal services for the general population. In the official statistics, some of these services still carry the old name of workers' hospitals and polyclinics. Three workers' hospitals belong to the networks of the Ministries of Defence, Transport and the Interior (one each).

Specialised municipal hospitals exist for pulmonary diseases (6), obstetrics and gynaecology (4), children's diseases (3), rehabilitation (3), infectious diseases (1) and ophthalmology (1). It does not seem very logical that this limited number of specialised hospitals belongs to the municipal health

care system consisting of 255 municipalities. One would rather expect them to be organised along district or even regional lines.

3.3.2 Outpatient specialist care

Outpatient specialist care is mostly given in so-called polyclinics. In the soviet ('semashko') type of health care, it is difficult to make a distinction between secondary (specialist) and primary (general) outpatient care.
Like all other Bulgarian health care facilities, polyclinics are organised on a territorial basis according to size of the population. The number of professionals in each specialty in each polyclinic is determined by norms set by the Ministry of Health. All polyclinics are categorised from type I (highest number of types of specialization available) to type V. Polyclinics of type I-III can be found in the towns and cities, whether attached to a hospital or not. Polyclinics of type IV-V are to be found in smaller towns and larger villages. They have only two basic specialties: general (internal) medicine and paediatrics. Other types of specialists from nearby bigger polyclinics may visit from time to time. Type V has a smaller population base than type IV.

Most of the 202 other polyclinics than the 31 in integrated district hospitals are attached to municipal hospitals. A smaller number are non-integrated polyclinics, i.e. physically separated from a hospital, mainly in cities (see § 3.5). Thus the 202 polyclinics are divided in 53 non-integrated polyclinics, 6 workers' polyclinics and 143 polyclinics of type IV-V.
Workers' polyclinics are organised at some industrial sites, usually affiliated to a workers' hospital.

In some cases it is esteemed that hospital treatment can better take place at home, supervised by the appropriate specialist and nurses from a polyclinic. This system is called 'home treatment' (in Bulgarian: 'domashen statsionar'). Examples are the treatment of children at home to avoid emotional problems, the treatment of some infectious diseases and the long-term care of the elderly. In this case, drugs are supplied free of charge. The home treatment system saves money and is appreciated by the patients.

Dispensaries are polyclinics for the ambulatory detection and treatment of specific diseases or health problems: pulmonary diseases (13), dermatovenereological diseases (12), sports medicine (12), mental disease (12), oncology (13), drug abuse (2) and rehabilitation (1). They are physically separated from the other polyclinics. Many dispensaries have beds as well: together they had 4771

beds in 1993. Actually, the dispensary network in Bulgaria could be seen as an example of so-called 'vertical programmes', i.e. non-integrated health services for specific health problems with their own network in the country separately from the general comprehensive health services. However, in Bulgaria each of these vertical programmes depend on a national institute for scientific guidance, but the decentralised units of each programme depend on local authorities for management including financing. Again, this type of specialised care calls for management at district or regional level rather than municipal level. At present, the patients of several (former) districts share one dispensary for e.g. oncology.

3.3.3 Primary care

Primary care is outpatient by definition. Much of the care given by paediatricians, gynaecologists and specialists in internal medicine in polyclinics is primary care in the sense that they can be the first health professional from whom treatment is sought for an episode of illness. For example, the parents of a sick child can and often will directly consult a paediatrician when such a specialist is available. This, however, is a different definition from the one used in many western countries and by the World Health Organisation.

In rural areas, primary care is given by so-called district doctors and by assistant-doctors ('feldshers').

District doctors do not have a special training as general practitioners; they can be specialists in internal medicine or doctors waiting to start their specialisation. They work in one of the 88 rural health centres (which sometimes also have a few beds, nowadays mostly unused) or 1054 rural health posts. The only difference between a rural health centre and a rural health post is that the latter covers a smaller population. District doctors are assisted by nurses who have no independent role in either prevention or treatment.

A feldsher is a medical officer with three years of training after secondary school. They work with a nurse in so-called feldsher outposts; there are 2075 of them in Bulgaria. Feldshers provide both curative and preventive care. They can prescribe drugs from their own stock (except for the more sophisticated ones), do minor surgery and perform simple laboratory tests. They are supervised by the nearest polyclinic or district physician.

The Ministry of Health has defined the time schedule and tasks of staff in primary care: how much time should be spent on home visits, how much in the office, etc. There are norms for the number

of inhabitants, workers, younger and older children that will be served by each primary care establishment and each professional working in primary and preventive care.

In polyclinics in towns and cities one can also find district doctors that formerly acted as the obligatory point of entry into the health care system. Nowadays sick people have the right to go straight to one of the specialists and often do so. The territorial base of such primary care physicians in cities is the neighbourhood (in Bulgarian: 'ucastok').

3.3.4 Preventive health care (see also § 2.4.2)

Generally speaking, Bulgarian prevention programmes - e.g. immunisation, family planning, health promotion or screening programmes - are developed at the central level by the Ministry of Health and the national institutes affiliated to it. These programmes are executed by the regular network of health services at peripheral level.

Antenatal care, immunisation of infants and the monitoring of normal growth are carried out by specialist and generalist physicians working in ambulatory health care (polyclinic or village health centre), according to guidelines issued by the Ministry of Health and under the supervision of the District Centre of Hygiene and Epidemiology.
Oral and intrauterine contraception can be prescribed by a gynaecologist, but these methods are little used. The most common form of contraception is abortion.

School health care is carried out by school physicians, mostly in the form of screening for abnormalities and little in the form of health education. These physicians are appointed by the hospital or the polyclinic of the municipality.
Health education in schools and elsewhere is the responsibility of the District Centres of Hygiene and Epidemiology. The health education programmes are developed by the Centre for Health Promotion in the Centre for Hygiene. General target groups for health promotion activities are women and children; prevention of substance abuse is one of the priority subjects. The District Centres are also responsible for the control of infectious diseases and the control of drinking water, food, environment and safety measures.

3.3.5 Dental care

Dental care (in Bulgaria usually called stomatology) is provided at three levels of sophistication.
In village centres for primary care and polyclinics of type IV-V, general dentistry services are provided.
More complicated treatment is given in dental polyclinics which used to be part of a medical polyclinic, but nowadays are mostly independent. The most sophisticated treatment is available from independent dentistry departments in the major towns. The latter two categories comprise 94 establishments.
There were 3669 private dentists registered in Bulgaria as of 31 December 1993, i.e. more than 60% of all dentists in the country.

3.3.6 Pharmaceutical services

Drugs are supplied by 'pharmaceutical stations' in the smaller rural primary care centres and feldsher outposts, by larger pharmaceutical branches in the bigger villages and by pharmacies in towns. Altogether there were 1044 state pharmacies and 2305 smaller rural units in 1993. In addition, there are also numerous private pharmacies of varying degrees of expertise and sophistication.
In 102 so-called sanitary shops, medical aids such as glasses were provided in 1993.
The pharmaceutical network employed 2376 pharmacists in 1993, including the pharmacists working in hospitals.

3.4 Data collection and administration

At the peripheral level, data on the activities of health care establishments and the health of the population are collected by the district outposts of the National Centre of Health Informatics, the so-called District Health Information Centres. As was already mentioned in § 2.1.5, these 28 District Health Information Centres are to be transformed into District Centres for Health Care by adding managerial responsibilities in the fields of organisation & control, economics & financing, and administration. The District Centres for Health will not, however, exercise direct managerial control over the municipalities and the health care facilities on their territory. Within the new

District Centres for Health Care, a deputy director will be in charge of the collection and analysis of data. It is important that the data collection and analysis activities can continue as before. The total number of staff in the new District Centres will be 649, including 140 new positions.
In the same decree that established the new District Centres, two types of consultation bodies have been created, one for the district ('rayon') level and one for the regional ('oblast') level.

In the past, some morbidity and mortality data were collected and processed by the National Institute of Statistics. At present, this is done by the National Institute of Health Informatics which then supplies relevant data to the National Institute of Statistics. Death certificates are still sent to both institutes.
The collection and analysis of data on notified infectious diseases is executed by the network of the District Centres of Hygiene and Epidemiology.

3.5 Specific aspects of health care in major cities

Although health care in major cities does not essentially differ from that in smaller towns, its aspect is more complex because more organisations are involved, especially in Sofia. In Sofia one finds parallel health services managed by the Ministries of Health, Defence, Transport and Internal Affairs, by the Medical Faculty (Higher Medical Institute), by more or less independent so-called National Centres and by the municipality. University health services are to be found in all five cities with Medical Faculties, health services of the four above-mentioned ministries in other cities, etcetera. Access is not clearly regulated, which means among other things that both secondary and tertiary care is provided by the same facility and that hospitals of certain ministries accept patients who are not connected with them, apparently without creating animosity (or relief) on the side of the municipal establishments.
Typical of major cities is also that one can find there a higher percentage of polyclinics that are 'non-integrated', i.e. physically separated from a hospital. These polyclinics cover designated neighbourhoods (in Bulgarian: 'ucastok').
In three of the major cities in Bulgaria, the municipal health services are managed by special municipal health departments: Sofia, Plovdiv and Varna. These departments produce detailed overviews of their activities and expenditures.
Because national non-municipal health services are concentrated in the larger towns, taking a significant share of the patient volume, and possibly also because larger towns have more

responsibilities than smaller municipalities, these larger towns spend a lower percentage of their total budget on health care. As the most extreme example, the 1995 health care budget of the municipality of Sofia (1.2 million inhabitants) is 2,589,000,000 leva which is roughly 10% of the total municipal budget. With this budget, the municipality of Sofia operates 167 health care facilities, including 6 general hospitals, 13 specialised hospitals, 30 (medical) polyclinics and 28 dental polyclinics. The salaries for the 3067 physicians, 1045 dentists, 7429 middle-level staff (e.g. nurses) and 4655 other staff account for 49% of the budget. Strong financial discipline is being maintained. Approximately 35% of the patients treated (without payment) in the Sofia municipal facilities are from outside Sofia.

4. CONCLUSIONS OF THE ANALYSIS

4.1 Introduction

In chapters 2 and 3, we have presented an overview of the organisation of the Bulgarian health care system as it exists today. Especially for relative outsiders but also for most Bulgarian experts, it is sometimes difficult to understand all aspects of the system. The terminology used for facilities, activities and professionals in Bulgarian health care can be confusing; this terminology sometimes differs even from one official publication to another. Although much printed information is available about some aspects of the system, for other aspects it is nearly absent.
We have tried to present the overview in the two preceding chapters in an objective way, i.e. as facts. Gradually, we have also been developing some opinions and conclusions about the organisation of Bulgarian health care which we want to present in this short separate chapter 4, as a step towards the presentation of options for the future organisation of Bulgarian health care in the next chapters.

The good things that can be said about Bulgarian health care is that - notwithstanding the difficult economic situation - the system is functioning everywhere, that nearly all patients receive the care they require, that the technical level of health care seems to be adequate and that data are collected according to official guidelines. These are the aspects of the system that one should keep intact, of course, and that should prevent one from becoming too gloomy about the errors in the system. However, there are major problems which to a large extent are not different from the problems other former communist countries are facing and which must be addressed. Little progress has been made in this field in Bulgaria in the past five years.
One could say that at present the health services are administered rather than managed. By this we mean that the health care managers make little use of the management tools described in § 1.2 to direct the health care system in the direction they wish it to go. Often, they have no freedom to do so even if they wanted. Existing legislation and the rigid regimentation of the past make it very difficult to implement changes, especially for managers at the level of the health care facilities, some of whom are clamouring for more freedom in this respect.
The main bottlenecks and obstacles in the Bulgarian health care system at the moment have been summarized in Table 4.1 and will be elaborated in the text. It is difficult to give a rank order according to the importance of these 9 problem areas, because they cannot be quantified with

common indicators and they are also to some extent interconnected and overlapping. Although most bottlenecks mentioned below have managerial aspects or are even purely managerial in character, some of them also have aspects that are not related to management problems, especially e.

Table 4.1 Main bottlenecks in Bulgarian health care

	management aspects
a	unclear control mechanisms within the health care system
b	unclear role of the municipalities
	financing aspects
c	underfunding of the system, especially for equipment, drugs and maintenance, coupled to existing inefficiencies
d	malfunctioning resource allocation system and insufficient relation between funding and activities
	health care aspects
e	oversupply of beds, some types of facilities and some types of professions according to international standards
f	specialist-centred without real primary care
g	overcomplicated specialization in too many different types of health services provided, with sometimes confusing terminology and unclear mission
h	inappropriate level of executing certain tasks
i	unclear division between social care and health care in some respects

4.2 Management aspects

a Unclear control mechanisms within the health care system

The relations between the various levels of the management pyramid and between the components of the system within each level are insufficiently clear. Modern management skills are not well developed in any part of the system. These factors make management and control of the Bulgarian health care system difficult.

Large sectors of the Bulgarian health care system escape direct control by the Ministry of Health, adding to the fragmentation described under g. The Ministries of Defence, Transport and the Interior have important health care systems of their own. With quantity, quality and financing of Bulgarian health care services becoming important subjects for the planned health care reform, this will complicate policy development and implementation. Most countries have a certain preparedness for wartime pathology and therefore develop experience and capacity in military medicine, but this is not really needed for the families of the military and even less so for citizens not connected to the military at all. There may be a historical explanation but there is no scientific or economic justification for special health services for railway workers or policemen either.

The Ministry of Health should also define the degree of control it wants to retain over the budding private health services in the country.

b Unclear role of the municipalities

At present, the only really important management levels in Bulgarian health care are national and municipal (and - of course - the management of the health care facility itself). The consequence of this is that facilities of intermediate level of sophistication, such as district integrated hospitals, dispensaries or some specialised hospitals, are administered and financed by the single municipality where they are located. This leads to a financial disadvantage for these municipalities, only partly corrected by the allocation of extra funds. Municipal expertise and intermunicipal coordination are absent in these cases.

4.3 Financing aspects

c Underfunding and inefficiency

Compared to most western countries, the Bulgarian health care system is probably underfunded as regards the percentage of the Gross National Product spent for health care. It must be said, however, that it is not clear how much is spent on health care by the Ministries of the Interior and Defence. It is an urgent recommendation to calculate these figures. It is also necessary to monitor the sum of all municipal health care expenditures in Bulgaria. The scope for improving the funding of health care will be limited, however, because this depends on the long-term improvement of the national economy. It is therefore of paramount importance to eliminate the inefficiencies in the system in order to focus scarce resources on the most serious health problems. Major targets for increasing efficiency are especially the bloated hospital system and the pool of human resources. It will also be necessary to create incentives for efficiency, such as payment systems that limit production without endangering quality. Indexed salaries - although low even by Bulgarian standards - consume an ever-increasing part of the budgets of the health care establishments, because of the oversupply of personnel. Also, the low level of the salaries leads to a growing demand by physicians for extra out-of-pocket payments by patients. Most district hospitals are running up debts of millions of leva and still cannot provide sufficient drugs, food for the inpatients, equipment or maintenance. Other methods to increase efficiency must be found as well, such as the introduction of real primary care (see below) and possibly the reduction of the package of benefits.

d Insufficient relation between funding and activities

The resource allocation system is not functioning well at either the national level or the municipal level. The relation between funding and health care activities is not strong. The motto 'money follows the patient' is not rigorously applied in Bulgaria. Health care professionals receive their salaries according to professional level and age, not according the volume and quality of work. One result of this lack of incentives is low productivity. To a large extent, hospitals formerly received their budget according to their number of beds and staff, again regardless of the volume and quality of their work. Nowadays, the number of patients admitted also plays a role (increasing the admission rate!), but there is still no relation with the complexity of the cases, the need for laboratory tests, the outcome of the treatment process, and so on. Although all health care facilities prepare their statistics according to official guidelines, there has been insufficient analysis of factors causing inefficiency and low quality in health care. This is exactly one of the tasks of the project described in this report and executed by the Centre for Financial and Managerial Technologies of Health Care. This information is needed for any improvement in the management and financing of health care, not just for the introduction of health insurance. With this information and with a more independent legal status, health care facilities could be managed in a more flexible and efficient way.

4.4 Health care aspects

e Oversupply

The oversupply of hospital beds is typical of all Central and Eastern European countries. There were 13 hospital and sanatorium beds per 1000 population in Bulgaria in 1993. One could say that roughly half of these beds are superfluous.

There is also an oversupply of certain facilities, such as - again - hospitals in places with an inadequate population base but also in cities. The city of Sofia alone has more than 40 hospitals, excluding the hospitals in the district of Sofia.

The problem with too many hospitals and hospital beds is, of course, that hospitals are the most important cost-generating factor in any health care system. The hospitalisation rate (18.6 admissions per 100 population in 1993) and the average length of stay in a hospital (13.8 days in 1993) are higher in Bulgaria than in western countries.

On the other hand, it could be said that the number of some other types of facilities is insufficient, e.g. nursing homes.

The number of most types of health care personnel, and especially physicians (34 per 1000 inhabitants or one physician per 297 inhabitants), is too large, leading to both unnecessary activities and under-employment. One could say that the number of Bulgarian physicians can be reduced by 30% without endangering the quality of health care. Enrolment of students at medical faculties has already been drastically curtailed during the last few years.

f No real primary care

Although one can find so-called district doctors in polyclinics, they do not and cannot provide effective primary care, because they are not trained for it, are often bypassed and have to function in a system where medical specialists are considered to be primary care doctors. The whole 'semashko' type of health care is specialist-centred and hospital-centred. A much higher percentage of Bulgarian physicians is medical specialist (approximately 90%) than is usual in most western countries. Too many patients end up at a level which is of inappropriate (too high) sophistication or cost: simple complaints are being treated by specialist physicians and patients who could have been treated in ambulatory care are hospitalised. This point is connected to problem area h.

g Overspecialisation

Overspecialisation in Bulgarian health care facilities leads to a very fragmented system, physically and organisationally. We shall give a few examples.

Although all district capitals have a so-called integrated hospital, offering a wide range of specialist in-patient and ambulatory services, one usually also finds in these towns one or more so-called dispensaries which offer ambulatory and often also in-patient care for specific diseases, e.g. psychiatry or tuberculosis. These dispensaries are usually located in a separate place from the hospital. However, the dispensary system is not based on the (former) district division, which usually means that several districts have to share one dispensary for e.g. psychiatry, tuberculosis or oncology.

Another example is the presence of specialised hospitals - e.g. pulmonary hospitals or paediatric hospitals - in most districts. These exist also in western countries, especially mental hospitals, but not to this extent.

A third example is the differentiation of polyclinics into five different types according to the number of services offered, plus still more types such as workers' polyclinics. One could imagine, for example, two different types of polyclinics according to the size of the population served, but not six or more.

The conclusion is that integrated hospitals and polyclinics offer different services in different towns, sometimes in competition with specialised facilities.

h Inappropriate level of executing certain tasks

In Bulgaria, some relatively simple tasks are executed by highly qualified physicians, causing inefficiency. This is not to say that personnel with a lower degree of training is ready at present to assume these tasks. A major example is the fact that primary care is mostly provided by paediatricians, gynaecologists and specialists in internal medicine. Another example is the lack of a gatekeeper function by lower levels of health services, allowing unjustified access to specialist, inpatient or even tertiary care. Another example is the execution of preventive tasks by medical specialists, e.g. contraception by gynaecologists and immunisations by paediatricians. On the other hand, nurses have insufficient freedom to develop their profession and to enlarge their scope of activities.

The lack of autonomy of health care facilities to manage their own affairs could also be seen as a lack of delegation of responsibilities.

i Social care

The Ministry of Health is responsible for a relatively large sector of social services. This can be explained by historical reasons, but these services do not belong in an efficient and scientific standard package of health care benefits, regardless of the type of health care financing. Examples are the so-called prophylactoria, the balneological resorts (except for revalidation services with a proven scientific foundation) and the children's nurseries.

Possible solutions to the 9 above-mentioned problems will be presented in the next two chapters.

5. DISCUSSION ABOUT HEALTH CARE REFORM

5.1 Introduction

Changes in the organisation of a complex system such as the health care system are difficult at the best of times. Western countries are constantly grappling with reform, with mixed results. Countries in Central and Eastern Europe are searching for solutions to their problems, sometimes following quite different paths. Health care reform in Bulgaria cannot escape the usual opposition by vested interests and the conflicting opinions of various actors in this field including those calling for a complete overhaul of the system.
Health care reform takes time to implement, but after several years of uncertainty following more than 40 years of a system copied from the former Soviet Union, the presentation of the outline of the proposed reform should not be delayed much longer. The Bulgarian Ministry of Health has announced that it will produce a national health strategy by the end of 1995. An unedited draft version of a strategy document called 'Health for the nation' has become available at the end of August 1995 (see § 1.1 and § 5.3). We hope that the options described in the following chapters will help the Ministry and its partners to formulate their policies. Implementation will take much longer; sometimes experiments are needed to test certain proposed solutions in the field and changes in legislation are always difficult to achieve. The legislative changes needed for the various options are not mentioned explicitly in this report.

The historically grown large diversity of health care systems in western countries suggests that none of them can be copied directly in Bulgaria and, on the other hand, that there is no single system which can be called best. We want to stress the fact that we do not propose any single health care system anywhere in the world as the one most useful for Bulgaria. Bulgaria should establish a system of its own that raises sufficient revenues in an acceptable way to deliver a package of benefits, the size and quality of which has been agreed upon by population, the purchasers and the providers. It is, however, useful to learn from the achievements and mistakes in other countries.

Although it will complicate the decision-making process, it is necessary to inform all actors and engage them in the discussions about possible changes and consensus-building. Therefore, this report is written for a wider audience than the Ministry of Health. The most important actors in the

Bulgarian health care reform are already represented in the Steering Committee which is overseeing the project described in chapter 1 of this report.

5.2 Method

In chapter 6, we shall describe options for the main elements of the package of benefits, i.e. the type of health care provided for the population. Options for the management of the health care system will be described in Chapter 7.
We can only describe the options for a limited number of the more important aspects of health care and health care management. For each aspect, we shall describe more than one option, often including the option not to change the present situation or sometimes even the option *not* to take a decision. The implications, advantages and disadvantages of each option shall be briefly presented. In some cases, the choice for a certain option seems rather obvious, but other options are real alternatives. To stress the differences between options, they are presented in a rather black and white way. In practice, policy makers often arrive at a decision that has elements of more than one option in it.

It is often not possible to consider the options for one aspect of health care reform without taking into account some other aspects. For example (in chapter 6), it is obvious that the decision about the introduction of a new type of general practitioner in Bulgaria is related to the position of other professionals such as medical specialists and feldshers. As another example (in chapter 7), decisions about the position of the Ministry of Health in the management structure are directly related to the position of districts and municipalities. For this reason, clusters of inter-related subjects have been formed, such as 'primary care' in chapter 6 and 'centralisation-decentralisation' in chapter 7.

It is, of course, not possible to go into too many details in these two chapters, otherwise the report could not serve its purpose: to be a framework (a tool) for the discussion about health care reform. Some readers will miss certain aspects of the health care reform and certain options for some aspects. If they introduce these remarks into the discussion - during the workshop planned for November 1995 and elsewhere - this is exactly what we want to achieve with this exercise: to stimulate the discussion about health care reform.

5.3 Draft strategy document 'Health for the nation'

The unedited first draft of the Bulgarian health strategy paper 'Health for the nation' (Bulgarian and English versions) was discussed during a workshop in Sofia on 31 August - 2 September 1995. The emphasis of this paper is on health aspects and as such it is complementary to our efforts concerning health care management. The draft strategy paper, however, also contains sections on the present and future management and financing of health care which we have studied for the preparation of our report. We hope that our report may be useful for the task force of the Ministry of Health responsible for completing the strategy document.

5.4 How to use this report

In chapter 1 we already explained that the major objective of this report is to serve as the guiding document during a workshop about the reform of the health care management system in Sofia in November 1995. The usefulness of the report will not end there, however. It will continue to provide information for all those involved in health care reform and policy development in Bulgaria, especially in the Ministry of Health but also elsewhere, e.g. by professional organisations.

For the participants of the workshop in November, we have the following suggestions:

* The participants who are familiar with the existing Bulgarian health care system can save time by skipping chapters 2-3.
* The participants should read chapter 4 because it will be discussed briefly in the beginning of the workshop.
* The participants should read chapter 5, because it explains the method to be used for the discussion of options for health care reform.
* In chapters 6-7, there are too many subjects and options to be discussed during a workshop that lasts only one day. Participants should therefore focus on two clusters of subjects from chapter 7 only: the centralisation-decentralisation issue and financing issues (subjects J-S).

6. OPTIONS FOR THE TYPE OF HEALTH CARE PROVIDED

6.1 Introduction

Table 6.1 presents an overview of the subjects covered in this chapter with - in a few keywords - the options available concerning each subject.

Table 6.1. Overview of subjects and options concerning the type of health care

	SUBJECTS		OPTIONS
A	GENERAL PRACTICE	1	introduction of modern general practice nation-wide
		2	modern general practice in rural areas only
		3	primary care is provided by medical specialists (except in villages)
		4	no decision taken
B	FELDSHERS	1	phase out the feldsher system slowly
		2	keep the feldsher system
		3	abolish the feldsher system now
C	PROVISION OF SPECIALIST OUTPATIENT CARE	1	only referred patients
		2	decrease the number of specialists
		3	keep the present polyclinic system
		4	no decision taken
D	DIVERSITY OF SPECIALIST OUTPATIENT CARE	1	keep the system as it is (various types of polyclinics, dispensaries, etc.)
		2	integrate and standardise specific outpatient care in multipurpose polyclinics
		3	no decision taken
E	INTEGRATION OF OUTPATIENT AND INPATIENT CARE	1	keep the system as it is (mostly integrated)
		2	separate outpatient and inpatient care
		3	no decision taken
F	HOSPITAL BEDS	1	reduce number of hospital beds drastically
		2	reduce number of hospital beds slightly
		3	no change in number of hospital beds
		4	no decision taken
G	HOSPITAL SPECIALISATION	1	keep general and specialised hospitals separate
		2	partial integration of specialised hospitals in general hospitals
H	NURSING HOMES	1	establish a system of nursing homes
		2	do not establish such a system
I	PREVENTIVE HEALTH CARE	1	more emphasis on health promotion and health protection
		2	less emphasis on screening
		3	improve mother and child care
		4	continue the present offer
		5	no decision taken

Pharmaceutical supply is not mentioned in this table, but it is extensively treated in the draft strategy document 'Health for the nation'.

6.2 Primary care

SUBJECT A: GENERAL PRACTICE

We cannot discuss here the merits and disadvantages of the various forms of primary care as they exist in different countries. Generally speaking, there seems to be a consensus that comprehensive and continuous health care by professionally trained general practitioners (GPs) is useful for both purchasers and consumers of health care. It is supposed to be useful for purchasers, because up to 90% of all complaints can be handled adequately with relatively inexpensive diagnostic and therapeutic technology, thus avoiding unnecessary access to more expensive specialist care, especially inpatient care. It is profitable for the population because most patients can be treated in or near their homes, 24 hours a day and 365 days a year, by a doctor who knows the situation and medical history of the patients and his family. It is essential that GPs receive initial and continuous training at the level required to ensure that the quality of health care is guaranteed. The general practitioner protects his patients against overuse of diagnostic technology by recognising serious pathology in a sea of minor complaints. This is, however, not always what patients want. There are also many specialists who do not believe that GPs are able to function in this way.

An important role of a well-trained GP is that of a gatekeeper; this role needs to be enforced by legal and financial measures, however, by prohibiting or punishing free access to medical specialists.

The situation in Bulgarian primary care has been described in § 3.3.3. In chapter 4 we concluded that this situation differed from that in many western countries.

Option A1: introduce modern general practice nation-wide

Advantages:

* a clear choice for modern general practice should lead to the above-mentioned benefits: efficiency, quality
* conforming to international trends

Disadvantages:

* many new GPs must be trained
* major change and unrest in the Bulgarian health care system
* opposition by medical specialists, either because they believe that GPs cannot provide good primary care, or because they are afraid of losing their employment
* opposition by those citizens who value free access to specialist care

The disadvantageous effects can be mitigated if the introduction takes place gradually. Some redundant medical specialists could be retrained as GPs.

Option A2: introduce modern general practice in rural areas only

For primary care, one can imagine a network in rural areas only, because primary care by medical specialists is not feasible there. Actually, this option implies that health care based on GPs is second best only: if medical specialists are available they are preferred. It therefore seems a hybrid option, but it is the proposed policy of the draft strategy document 'Health for the nation'.

Advantages:

* less GPs to be trained
* improvement of primary care in rural areas
* less opposition by urban medical specialists

Disadvantages:

* no improvement of urban primary care (if one believes that GPs are the best providers of primary care)
* non-standardised primary care in the country
* a decision must be taken about the feldshers (see subject B)

Option A3: primary care is provided by medical specialists (except in villages)

This option chooses continuation of the present situation: primary care by paediatricians, gynaecologists and specialists in internal medicine, sometimes preselected by so-called district physicians.

Advantages:

* no GPs to be trained
* high quality primary care (if one believes that specialists are the best providers of primary care)

Disadvantages:

* inefficient use of high-technology health care
* population is missing the benefits of modern general practice (if one believes in them)
* this option is contrary to international developments

Option A4: no decision is taken

Advantages:

* no need to take a decision

* avoidance of controversy

Disadvantages:

* what to do with the 1200 physicians who received a first two-months course in general practice?
* otherwise as in option A3.

SUBJECT B: FELDSHERS

A special feature of Bulgarian primary care is the feldsher. It should be determined if this feature is to remain or not. If it is not to remain, it could be abolished slowly (waiting for their departure or pensioning age) or abruptly. If no decision is taken, one has to guarantee correct functioning of a slowly diminishing number of ageing feldshers in Bulgarian primary care, in relation to other health care professionals.

The option not to take a decision will have more or less the same results as option B1, because the feldsher training school seems to have discontinued its activities.

Some tasks of feldshers could be taken up by nurses after some retraining.

Option B1: phase out the feldsher system slowly

Advantages:

* no social unrest among feldshers
* gaining time for their slow replacement by newly trained GPs

Disadvantages:

* possibly decreasing quality of work by an ageing and diminishing group of feldshers
* for a long time: two parallel types of primary care
* some villages may end up without primary health care

Option B2: keep the feldsher system

Advantages:

* no social unrest among feldshers
* continuation of good primary care (if one believes that feldshers provide good primary care)
* feldsher care is probably cheaper than GP care

Disadvantages:

* unclear relation to the planned new GPs
* training and continuing education of the feldshers has to be resumed

Option B3: abolish the feldsher system now

Advantages:

* clear choice for a different system of primary care
* more standardisation in primary care

Disadvantages:

* what to do with the ex-feldshers?
* no time to replace them with new GPs

6.3 Specialist outpatient care

SUBJECT C: PROVISION OF SPECIALIST OUTPATIENT CARE

The provision of specialist outpatient care is concerned with the access to this type of health services, to the number of medical specialists providing these services and the integration of these services with hospital care (or not). By international comparison, the number of medical specialists per 1000 inhabitants is high in Bulgaria. Specialist outpatient care was discussed in § 3.3.2.

Option C1: only referred patients

Access to outpatient specialist care can be restricted by according a strong and professional gatekeeper function to primary care.

Advantages:

* less patients in outpatient specialist care, leading to lower cost in general
* specialists are not overburdened with simple pathology but concentrate on specialist cases

Disadvantages:

* medical specialists may object because of fear of unemployment or fear of deteriorating quality of health care
* the population may object because they have become used to free access and because they want 'the best'

* primary care physicians will become overburdened if not adequately trained in sufficient numbers

Option C2: decrease the number of specialists

A decrease of the number of medical specialists cannot be taken into consideration without taking the options concerning general practice and hospital beds into account as well. A decrease in the number of medical specialists can be achieved by not replacing specialists who leave or retire, by accepting less specialists in training, by retraining some specialists (e.g. into GPs) or by laying off specialists.

Advantages:

* reducing the cost of health care (less salaries and less technology)
* a reduction of the number of physicians is one of the prerequisites for the needed increase in salaries of the remaining physicians
* retraining medical specialists (e.g. district doctors) into GPs will decrease the oversupply of specialists and diminish the shortage of modern GPs.

Disadvantages:

* strong opposition from medical specialists
* social cost if laying off highly qualified professionals
* decline in quality of care if primary care is not strengthened simultaneously

Option C3: keep the present polyclinic system

The present polyclinic system is characterised by free access for the population, limited or no gatekeeper action by district physicians and a mixture of primary and secondary care.

Advantages:

* no complicated organisational changes necessary
* no explication needed for the population

Disadvantages:

* the present polyclinic system is an inefficient way of providing primary care
* this option will block endeavours to install a GP system and make superfluous projects going on in this field

Option C4: no decision taken

This option is similar to option C3, but does not stop present projects making a beginning with general practice in Bulgaria.

Advantages:

* as in option C3
* no decision has to be taken

Disadvantages:

* as in option C3
* present projects concerning general practice will become rather useless and physicians trained in these projects will be frustrated

SUBJECT D: DIVERSITY OF SPECIALIST OUTPATIENT CARE

At present, specialist outpatient care is fragmented in many different types of facilities: integrated and non-integrated polyclinics, polyclinics of type I-V, workers' polyclinics, dispensaries and polyclinics of specialised hospitals. This was shown in § 3.3.2 and discussed in chapter 4.

Option D1: keep the system as it is

This option is closest to the one presented in the draft strategy document 'Health for the nation', with continuation of separate general polyclinics, workers health services and dispensaries. The document even wants to expand the dispensary system with new types such as diabetes dispensaries.

Advantages:

* no difficult reorganisation process
* no unrest among the professionals working in the various facilities

Disadvantages:

* very fragmented system with unclear relations between the facilities and nearly impossible to manage as a system
* no comparative evaluation possible of non-standardised facilities
* inefficient system with duplication of activities and waste of resources
* unclear relations with primary care and inpatient care
* see also option C3

Option D2: integrate and standardise specialist outpatient care in multipurpose polyclinics

By integration is meant the incorporation of specific polyclinics and dispensaries (e.g. for tuberculosis or cardiovascular disease) into multipurpose polyclinics. One could chose not to integrate certain specific polyclinics, e.g. for psychiatry.

By standardisation is meant that the many different types of outpatient care are reduced to a very limited number of standard types, e.g. a basic specialist polyclinic (with internal medicine, gynaecology, paediatrics and surgery only) for smaller towns and a comprehensive polyclinic (with all major specialties) for large towns. This is just an example, of course. One could also have one single type of polyclinic, a standard diagnostic and treatment centre for ambulatory specialist care. The question of integration or non-integration with inpatient care will be discussed under subject E. The present standardisation of general polyclinics in five levels seems too detailed and there seems to be little need for independent workers' polyclinics and certain types of dispensaries.

Advantages:

* better management perspectives
* streamlining the system will increase efficiency (i.e. reduce cost)
* less confusion for patients and health care professionals

Disadvantages:

* unrest among facilities and professionals threatened by reorganisation or even closure
* loss of specific know-how, e.g. in the field of tuberculosis control

Option D3: no decision taken

This option is similar to option D1, except that uncontrolled developments could cause changes in the present outpatient services. These developments could be local decisions to integrate in some places and not in other places, or the establishment of yet another type of specialised polyclinic, e.g. for treatment of infertility or phlebitis.

Advantages:

* no need to take a decision
* no unrest among health care professionals

Disadvantages:

* risk of even more fragmented outpatient services
* geographical inequalities in the offer of outpatient services

SUBJECT E: INTEGRATION OF OUTPATIENT AND INPATIENT CARE

At present, most polyclinics are integrated, i.e. attached to a hospital, physically and organisationally. Each medical specialist usually works in both inpatient and outpatient care, and the inpatient and outpatient departments belong to the same hospital organisation. Internationally, there is no consensus that this is a good situation or that it would be better to separate polyclinics and hospitals: different management and different physicians. Bulgarian experts also express different opinions about this subject.

Option E1: keep the system as it is (mostly integrated)

Advantages:

* no need for reorganisation with the accompanying unrest
* common use of facilities: laboratory, X-ray, administration, etc., leading to cost savings

Disadvantages:

* less emphasis on the role of a polyclinic to keep patients out of hospital
* less transparency of the costs of either inpatient or outpatient care

Option E2: separate outpatient and inpatient care

Advantages:

* strengthening of ambulatory care
* less pressure for hospital admissions
* better transparency of the costs generated in either inpatient or outpatient care

Disadvantages:

* doctors become too specialised in either ambulatory or inpatient care
* duplication of diagnostic facilities

Option E3: no decision taken

This option is rather similar to option E1.

Advantages:

* no decision to be taken
* no unrest among the staff

Disadvantages:

* lack of standardisation: both integrated and non-integrated polyclinics continue to exist
* no answer to the question which option is more efficient

6.4 Inpatient care

SUBJECT F: HOSPITAL BEDS

In countries with a surplus, the reduction of the number of hospital beds is probably the best method to contain or reduce the cost of health care by trimming the physical infrastructure, the personnel that goes with it and the medical activities that are generated in it. One could either diminish the number of beds in hospitals or close entire hospitals. There is no internationally recognised optimal number of hospital beds per 1000 population, but few people would deny the severe excess in Bulgaria. In countries with low ratios of beds per population, further reduction could endanger public health, but this cannot be the case in Bulgaria. Chapter 4 concluded that the oversupply of hospital beds is one of the major bottlenecks in the Bulgarian health care system.
Apart from the number of beds, it is important to control the supply of high-tech equipment which is expensive but has only limited impact on the health status of the population.
It may not be necessary to close all redundant hospital capacity; some of it may be turned into nursing homes and other types of care for old and chronically ill people (see subject H).
The draft strategy document 'Health for the nation' does not pronounce itself on the number of hospital beds needed in the country.

Option F1: reduce number of hospital beds drastically

Advantages:

* probably the best method of containing or reducing the cost of health care
* possibility of transforming hospitals or hospital wards into nursing homes
* the reduction of the number of hospital beds puts more emphasis on admission criteria and length of stay

Disadvantages:

* generally speaking, hospital directors will oppose this reduction
* the population does not like it when they have to travel to another municipality for hospital care
* a policy to reduce the number of beds may give rise to conflicts between the 6 organisations which operate hospitals in Bulgaria (4 ministries, faculties, municipalities)
* social unrest if hospital staff is laid off

Option F2: reduce number of hospital beds slightly

Advantages:

* it is better than no reduction at all
* less unrest among hospital staff and the population

Disadvantages:

* no clear signal for cost containment
* a minor reduction still calls for the same discussion with the 6 hospital-operating organisations as a major reduction

Option F3: no change in number of hospital beds

Advantages:

* no unrest among staff and population
* other advantages are difficult to imagine

Disadvantages:

* Bulgarian health care will collapse under the weight of its inpatient sector

Option F4: no decision taken

It is difficult to say if in practice this will lead to a slight increase in the number of hospital beds (because some hospitals are still under construction), a stable situation, or a slight decrease (because some hospitals become bankrupt or others reduce their number of beds without central directives). This option is rather similar to option F3.

Advantages:

* no need to take decision
* no unrest among staff and population

Disadvantages:

* there is no knowing how many hospital beds there will be (but there will be far too many)
* little chance to improve other aspects of Bulgarian health care, such as primary care or the salaries of health care professionals

SUBJECT G: HOSPITAL SPECIALISATION

Bulgaria has a high number of specialised hospitals: psychiatric hospitals, pulmonary hospitals, paediatric hospitals, and so on. There are also specialised polyclinics called dispensaries which

provide inpatient treatment as well and therefore could be called hospitals too, e.g. oncological or tuberculosis dispensaries. There are probably no countries in the world that have no specialised hospitals; for example, psychiatric hospitals are often separate. The question is: to what extent is specialisation of hospitals beneficial for patients and expertise of staff and to what extent is it a bottleneck for comprehensive care? This question is not addressed in the draft strategy document 'Health for the nation'. In chapter 4, we concluded that both inpatient and outpatient care were overspecialised.

Option G1: keep general and specialised hospitals separate

Advantages:

* no unrest among hospital managers
* possibly better protection of specific know-how in specialised hospitals

Disadvantages:

* comparative evaluation of non-standardised facilities is not possible
* lack of more comprehensive approach of the patients in specialised hospitals
* lack of development of expertise in some specialties in general hospitals

Option G2: partial integration of specialised hospitals in general hospitals

Advantages:

* a standardized offer of services in most hospitals makes referral from primary care easier
* less narrow specialisation and better coordination between doctors and nurses
* patients with specific diseases will benefit from more comprehensive care
* easier planning and management of standard hospital services

Disadvantages:

* integration will be more difficult if the hospitals are physically separated (as will be mostly the case)
* reorganisation causes unrest among the staff, especially in specialised hospitals
* possibly less focus on some specific diseases

SUBJECT H: NURSING HOMES

There are some retirement homes and institutes for mentally or physically handicapped people in Bulgaria, but no network of nursing homes. Nursing homes in other countries provide nursing care

to patients with long-lasting or terminal disease that cannot be kept at home. Nursing homes for the terminally ill are also called hospices. Because no diagnostic and only limited therapeutic technology is used, a bed-day in a nursing home costs 2 to 3 times less than in a hospital. Nursing homes should also have a more 'homely' appearance than hospitals, although nobody in the population looks forward to a period in such a home.

Option H1: establish a system of nursing homes

This is the preferred option of the draft strategy document 'Health for the nation'.

Advantages:

* a shift from hospital care to nursing home care will reduce the demand for expensive hospital beds
* a network of nursing homes could absorb some of the overcapacity in hospitals and sanatoria while keeping most of the personnel (sometimes after retraining)
* high-quality care becomes available for the increasing number of chronically ill and terminal patients in an ageing population

Disadvantages:

* there will be new costs if there is a shift from home care to nursing home care
* the organisation of nursing homes and possibly some extra training will be a certain effort

Option H2: do not establish such a system

Advantages:

* no effort needed to organise a new form of care
* no creation of a new type of demand

Disadvantages:

* expensive hospital beds will continue to be occupied by patients who actually need less sophisticated care
* patients with chronic or terminal disease will not receive optimum care

6.5 Preventive health care

SUBJECT I: PREVENTIVE HEALTH CARE

It was already stated in chapter 1 that health policy is important but that it is hardly the subject of this report. The effects of health policy on the health status of the population are more long-term than the effects of reform in the field of management on the functioning of the health services. However, we want to include the subject of prevention in this chapter. More emphasis on health promotion and protection activities does not necessarily mean discontinuation of screening activities of proven benefit.

Preventive health care in Bulgaria was discussed in § 2.4.2 and § 3.3.4. The options for the management of preventive health care are mentioned in chapter 7.

Option I1: more emphasis on health promotion and health protection

This option is one of the policy elements of the draft strategy document 'Health for the nation'.

Advantages:

* health promotion has a higher potential for health benefit than screening activities, especially in Bulgaria
* the emphasis on health promotion will link Bulgaria to modern international developments
* a network for health promotion and protection activities is already in place

Disadvantages:

* it is often difficult to convince physicians and the population of the importance of changes in life style
* intersectoral policy is difficult to organise

Option I2: less emphasis on screening

Screening activities are carried out for women (antenatal care and cancer screening), children, employees and the general adult population, e.g. for risk factors for cardiovascular disease. This was described in § 2.4.1 and § 3.3.4 and also in the draft strategy document 'Health for the nation'.

Advantages:

* less cost without concomitant increase in morbidity, because some screening activities have no scientific basis and others carry only limited benefit
* less screening will lead to fewer referrals to polyclinics

Disadvantages:

* physicians and population may miss a sense of security, even if misplaced
* some pathology will be missed at an early stage
* health care professionals involved in screening will disagree about the limited efficiency of certain screening procedures

Option I3: improve mother and child care

By mother and child care we mean contraception, antenatal care, well-babies clinics, immunisation and school health. These subjects are discussed extensively in the draft strategy document 'Health for the nation'. Reduction of the infant mortality rate is one of its objectives.

Advantages:

* great health benefit of the introduction of modern contraceptive methods
* modern contraception will lessen the demand for abortions
* better obstetric outcomes
* reduce infant mortality and maternal mortality

Disadvantages:

* improvement of mother and child care may cost extra money, e.g. for the training of health care professionals
* intensification or changes in mother and child care will need an information campaign in the population

Option I4: continue the present offer

Advantages:

* no need for reorganisation causing unrest among managers and employees
* continuing good results from those activities that are well executed, such as antenatal care and immunisation

Disadvantages:

* insufficient offer of some activities, e.g. contraception or health promotion
* emphasis on the less effective forms of prevention, i.e. screening
* inefficient use of medical specialists for relatively simple tasks
* unclear division of tasks in preventive health care

Option I5: no decision taken

Advantages:

* no decision to be taken
* no need for reorganisation and explanation

Disadvantages:

* see option I4
* further deterioration of preventive health care

7. OPTIONS FOR HEALTH CARE MANAGEMENT

7.1 Introduction

Chapter 7 is organised in the same way as chapter 6, but focuses on the management aspects of health care reform. It is important to discuss the roles that the various actors in health care could play, with the advantages and disadvantages of each option. Most of these actors are already on stage, but there may be newcomers such as district health authorities or insurance carriers.
In any health care system there are relations between purchasers, providers and consumers of health care. In Bulgaria at present, national and municipal authorities are the purchasers of health care, although they may not feel that they are really purchasing anything. The providers are the various health care professionals and the consumers the total population. Relations between these three groups may change completely, to some extent, or not at all.

Generally speaking, Bulgarian health care seems in need of simpler and more transparent management in a reduced and less fragmented field, steering the health care activities on the basis of real data. Because bureaucracy - i.e. administrative procedures that are not relevant for management - always has a tendency to grow, one of the aims of health care reform should be to reduce it.

Table 7.1 presents an overview of the subjects covered in this chapter with - in a few keywords - the options available concerning each subject.

Table 7.1 Overview of subjects and options concerning health care management

	SUBJECTS		OPTIONS
J	ROLE OF THE MINISTRY OF HEALTH	1	strong centralised management
		2	strong decentralisation and delegation, only key functions retained by the Ministry of Health
		3	new mix of centralisation and decentralisation
		4	no changes in the role of the Ministry of Health
K	ROLE OF THE MUNICIPALITIES	1	continue the present (large) role of municipalities in health care
		2	eliminate the role of municipalities in health care altogether
		3	municipalities will retain only a limited role in health care
L	ROLE OF DISTRICTS AND REGIONS	1	no role for districts or regions
		2	the recent District Centres for Health Care will have a management function as district health authorities
		3	the District Centres will only have a monitoring role
		4	certain role for regions (to be defined)
M	ROLE OF OTHER MINISTRIES INVOLVED IN HEALTH CARE	1	present role of the Ministries of Defence, Transport and the Interior will continue
		2	the role of these ministries will be reduced
		3	the role of these ministries will be discontinued
N	AUTONOMY OF HEALTH CARE ESTABLISHMENTS	1	health care facilities remain departments of a ministry or municipality
		2	health care facilities become legal independent entities
O	MACRO-FINANCING OF HEALTH CARE	1	tax-based budgetary system
		2	social health insurance
		3	mixed system
		4	no decision taken
P	COST CONTAINMENT	1	a comprehensive cost containment policy
		2	containment of some costs only
		3	no decision taken
Q	PAYMENT OF HEALTH CARE PROFESSIONALS	1	fixed salary by state, municipality or other employer
		2	remuneration according to volume and/or quality of work (several methods)
R	PRIVATIZATION	1	no steering of the privatization process
		2	no privatization allowed in most or all sectors of health care
		3	privatization in certain sectors of health care will be encouraged
S	CONTRACTING OF HEALTH CARE	1	contracting methodology will not be used
		2	standard contracts between purchasers and providers
		3	no decision taken
T	QUALITY CONTROL	1	quality control measures remain as they are today
		2	a revised and enlarged system of quality control will be developed
		3	no decision taken
U	POSITION OF CUSTOMERS	1	no influence of organised customers on health care reform and management
		2	establishment of customers' organisation(s) will be promoted
		3	establishment of customers' organisation(s) will be left to private initiative
V	POSITION OF PROVIDERS	1	providers have to compete for patients
		2	providers associate to obtain a maximum of benefits
		3	the rights and duties of providers are formulated in legislation
W	MANAGEMENT OF PREVENTIVE HEALTH CARE	1	mother and child care is managed as a separate organisation
		2	one organisation for most forms of preventive health care
		3	keep the organisation of preventive health care as it is now

The subjects of training health care professionals and health information systems do not appear in the table, but they are mentioned in options for several subjects. They are also extensively treated in the draft strategy document 'Health for the nation'.

7.2 The centralisation-decentralisation issue

SUBJECT J: ROLE OF THE MINISTRY OF HEALTH

This subject can be discussed in terms of centralisation and decentralisation. In this discussion one has to determine the optimal level of control in terms of effectiveness, efficiency and job satisfaction of politicians and health care professionals.
In every health care system the Ministry of Health has to play a certain role. The legal aspects of the role of the Bulgarian Ministry of Health have been discussed in § 2.1. The present role of the Ministry of Health concerns both elements of policy development and direct influence on certain health care facilities.
The problems concerning the position of the Ministry of Health have been discussed in chapter 4.
Under any option, the relation with other ministries involved in health care will be one of the tasks of the Ministry of Health.
The introduction of new District Centres for Health Care (see § 3.4) is related to the centralisation-decentralisation issue; however, it will be discussed under subject L.

Option J1: strong centralised management

Advantages:

* a clear and transparent system
* the most effective way for cost containment
* good conditions for a comprehensive policy

Disadvantages:

* rigid and inefficient management
* no incentive for other stakeholders
* strong opposition from the municipalities
* possibly opposition from the Ministries of the Interior, Transport and Defence

Option J2: strong decentralisation and delegation

In this option, the Ministry of Health will delegate power to peripheral parts of the health care system and will retain only the following key functions: strategic planning, macroeconomic control, and control of the public health status and the quality of health care. The Ministry will not be at all involved in the management of health care facilities, neither at national nor at district or municipal level. This will also enable the Ministry to focus on neglected areas, such as health policy, preventive health care, quality control, cost containment, standards for professions and facilities, and the development of a policy to regulate the purchase of high-tech equipment.

Advantages:

* incentives through involvement of other stakeholders
* less bureaucracy in the Ministry
* probably better conditions for the quality of the policy making process in the Ministry of Health
* better conditions for good management in the health care system

Disadvantages:

* need to train staff at the peripheral level
* fewer possibilities for cost containment
* danger of introducing bureaucracy at the peripheral level

Option J3: new mix of centralisation and decentralisation

Advantages:

* item-wise choices for centralisation or decentralisation may lead to a better management model
* avoids some of the controversy created by strong centralisation
* avoids some of the possible lack of coherence created by strong decentralisation

Disadvantages:

* the contents of the new mix still have to be elaborated
* implementation needs time, explanation and training
* probably more bureaucracy

Option J4: no changes in the role of the Ministry of Health

Advantages:

* no need for reorganisation causing unrest among the staff
* no opposition from the municipalities
* no need for training additional staff

Disadvantages:

* management and control of the health care system will remain difficult
* opposition from stakeholders who want change
* it blocks the health care reform process

SUBJECT K: ROLE OF THE MUNICIPALITIES

The present role of the municipalities is very important compared to other countries in Western and Eastern Europe. Responsibilities include policy-making and the financing and provision of the majority of the health services in the country. Some see the municipalities as the best organisation to represent the health interest of the population. According to our conclusions in chapter 4, the municipalities may not be well equipped to play their role in the management of health care. If this is true, they could either prepare themselves for this role or relinquish it. The municipal role in health care could also become smaller and more specialised, e.g. only preventive health care. Municipalities could associate on a voluntary basis to share knowledge and resources. Municipalities could explain and defend their role in intersectoral policy, i.e. health promotion and protection measures that also need other partners than the health services themselves.

Option K1: continue the present (large) role of municipalities in health care

Advantages:

* no decision has to be taken
* no unrest at the municipal level
* local taxes remain available for financing health care

Disadvantages:

* a growing burden for the municipal budget
* continuing differences between the municipalities concerning the spending for health care
* no improvement in the transparency of the system
* no improvement in the management of the system

Option K2: eliminate the role of municipalities in health care altogether

Advantages:

* relief for the municipal budget
* no more differences between the municipalities concerning the spending for health care

* a more transparent structure of the system
* better possibilities for managing the system

Disadvantages:

* opposition from the Ministry of Finance
* opposition from the municipalities
* local taxes no longer available for the financing of health care
* possibly less coordination between health care and other care at the local level

Option K3: municipalities will retain only a limited role in health care

Advantages:

* municipalities remain involved in health care
* a smaller burden for the municipal budget

Disadvantages:

* a decision must be taken about the precise role of the municipalities
* the municipalities may oppose this option (although less than option K2)

SUBJECT L: ROLE OF REGIONS AND DISTRICTS

Officially, districts ('okrag') do not exist any more and regions ('oblast') have no role in health care. As was described in § 2.1.5, in practice districts do play a certain role in health care. With the new decree establishing District Centres for Health Care, the role of the 28 (former) districts in health care has been accepted again, albeit under a different name ('rayon'). These new District Centres cannot (yet) be seen as district health authorities; their role in health care management (if any) has not yet been specified.

In § 3.3 we already suggested that it did not seem logical that certain types of health services - e.g. dispensaries or specialised hospitals - are managed by the single municipality where they are located. It is conceivable that some forms of health services are best planned and managed at an intermediate level between the Ministry of Health and the municipality; this could be either district or regional level. However, for planning and management these intermediate levels would need the required resources and skills. Other roles for the intermediate level could be coordination of data gathering and analysis, coordination of intersectoral policy, and advising about the planning of health services (avoiding over- and under-capacity). The division of responsibilities between the three levels of management has to be clarified. This is discussed under subjects J, K and L.

Option L1: no role for districts or regions

Advantages:

* simple management model with two levels only
* no need to prepare district and regional managers for these tasks
* no need to define the role of districts or regions

Disadvantages:

* some types of health care are too burdensome for central management and too complex for municipal management
* existing role of districts in health care must be eliminated
* this option is contrary to the recent establishment of District Centres for Health Care

Option L2: the recent District Centres for Health Care will have a management function as district health authorities

Advantages:

* for several sectors in the health care system, the district seems to be the best management level (e.g. hospital care or polyclinics)
* further expansion of the responsibilities of the new District Centres for Health Care can be seen as a logical step after the reinforcement of the former District Centres for Health Information

Disadvantages:

* opposition from the municipalities
* before the new District Centres can assume a management role, staff must be trained
* probably an obstacle for the introduction of social health insurance

Option L3: the District Centres will only have a monitoring role

Advantages:

* conforms well to their present role
* no opposition from the municipalities
* no further unrest after the unrest created by the decree that established the new District Centres

Disadvantages:

* there will be no management role at district level
* possibly contrary to the expectations raised by the decree

Option L4: certain role for regions (to be defined)

Advantages:

* a regional role in health care would be conform the administrative procedures in other governmental sectors
* for some sectors in the health care system, the region could be the best management level (e.g. tertiary care or dispensaries)

Disadvantages:

* adding yet another level to the management pyramid
* no staff is available at regional level to assume a role in health care management

SUBJECT M: ROLE OF OTHER MINISTRIES INVOLVED IN HEALTH CARE

The role of the Ministries of the Interior, Defence and Transport in health care has been described in § 2.3. Their separate status was characterised as a bottleneck in chapter 4. The draft strategy document 'Health for the nation' does not discuss this subject.

Option M1: present role of the Ministries of Defence, Transport and the Interior will continue

Advantages:

* no need to take a decision
* no opposition from the other ministries and their health care staff

Disadvantages:

* obstacle for comprehensive policy
* obstacle for the management of the system
* possibly an obstacle to the introduction of social health insurance

Option M2: the role of these ministries will be reduced

One could envisage that these ministries fall back on their essential roles (e.g. military medicine) and leave the treatment of families and outsiders to the network under the Ministry of Health.

Advantages:

* more transparency in the system
* emphasis on the essential role of these ministries, i.e. the development and maintenance of expertise in treating battlefield casualties etc.

Disadvantages:

* opposition from the other ministries and their health care staff
* the coordination problem between the four ministries remains

Option M3: the role of these ministries will be discontinued

Advantages:

* clear planning and management model
* better possibilities for comprehensive policy
* possibility to reduce the size of the health care network

Disadvantages:

* strong opposition from the other ministries
* unrest among the staff of the facilities operated by these ministries

SUBJECT N: AUTONOMY OF HEALTH CARE ESTABLISHMENTS

At present, health care establishments are departments of municipalities or ministries. Autonomy of these establishments has advantages and disadvantages. Every establishment would like to keep the money it saves on its budget, but it is another matter to be responsible for losses and debts. Generally speaking, autonomy should be an incentive for increased efficiency. It is difficult to oversee the legal consequences of an independent status of health care facilities. Would they be free to determine the salaries they want to pay to their staff or to licence staff? Which control mechanisms should the government have to avoid unwelcome developments such as bankruptcy?
The subject of autonomy of health care facilities is related to several other subjects discussed in this chapter and especially to subject S (contracting). It is shortly dealt with in the draft strategy document 'Health for the nation' by recognising the need for a different juridical status for health care facilities.

Option N1: health care facilities remain departments of a ministry or municipality

Advantages:

* no unrest among the staff
* easier to standardise health services this way

Disadvantages:

* no incentives for improvement of the management
* continuation of the rigid bureaucratic budget regulations
* introduction of contracting is hardly possible
* continuation of political influence in the management of health care facilities

Option N2: health care facilities become legal independent entities

Advantages:

* creation of incentives for the management
* discontinuation of the bureaucratic budget regulations
* contracting becomes possible

Disadvantages:

* a decision must be taken concerning the type and degree of autonomy
* legal preparation needed
* unrest among the staff
* need for management training

7.3 Financing issues

SUBJECT O: MACRO-FINANCING OF HEALTH CARE

Under the heading of 'macro-financing of health care' we want to discuss the broad choices to be made for the financing of Bulgarian health care, which basically amounts to a choice between a tax-funded system, a system based on health insurance, or (most probably) a mixture of both.
The financing of Bulgarian health care was presented in § 2.7 and § 3.2 and underfunding, inefficiencies and the weak relation between funding and activities were considered to be major bottlenecks in chapter 4.
The draft strategy document 'Health for the nation' proposes better resource allocation (by increasing transparency of costs and activities), more efficiency (by various incentives) and increased funding (by more payments by private citizens and companies). It also declares itself in favour of a system based on social health insurance with some budget-financing as a medium-term goal, but recognises the difficulties ahead. The possibilities and pitfalls of the various systems of health care financing have been described in many publications. The reader can find a number of

them in the list of references in this report, especially the WHO book by Normand and Weber. We cannot give a summary here, but we want to make the following remarks that are relevant for the Bulgarian situation:

- Some advocate the idea to separate ('earmark') funds for health care from other funds at national and municipal level, so as to make them more visible and to protect these funds from use for other purposes.
- Cost containment has become one of the most important motives for choosing or adjusting a system of health care financing (see subject P).
- Better criteria are needed to establish the health care budget at the national level.
- Financing of health care at the peripheral level (i.e. municipalities and health care facilities) should be based on transparent criteria of real activities and cost, coupled to incentives to increase quality but limit production. There are various principles and techniques to achieve this goal: 'money follows the patient', patient classification systems, sub-dividing the various costs (investment vs running cost, treatment vs teaching cost, inpatients vs outpatients, etc.), capitation vs fee-for-service payment, economic incentives, etc.
- Administrative cost varies between the various financing systems; generally speaking, this cost is lower in national health service type of systems than in social health insurance systems.
- The reason to chose a health insurance system can *not* be that it will raise more money. In the present situation of underfunding, extra funds must be found in another way or inefficiencies should be eliminated.

Option O1: tax-based budgetary system

Advantages:

* no difficult implementation of a new system
* no opposition at national and municipal level
* no unrest among the population

Disadvantages:

* transparency of costs and activities must still be achieved
* a better formula for resource allocation must still be found
* more difficult to introduce economic incentives in such a system

Option O2: social health insurance

Advantages:

* a clear decision
* introduction of other stakeholders in the system
* introduction of new incentives
* money follows the patient
* a separate budget for health care

Disadvantages:

* a difficult decision to be taken
* much training of new staff needed
* implementation must be organised
* major change leading to major unrest in the sector and in the population

Option O3: mixed system

Advantages:

* a chance to decide on a good mixture
* more acceptance by the citizens and the health care professionals
* less unrest in the sector and in the population

Disadvantages:

* decisions must be taken
* it is not so easy to determine the 'ideal' mix
* danger of an unbalanced system

Option O4: no decision taken

This option is the same as option O1, except that in O1 a conscious choice has been made to improve the situation based on a tax-based budgetary system and that in O4 the uncertainty continues.

Advantages:

* no need to take decisions
* other advantages as in option O1

Disadvantages:

* no preparation can be made for any system, not even improvement of the present system
* obstacle for transparent financing
* continuation of resource allocation that is not related to cost

* continuation of unequal financial burden among the municipalities
* continuation of open-end financing at municipal level
* no economic incentives for the health care facilities

SUBJECT P: COST CONTAINMENT

The containment of health care costs has become an important concern for many governments. Essentially, costs are controlled by decreasing health care consumption without risks for the health status of the population. There are many methods and ideas to do so, such as:

- economic incentives for health care professionals and consumers to limit production and consumption, especially in specialist and inpatient care and drug treatment
- treatment should be in the lowest level of sophistication required for each condition and the number of referrals should be kept limited
- diminish the number of facilities, beds, doctors, etc.
- limiting the size of the basket of benefits that the population is entitled to
- non-effective forms of treatment should not be financed anymore.

The draft strategy document 'Health for the nation' briefly mentions incentives for health care establishments and more private payments by the citizens as methods for cost containment.

Option P1: a comprehensive cost containment policy

Advantages:

* costs will be contained
* funds become available to finance priorities
* the financial burden for the municipalities and the state budget will remain acceptable
* incentives for more efficiency

Disadvantages:

* opposition from health care professionals
* opposition from trade unions
* need to formulate and implement a policy

Option P2: containment of some costs only

Advantages:

* costs will be contained, though only partially
* less unrest among health care professionals
* a signal that health care is not free and funds are limited

Disadvantages:

* no comprehensive analysis of the financing of the health care system
* it is difficult to identify areas in which costs are to be contained
* cost savings in one area may be offset by increased costs on other areas; total costs may still rise

Option P3: no decision taken

Advantages:

* no opposition from health care professionals
* no opposition from trade unions
* no need to formulate and implement a policy

Disadvantages:

* costs will continue to rise
* no or insufficient funds to finance priorities
* a growing financial burden for the municipalities and probably for the state budget
* no incentives for more efficiency
* probably a general decline in the quality of health care

SUBJECT Q: PAYMENT OF HEALTH CARE PROFESSIONALS

At present, health care workers are state or municipal civil servants who receive in fact a fixed salary irrespective of the volume and quality of their activities. Most experts agree that this is an unwelcome situation. Professionals should be paid according to their volume and quality of work, at least to some extent. 'Money should follow the patient', but total costs should be contained (see subject P). In other countries various payment systems are in use, such as capitation, fee-for-service and mixed systems. Payments can be a direct transaction between health care professionals and patients (usually with subsequent reimbursement of the patient by an insurance company) or indirectly via a third party, e.g. an insurance company or the state.

Unofficial payments by patients to health care professionals are said to be a problem in Bulgaria, but the size of the problem is not known.

Theoretically, health care professionals can be paid in different ways irrespective of the introduction of health insurance (subject O) and privatization (subject R). In practice, payment according to the volume of work is very much a feature of health insurance and privatization.

The draft strategy document 'Health for the nation' announces social health insurance as a medium-term goal, but does not pronounce itself on how the professionals should be paid.

Option Q1: fixed salary by state, municipality or other employer

Advantages:

* budgeting of salary costs relatively easy
* easier cost containment
* no incentive for health care professionals to produce as many services as possible
* no antagonism or competition between health care professionals
* no change from the present situation

Disadvantages:

* incentive for low quantity and/or quality of work
* incentive for unofficial payments
* not compatible with health insurance

Option Q2: remuneration according to volume and/or quality of work (several methods)

Advantages:

* good preparation for future health insurance system
* incentive for health care professionals to increase the quantity and/or quality of their work
* may decrease the number of unofficial payments

Disadvantages:

* will increase the cost of health care by overproduction if not kept in check by additional measures
* what to do with the health care professionals who are unable to achieve sufficient quantity and/or quality?
* there may be legal or political obstacles to differentiate payment to health care professionals
* extra administrative costs

SUBJECT R: PRIVATIZATION

Privatization by individual health care professionals and health care establishments is allowed according to Bulgarian law, but little use has been made of this possibility except by dentists.
The draft strategy document 'Health for the nation' does not state its policy intentions on this subject. In some Western countries, most doctors are private entrepreneurs, in other countries only a minority.
The government should determine to what extent it wants to promote, discourage or forbid privatization in health care, and to what extent it wants to control the private sector. The side-to-side existence of state and private facilities calls for special relations between the two. It is especially important to determine if state employees can also have a private practice and if private patients can be received in government buildings with government equipment.
Apparently, privatization has advantages and disadvantages which can be discussed with help of the following options. Privatization is related to the payment of health care professionals (subject Q) and contracting (subject S).

Option R1: no steering of the privatization process

Advantages:

* no need to develop a policy on privatization
* market forces will determine the right balance between public and private services
* this option will please many health care professionals
* the free market mechanism has a positive effect on the quality of services
* less bureaucracy

Disadvantages:

* 'wild' privatization leads to a situation that can hardly be corrected afterwards
* private practice will absorb the 'advantageous' patients, leaving the poor, old and chronically ill to the public sector
* the free market mechanism may lead to increased production of services
* privatization will necessitate the introduction of new mechanisms for paying providers

Option R2: no privatization allowed in most or all sectors of health care

Advantages:

* a clear policy
* easier managerial, financial and quality control over the health care system

Disadvantages:

* existing private practice must be abolished
* the number of civil servants in the health care sector will remain high
* the present bureaucratic, centralised health care system continues to exist
* encouragement of unofficial payments

Option R3: privatization in certain sectors of health care will be encouraged

One could envisage this option for certain sectors that are not essential for survival, e.g. dentistry, cosmetic surgery, treatment for infertility and most of the balneological services and prophylactoria. In the future, such services could be covered by additional (voluntary) insurance.

Advantages:

* this will lead to less civil servants in Bulgarian health care
* it could be a first step in a process of gradual privatization, causing less unrest than option R1

Disadvantages:

* opposition from (part of) those sectors that are losing their public status
* but also opposition from (part of) those sectors in which privatization will not be allowed
* less control over the privatised services

SUBJECT S: CONTRACTING OF HEALTH CARE

It is often said that health care is a market, but for various reasons that cannot be explained here one should realise that health care cannot be left to market forces only. It is, however, generally agreed that the introduction of some market elements such as competition could increase the efficiency of the provision of health care under proper conditions. The contracting of health services can also be seen as a market element: the purchaser (the state, a municipality, an insurance company, etc.) buys a package of health care on behalf of his customers. In Bulgaria, both purchasers and providers belong to the same organisation (i.e. the Ministry of Health or a municipality) which can be seen as contrary to the functioning of the market. Therefore, health care facilities should become independent (see subject N) and obtain a contract from the purchaser, specifying how much will be paid for how many activities of a certain kind and quality. The purchaser will not interfere with the number of beds or staff in a facility, but only wants to make sure that the provider can indeed provide what has been contracted. Providers could be either public institutions or private.

Real competition is not possible in towns with only one hospital or in villages with only one general practitioner. Even in a town with several hospitals it will be difficult (but not impossible) *not* to contract a certain hospital or certain other services.

The contracting process will lead to a much better relation between funding and activities, but for this it is necessary to have complete transparency of medical activities and the costs of salaries, drugs, laboratory, food, etc. Health care managers therefore need refined budgeting, cost-accounting and decision-oriented information and reporting systems.

In case purchasing and providing health care are to become two separate responsibilities it will be necessary to create the legal conditions for this, including the need for arbitration in case of conflicts.

Some simulation experiments with contracting are taking place in Bulgaria at the moment.

Option S1: contracting methodology will not be used

There are two options in case the contracting methodology is not being used: direct financing of health services by the government (present situation) or by health insurance organisations (option for the future). In the latter option, the health care personnel is employed by the insurance fund.

Advantages:

* direct financing is easier to organise than contracting
* no need to develop the contracting methodology

Disadvantages:

* no chance to obtain the increased efficiency associated with contracting
* no incentive to analyse the relation between activities and costs in depth

Option S2: standard contracts between purchasers and providers

Advantages:

* good method to obtain increased efficiency
* it is clear what is expected from providers in terms of quality and volume of care and access to services

Disadvantages:

* parties need to be legal entities, which requires a change in the legal position of at least the providers
* contracting needs detailed information that may not (yet) be available
* need to train staff for this methodology
* health care facilities may not like it

Option S3: no decision taken

This option is rather similar to option S1.

Advantages:

* no need to take a decision
* no need to train staff in the methodology of contracting
* many facilities will welcome the absence of a decision

Disadvantages:

* what to do with the present experiments in simulation of contracting?
* purchasers may become wary of handing out funds to facilities without knowing what they buy

7.4 Other issues

SUBJECT T: QUALITY CONTROL

Quality of health care is an important but complicated conception that among others is characterised by health outcomes of treatment, consumer satisfaction, accessibility, educational requirements for health professionals and professional standards. The Centre for Financial and Managerial Technologies in Health Care is studying which quality criteria should be used in Bulgarian health care. Quality control is a fashionable subject, but we should realise that in some form or another it has existed for a long time. What is new is that quality is being monitored with more or less objective yardsticks not by the health care professional himself but by somebody else, and that insufficient quality has consequences such as denial of certification, accreditation and relicensing or the obligation to change a situation or to follow extra courses. Basically, quality control can be done by internal and/or by external audit, depending on the situation and on existing legislation. Facilities such as hospitals can control the quality of their services themselves (internal audit). External audit can be performed by various organisations, such as the State Inspectorate, professional organisations, consumers' organisations and representatives from other health care facilities. Usually the State assumes a broad responsibility for the availability and quality of health care in a country. Control mechanisms may vary from one country to another.

Various measures can be used to improve quality, such as:

- good initial and continuous education;
- the availability of clinical guidelines, protocols and other supplies of information
- regular audits;

- continuous analysis of morbidity and mortality data, e.g. on hospital infections and surgical mortality.

Quality standards can be included in contracts between purchasers and providers (see subject S).

Option T1: quality control measures remain as they are today

Advantages:

* no effort asked from anybody (policy changes, training, reorganisation, new methods)
* postponement of an issue which may not be regarded as a priority among the pressing needs of Bulgarian health care

Disadvantages:

* quality control will remain insufficient in certain areas
* new methods of quality control cannot be explored and tested in practice

Option T2: a revised and enlarged system of quality control will be developed

Advantages:

* the quality of Bulgarian health care will improve
* Bulgaria joins the international effort in this field

Disadvantages:

* an improved quality control system needs an investment in personnel and funds
* many health care professionals will have to be convinced of the usefulness of strict quality control

Option T3: no decision taken

Advantages:

* no need to take a decision
* no unrest among health care professionals and facilities

Disadvantages:

* quality will deteriorate because existing quality control measures are less and less adhered to
* this option will hamper the introduction of contracting, of which quality control is often an element

SUBJECT U: POSITION OF THE CUSTOMERS (PATIENTS)

At present, the position of the customers (patients) in Bulgarian health care has strong and weak elements. One can complain about health care, but most patients would not know how to do this. There is no general organisation of consumers that represents the consumers' interest vis-à-vis purchasers and providers such as exists in some other countries. On the other hand, patients are free to consult another physician if they are not satisfied with the first one, but this has no financial or other consequences for the first physician. The draft strategy document 'Health for the nation' has no separate chapter on the rights and duties of patients. It seems important to inform the patients - i.e. the population - about the health care reform and to involve them in its implementation, but the involvement of an official patients' organisation will also complicate the discussion. Most reform measures focus on the supply side, but it would be useful to see if we can also reduce demand without endangering the quality of health care. The reduction of the demand can be brought about by, for example, demanding co-payment for certain activities without prior consultation of the consumers, but, generally speaking, consultation and participation of the population is preferable.

Free choice of physicians is something that is valued by the consumers, but free access to specialist care is contrary to good primary care (see subject A) and cost containment (see subject P). A strong position of the patient will make it more difficult for the general practitioner to resist unnecessary referrals to specialist care.

Option U1: no influence of organised customers on health care reform and management

Advantages:

* this will make it easier to restrict the benefits to which the population is entitled
* quicker and easier decision making

Disadvantages:

* popular resentment, now or later
* no excuse if things go wrong in the future

Option U2: establishment of customers' organisation(s) will be promoted

Advantages:

* involvement of the customers assured
* will improve the quality of health care

Disadvantages:

* will let the spirit out of the bottle: if they exist, they want to play their role, even if contrary to government decisions
* policy-making becomes slower and more difficult

Option U3: establishment of customers' organisation(s) will be left to private initiative

Advantages:

* no effort needed by the government
* the organisations will be more independent

Disadvantages:

* organisations may become single-issue pressure groups
* it is not sure what the outcome of this process will be (if any)

SUBJECT V: POSITION OF PROVIDERS

There are several professional and scientific associations of Bulgarian health care professionals, some of which were mentioned in § 2.6. The main task of professional associations is to defend the material interest of their members (like a syndicate), while the goal of scientific associations is to maintain and improve the technical standards (quality) of the profession. Nobody will object to a strong scientific basis in health care, for example expressed as guidelines (standards) for professional behaviour and continuous education. However, the material interests of one party may conflict with the interests of another party. A 'cartel' of providers could strive for maximum financial benefits and for the protection of employment. In that case, purchasers and consumers would have to pay more for services and a surplus of certain professionals could not be tackled. A certain tension between purchasers and providers is a typical feature of any market-oriented health care system, especially if the providers are private entrepreneurs (see subject R, privatization). Against a tendency to the formation of cartels, the purchasers will try to introduce checks and balances in legislation and to organise competition between providers.

The position of professional and scientific associations in the triangle of consumers, providers and purchasers is briefly mentioned in the draft strategy document 'Health for the nation', without real policy recommendations.

Option V1: providers have to compete for patients

Advantages:

* good quality health care for the patients
* possibility to drive down the fees

Disadvantages:

* the risk that too many or irrelevant services will be offered to the patients for which the state or the insurance fund must pay
* some professionals will be unable to compete and must leave their employment

Option V2: providers associate to obtain a maximum of benefits

Advantages:

* easier to negotiate contracts with associations of providers
* probably no other advantages, except for the providers themselves

Disadvantages:

* health services become more expensive
* antagonism between purchasers and providers

Option V3: the rights and duties of providers are formulated in legislation

Advantages:

* clarity about rights and duties for both patients and providers
* improvement of the quality of health care

Disadvantages:

* this needs a complicated body of new legislation
* it will lead to new types of litigation in the courts

SUBJECT W: MANAGEMENT OF PREVENTIVE HEALTH CARE

Preventive health care is discussed extensively in the draft strategy document 'Health for the nation'. In our report, we mentioned it in § 2.4.2, § 3.3.4 and § 6.5. In this last subject of our report, we just want to present a few options concerning the management of preventive services. By preventive services we mean various programmes such as mother and child care (contraception, antenatal care, well-babies clinics, immunisation, school health), occupational health care, screening programmes (cardiovascular disease and cancer), health promotion and health protection. Some of

these programmes are not in good shape at the moment, for example health promotion. It could be discussed if the position of preventive health care could be strengthened by organising it in a different way. A very important aspect of prevention is that for most activities there is no real demand from the population as is the case with curative care. Preventive health care is offered to the population by the authorities. Financial barriers are counterproductive if one wants prevention programmes to succeed.

Option W1: mother and child care is managed as a separate organisation

Advantages:

* strengthening of mother and child care
* earmarked budget for these key programmes in preventive health care

Disadvantages:

* separation or even antagonism between the preventive and the curative sector
* new staff has to be trained
* a separate information system must be created

Option W2: one organisation for most forms of preventive health care

Advantages:

* stronger position of preventive health care
* separate budget for preventive health care
* preventive health care could more easily be left out of a future health insurance system

Disadvantages:

* it will be difficult to associate very different forms of preventive health care in a single organisation
* a preventive health care organisation may not attract the best professionals given its low status in the health care system

Option W3: keep the organisation of preventive health care as it is now

Advantages:

* no unrest among providers of preventive and curative health care
* there is nothing to explain to the public

Disadvantages:

* preventive health care will remain the poor relative in the health care family
* badly executed key programmes such as family planning and health promotion will not improve
* inefficiency because at present routine preventive activities such as immunisation or antenatal care are executed by medical specialists

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