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World Bank

Bulgaria: Improving quality and sustainability of the health system

Health Sector Reform Policy Note

September 2009[1]

Main messages

- **Bulgaria has undertaken several significant health sector reforms during the past decade, but a large unfinished policy agenda remains.** Compared to other EU countries, the share of out-of-pocket spending is significantly higher in Bulgaria, while government spending on health is relatively low. Various indicators of reported public satisfaction with the health system in Bulgaria are frequently the lowest in the EU.
- **The hospital sector has seen rapid growth in recent years, putting the sustainability of the system in doubt and crowding out expenditures on more pressing priorities such as primary health care and the reimbursement of cost-effective drugs.** Contrary to the imperative of improving health system efficiency, in recent years the Bulgarian hospital sector has grown in number of facilities, total number of hospitalizations, and the budget share dedicated to inpatient services. Each of these indicators is out of line with European standards.
- **The primary health care system is well established but does not live up to its potential to provide efficient, high-quality care**. Spending on primary health care is low, referral rates to higher levels of care are excessive, and the payment method does not provide adequate incentives for improved service provision.
- **New by-laws on pharmaceutical policy and a new positive drug list mark a step forward, but important risks remain.** The new drug list includes many new and expensive drugs, but the previous practice of using waiting lists to ration drug access in response to fixed budgets is no longer being implemented. As a result the new drug list poses a threat to the NHIF drug budget in 2009 which was originally programmed to be flat.
- **The future direction of the national health insurance system needs to be clarified** with reference to the key lessons emerging from the broad international experience with insurance system reform.

Policy Directions

- In the short-term, **protect health spending** to mitigate the impact on the poor; and **stabilize the drug budget during the final months of 2009**, for example by considering a re-introduction of waiting lists for certain high-cost drugs and ensuring that adequate funds are available for nationally procured drugs.
- In the medium-term, **initiate hospital sector restructuring** in line with the master plan; and consider **changing the financial incentives for hospitals**, for example by enabling the NHIF to selectively contract with hospitals and to determine their budgets on the basis of case mix and

[1] This note was prepared by Owen Smith, with inputs from Kari Hurt and Peter Pojarski.

projected service volume using the more accurate diagnosis-related groups (DRGs) instead of the current Clinical Care Pathways(CCPs);

- Focus on measures to **improve the quality of services provided** by strengthening the instruments of licensing and accreditation, for example through the establishment of an independent entity responsible for these functions; creating a link between hospital payment and information about the quality of their services; and reviewing the Clinical Care Pathways in light of up to date, international evidence on cost effective treatment protocols.
- Consider introducing **stronger pay-for-performance measures at the primary care level** and changing regulative standards to **re-define the responsibility of primary care physicians**.

Bulgaria: Health Sector Reform Policy Note

Introduction

Bulgaria has undertaken several significant health sector reforms during the past decade, but a large unfinished policy agenda remains in order to help narrow the gap with the rest of the European Union. Table 1 presents some basic health sector indicators for Bulgaria and the EU. Life expectancy in Bulgaria is about two years lower than among other new EU Member States, and over six years lower than the EU average. By far the major cause of this mortality gap is a higher death rate due to cardiovascular disease. With respect to health financing, compared to other countries government spending on health as a share of GDP is relatively low in Bulgaria, while the share of out-of-pocket (OOP) spending is significantly higher. In addition, various indicators of reported public satisfaction with the health system are frequently the lowest in the EU.

Table 1 **Selected health indicators: Bulgaria and the EU (latest available year)**

	Bulgaria	EU-10	EU
Life expectancy at birth	72.6	74.5	79.1
Government health spending as % of GDP	4.1	4.6	6.7
Out-of-pocket payments as % of total health expenditure	38	25	17
% satisfied with availability of quality health care	33	51	67

Sources: WHO Health for All database, NHIF, Gallup

Note: EU-10 refers to Estonia, Latvia, Lithuania, Poland, Czech Republic, Slovakia, Hungary, Slovenia, Romania, and Bulgaria

A closer look at out-of-pocket spending for health reveals the extent of its impact on households. As shown in Table 2, while the level of out-of-pocket spending is substantial for households across the spectrum of socioeconomic status, it imposes a relatively larger burden on the poorest segment of the population. A further decomposition of out of pocket payments by expenditure type is discussed below.

Table 2 **Out of pocket payments for health in Bulgaria (2007), by expenditure quintile**

	1 (poorest)	2	3	4	5 (richest)
Annual out-of-pocket spending for health, BGN	109.7	179.2	202.4	192.1	243.1
Out-of-pocket spending as a share of total household expenditure	8.1%	8.2%	7.2%	5.3%	4.1%

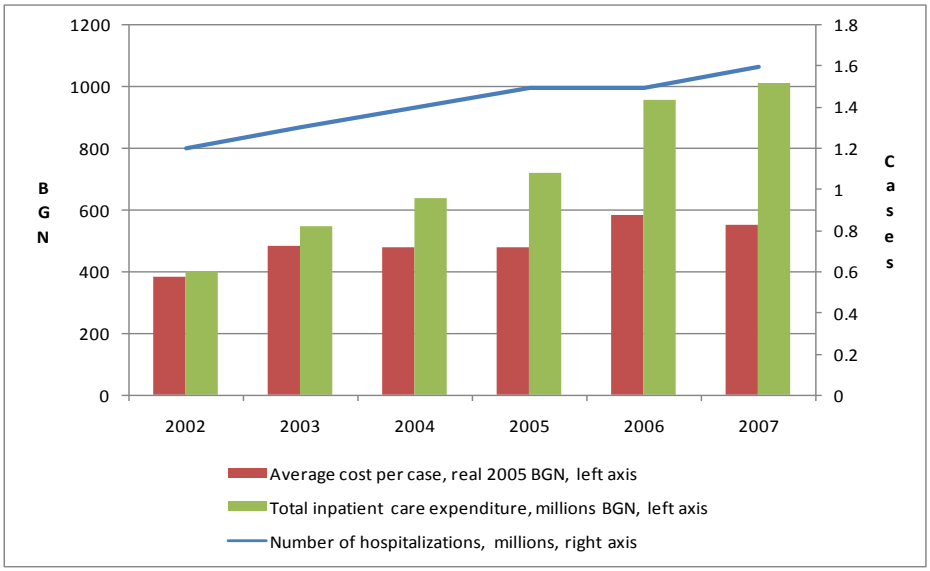
Source: World Bank Living Standards Measurement Survey (LSMS), 2007

This policy note addresses four key policy areas in Bulgaria's health sector. These are: (i) hospital efficiency and quality; (ii) strengthening primary health care; (iii) pharmaceutical policy; and (iv) the future development of the national health insurance system. The final section suggests potential priorities for managing the health sector through the economic downturn.

Rationalizing the hospital sector and improving quality of care

The hospital sector has expanded rapidly in recent years, posing significant challenges to system sustainability and crowding out potentially more productive expenditures in other areas. Between 2002 and 2007 the total number of hospitalizations increased by 33 percent, while the average cost per case rose by 44 percent in real terms. Total inpatient expenditure has doubled over this period (see Figure 1). Moreover, the total number of hospitals has increased from fewer than 300 to over 400 within five years, and many of the new entrants are specialized institutions that have opted for a narrow focus on the most lucrative services. Existing hospitals also seek to open new wards, in order to be contracted by the National Health insurance Fund (NHIF) for delivery of additional clinical care pathways (CCPs). Table 3 indicates that the gap between Bulgaria and the rest of the EU is more pronounced for hospitals than for hospital beds, although the latter is also problematic. The NHIF is legally obliged to contract with all new providers (and all existing providers for accredited services), with minimal delay, which further encourages new entrants seeking this assured revenue flow. Stemming the tide of new contracts to be signed by the NHIF should be seen as a top priority. Another persistent problem in recent years has been much higher rates of hospital-to-hospital referrals than in other countries, implying that the first hospital was unable to satisfactorily treat the patient. In many cases the initial admission is made chiefly in order to submit a medical claim (with CCPs requiring a minimum length of stay for payment) rather than provide any meaningful treatment services prior to referral.

Figure 1 **Hospital sector growth, 2002-2007**



Source: Sanigest 2008, based on NHIF data

Table 3 **Selected hospital sector indicators: Bulgaria and the EU (latest available year)**

	Bulgaria	EU-10	EU
Hospitals per 100,000 population	4.4	2.6	3.0
Hospital beds per 100,000 population	636	625	570
Bed occupancy rate, %	64.1	70.6	76.3
Average length of stay, acute care hospitals	10.7	7.6	6.5

Source: WHO Health for All database

Some positive steps have already been taken to help ensure sustainable hospital financing. A key reason for the rapid increase in expenditures up to 2007 was the prevailing hospital payment method at the time -- an open-ended, fee-for-service reimbursement scheme that imposed few constraints on the number of medical claims submitted by hospitals. Hospital re-admission rates that were much higher than international norms were one of the major symptoms of this tendency. The introduction of annual hospital budget ceilings in 2007 has played a major role in stabilizing this trend, as indicated in a slowdown in the annual increase in the number of hospitalizations from 22 percent to 7 percent following implementation of the new approach. However, these ceilings have been legally established each year through the Budget Act and have yet to become a more permanent part of hospital financing policy.

The adoption of a new NHIF information technology (IT) system also sets the stage for efficiency gains in the hospital sector. This offers a valuable tool for monitoring medical claims and enforcing the NHIF's business rules. The previous system was fragmented and did not generate the information flow required to make NHIF a more active purchaser of health services. The new system is enabling a reduction of the volume of ineligible claims reimbursed and allows the NHIF to exercise closer monitoring of inefficient practices such as excessive cross-regional referrals and inappropriate hospital re-admissions. A savings of up to 10 percent of the overall hospital budget might be achieved by maximizing its potential in the short term; however, international experience cautions that these savings are likely to erode over time as providers adjust to the new system and find other means of maximizing their revenue.

A further range of interventions could be considered to help rationalize the hospital sector. A master plan has been developed which offers a potential vision of a more optimal distribution of hospital capacity in the country. Key messages include the existence of an excess of acute care beds in Bulgaria, too many specialized hospitals, and too many small private hospitals. In addition to these inefficiencies, certain facilities or wards have such low case volumes that the quality of care is in serious doubt. The need to scale up new models of care such as one-day surgeries is also cited. Less than 3% of surgeries in Bulgaria are currently performed as ambulatory surgery, whereas in the Netherlands this figure is closer to 50%. Increasing the ambulatory surgery rate to just 30% would save approximately 2 million bed days per year, improve quality and allow patients to recover at home rather than in hospitals. However, lessons from elsewhere in the region indicate that master plan implementation is a complex, long-term endeavor requiring committed and consistent policies and investments.

Achieving progress towards this objective could be accelerated through measures that address the financial incentives faced by hospitals. Enabling the purchaser of health care (e.g., NHIF) to selectively contract with hospitals would be an important step in this direction, as it would oblige hospitals to make a stronger case that their health services offer good value for (public) money. This would represent a major step towards addressing the surge in new specialized hospitals. In addition, making the transition from determining hospital budgets on the basis of clinical care pathways (CCPs) to diagnosis-related groups (DRGs) would also be beneficial. Establishing a hospital's budget based on the DRG-determined case mix would improve the allocation of resources since these can more accurately reflect complexity

and associated costs. Additionally, the use of international DRG systems would allow Bulgaria to more easily benchmark its performance relative to other countries. The key preparatory steps needed for establishing a DRG-based system have already been taken and, therefore, Bulgaria could make the switch to DRGs more rapidly than elsewhere, although careful transition arrangements are essential. These and other decisions with respect to how public funds are allocated to hospitals will be important irrespective of the ownership status of those institutions (state, municipal, public, private, etc.).

The development of a comprehensive policy for long-term care (LTC) could also be undertaken as a key component of hospital reform in Bulgaria. Bulgaria's population is aging rapidly, and the need for LTC will continue to rise. At present many acute care hospitals are burdened with long-term care patients. Scaling up long-term care facilities, strengthening social services, and improving home care would allow acute-care hospitals to focus on their core activities and thus contribute to a more efficient hospital sector overall.

Reforms to promote hospital efficiency should be complemented by efforts to improve the quality of services provided. The key instruments of licensing and accreditation to ensure quality of care are currently under-utilized. The systems currently in place lack strong criteria, enforcement and, therefore, credibility. The establishment of an independent entity responsible for these functions, and creating a link between hospital payment and information about the quality of their services, both offer the potential to make a significant advance towards achieving European standards of health care in Bulgaria. The development of performance indicators that are regularly monitored and reported, including measures that reflect consumer satisfaction with the care they receive, would represent a key contribution to this agenda. Additionally, with the transition to a payment system based on DRGs, the current CCPs could be reviewed in light of international evidence of cost-effective care and re-invented as Clinical Care Guidelines.

In addition to creating an environment with incentives to provide high-quality services, the hospital sector is also in need of significant investment. Poor building conditions and equipment standards contribute to low public satisfaction with health care and constrain the scope for medical care to improve health status. Assisting hospitals in accessing EU structural funds for this purpose would be a helpful priority.

Strengthening primary health care

The rapid growth in the hospital sector is in part due to the under-performance of the primary care level. Policy reforms and investments aimed at primary care in the early part of this decade were followed by several years of relative neglect as the focus shifted to the hospital sector. Correcting this imbalance could be considered one of the top priorities for health reform. In fact strengthening the primary care sector could also be seen as an indispensable ingredient of hospital reform.

The weaknesses in the primary care sector are a result of several factors. Total spending for primary care is about 8 percent of the NHIF budget, roughly half the comparable share in Western Europe (see Table 4). The payment method of primary care doctors – mainly a capitation approach – does not provide adequate incentives for improved service provision, and referral rates to specialized out-patient

and hospital care are high. International data reveal that a primary care sector should be able resolve at least 80 percent of the cases of demand for medical care, while in Bulgaria this rate has been estimated at about 70 percent or lower. Furthermore, most primary care doctors were not originally trained as general practitioners, and a requirement to obtain this training has been repeatedly postponed (the target date is now 2015). As a result, population behavior reflects low levels of trust in family doctors, including low uptake of preventive exams and frequent bypassing of primary care in favor of direct contact with higher levels of care.

Table 4 **NHIF budget allocation, 2008**

	2008 budget share
Primary out-patient care	7.5%
Secondary out-patient care	8.0%
In-patient care	57.7%
Drugs	16.9%
Other	9.9%
Total	**100.0%**

Source: NHIF (excludes MoH and municipal spending)

Strengthening primary health care could reap benefits both by improving the overall health status of the population as well as by achieving greater system-wide efficiency. The disease burden in Bulgaria is dominated by cardiovascular disease (as indicated in Table 5, rates are far higher than regional averages), and primary care can play a central role in diagnosing and managing risk factors. The same is true for early detection of cancer. Initial steps that offer the potential to strengthen primary care have been undertaken and could be further supported. The introduction of stronger pay-for-performance measures at the primary care level could be considered as a key priority, and preliminary steps that have been taken in this direction should be closely monitored and evaluated to determine their impact. Implementing such a system will be facilitated by the new NHIF IT system, which offers a valuable tool for monitoring referral and prescription patterns by individual physicians, and taking corrective action when necessary. But ultimately a re-allocation of budget resources from hospital to primary care will be a crucial complement to these measures.

Table 5 **Diseases of the circulatory system, Bulgaria and the EU (latest available year)**

	Bulgaria	**EU-10**	**EU**
Diseases of the circulatory system, per 100,000 population (age-standardized)	685	468	252

Source: WHO Health for All database

Changes in regulative standards to expand the list of conditions under the responsibility of primary care physicians can help keep a greater number of patients away from specialized levels of care. In the past, for example, requirements have imposed a minimum number of annual visits to specialists by hypertensive and diabetic patients who could have otherwise been adequately treated at the primary care level. Changes were made to certain regulative standards applying to primary care doctors in 2009, and further revisions may be beneficial.

Efforts to improve primary care could be reinforced by simultaneously strengthening population-based health interventions. Multi-sectoral measures to combat risk factors for non-communicable disease, and in particular to reduce tobacco use, have made very significant contributions to improved health outcomes in advanced economies.

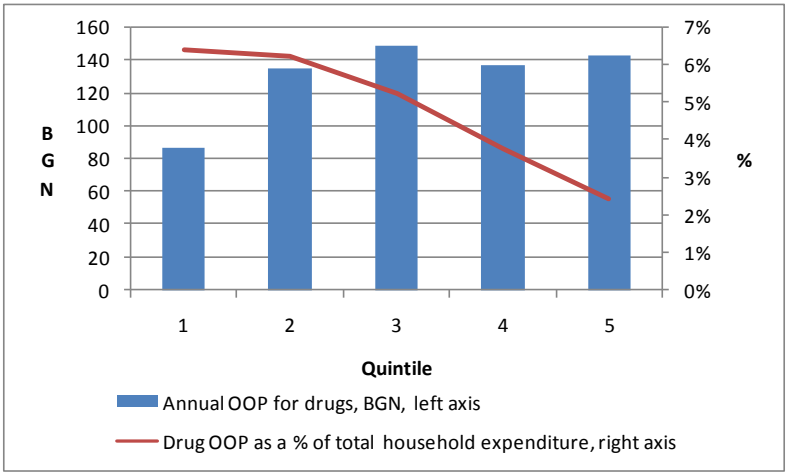
Pharmaceutical policy

Bulgaria has recently passed new by-laws regulating pharmaceutical policy, and on June 1st, 2009 it launched a new positive drug list for reimbursement. These measures represent a potential step forward, but important risks remain over both the immediate and medium-term horizons.

The new drug list represents a potential risk to the 2009 budget. It includes many new and expensive drugs (e.g., for hepatitis and multiple sclerosis), but the previous practice of using waiting lists to ration drug access in response to fixed budgets is no longer being implemented. As a result the new drug list poses a threat to the NHIF drug budget (originally programmed to be flat in 2009), and thus budget execution should be monitored closely during the second half of the year with corrective measures taken if necessary. Even if the budget impact is mitigated somewhat in 2009 as doctors take some time to become familiar with the new list, the prospect of drug cost increases will persist. Indeed, it appears that the new positive drug list was developed independent of any careful consideration of budget constraints.

The challenge of keeping pharmaceutical expenditures in balance is made more difficult by the already high levels of out-of-pocket spending for drugs by the population. Although one option would be to lower NHIF's reimbursement rates (currently ranging between 25-100 percent, depending on the drug), the overall level of reimbursement for drug expenditures in Bulgaria is already quite low compared to other countries. Figure 2 illustrates the extent to which out-of-pocket health expenditures are driven by drug spending. This is particularly detrimental to ensuring access to priority drugs for the poor.

Figure 2 **Out of pocket (OOP) health spending on drugs (by quintile)**



Source: Staff estimates based on Multi-Topic Household Survey (LSMS), 2007

In addition to the immediate challenge of ensuring sustainability of the drug budget, consideration should also be given to the medium-term pharmaceutical reform agenda. Several challenges stand out. First, inappropriate prescribing patterns are common (i.e., too many and/or too expensive drugs compared to an evidence-based approach), in part due to marketing programs pursued by the industry. Closer monitoring of prescription patterns (including performance incentives) has begun and should yield some returns, although a key challenge to this effort will be that many drugs are obtained without prescription, because NHIF reimbursement rates are low and thus patients prefer to avoid the hassle of consulting a physician first. Second, there is little oversight of those drugs that are directly procured by hospitals, such as prices or drug utilization parameters. Third, the pricing approach that underlies the new positive drug list encourages manufacturers to compete through alternative means (such as offering free drugs to retailers in order to squeeze out alternative brands), which ultimately reduces competition. The introduction by the Government of less rigid contracting models for pharmaceutical procurement (e.g., that move beyond price alone) would be a positive step to counteract this tendency. Overall, addressing the present weaknesses in the pharmaceutical sector could have a major effect on the population's satisfaction with the health system more broadly.

The Future Development of the National Health Insurance System

The NHIF has evolved and grown significantly since its establishment ten years ago. Its status as an autonomous payment agency for health care services is broadly consistent with the prevailing model of social health insurance common elsewhere in Europe.

A possible transition to a multiple insurer model has been under discussion for some time in Bulgaria. Each of the broad policy objectives outlined above – improved hospital efficiency and quality, strengthened primary care, and sustainable pharmaceutical policy– could in principle be successfully addressed either through a single payer model as embodied by NHIF or through a well-designed multiple payer system. Successful examples of both approaches – as well as less successful examples – can be found elsewhere in Europe. However, most multi-payer systems were originally designed as such, and few if any countries have successfully managed the transition from single payer. Multiple insurer models can be particularly complex (including mechanisms to reduce incentives for risk selection), and international evidence suggests they are often associated with a higher, not lower, level of health expenditures. Regardless of which model is adopted, success will depend on "getting the details right".

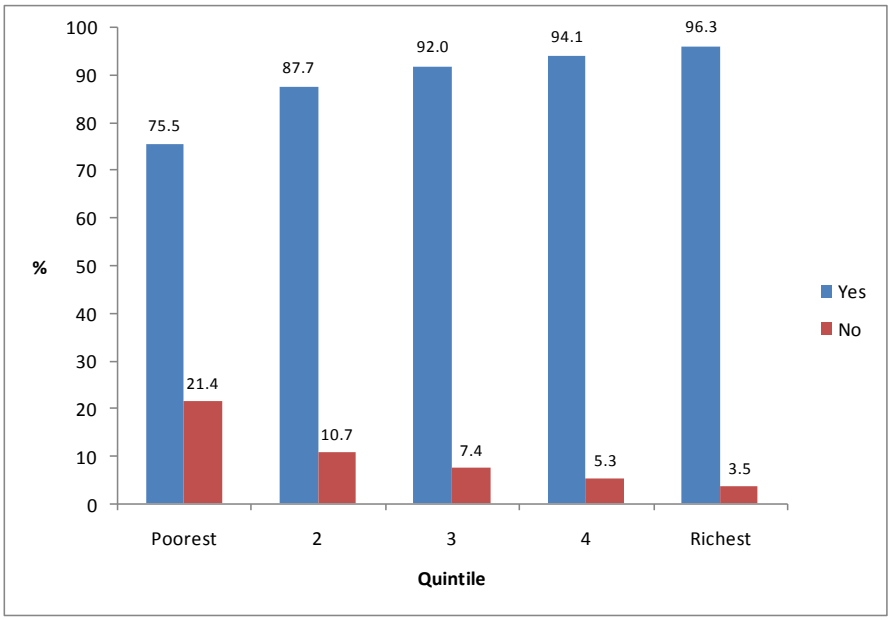
A potential option for insurance reform would be to strengthen the NHIF's role in financing the publicly-funded basic package while opening up the voluntary, supplementary health insurance marketplace to additional actors. An important pre-requisite for such an arrangement would be to achieve greater clarity in the benefit package covered by NHIF by explicitly defining excluded services. In addition, as noted above, allowing NHIF to selectively contract with hospitals could strengthen its ability to ensure financial sustainability of the health sector.

A key step toward strengthening NHIF would be to address the current organizational and legal model of negotiating the National Framework Contract (NFC), which has proven to be fundamentally flawed.

Legally, the NHIF is to negotiate a National Framework Contract (including fee schedules and provider penalties) with a single entity, the Bulgarian Medical Association (BMA). In addition to excluding key stakeholders (i.e. the providers), this procedure is not properly linked with the budget process. As such, it poses a challenge to the NHIF's fundamental responsibility to effectively and transparently allocate limited government health resources on behalf of the population. In the last few years, this system has led to a stalemate between the Government (represented by the NHIF) and the BMA with respect to the NFC and has required Parliament to enact the basic framework of the NFC. This has not been to the benefit of either side of the negotiations, as the BMA has been excluded and the NHIF has been able to introduce only limited changes to the original NFC Agreement. A revised approach to negotiations that addresses these weaknesses could be given active consideration going forward.

Pending further decisions on the health insurance model, issues related to the adequacy of health insurance revenue sources may also be revisited. The NHIF's main revenue stream, the health contribution rate, was increased from 6 percent to 8 percent in 2009 (the overall payroll tax did not increase due to reductions in the pension contribution rate). A significant share of the increased revenues was intended for reserves, but will also partly serve as a buffer against the impact of the economic downturn, thereby protecting the NHIF budget. Although the health contribution rate remains lower than in most other countries in the region, any proposed increases should await a return to economic growth as well as substantial progress on the hospital, primary care, and pharmaceutical sector reforms identified above. The adequacy of government contributions on behalf of non-contributing population groups may also be reviewed. Lastly, measures to stem the growing number of Bulgarians (over 1 million) who are not up to date with their health contributions should be explored on the basis of solid information about their characteristics. As indicated in Figure 3, many of those who are not insured belong to the lowest income quintile.

Figure 3 **Share of population with health insurance (by quintile)**



Source: Staff estimates based on Multi-Topic Household Survey (LSMS), 2007

Guiding the health sector through the economic downturn

This sectoral overview also suggests some key messages for managing the health sector through the economic downturn. Most health spending is channeled through the NHIF budget, in which capital and administrative expenses are negligible and expenditures are determined largely by the volume of services (in large part, population demand) times the pre-determined service price. For these reasons, achieving temporary expenditure reductions in the health sector is not straight-forward. Based on the policy issues reviewed above, the following key messages emerge:

- There are numerous potential transmission channels of the economic downturn into the health sector (through provider and patient behavior, effects on the labor force and thus the health contribution rates, etc.), and **data-monitoring should be undertaken** to gain a full understanding of this impact.
- Government spending on health in Bulgaria is not high relative to other new EU member states, while out-of-pocket spending is significant, and thus it will be **important to protect health spending to mitigate the impact on the poor**.
- An immediate priority should be to **stabilize the drug budget during the final months of 2009**, for example, by considering a re-introduction of waiting lists for certain high-cost drugs.
- The **judicious use of NHIF reserves to help absorb the impact of any required budget adjustments** offers one potential coping mechanism within the sector.
- If necessitated by the budget environment, **prices could be held constant in 2010**. A reduction of CCP (or DRG) prices of those services for which volumes have increased rapidly in recent years could also be considered. Such a measure may need to be supported by direct limits on volume growth. Implementing cutbacks to the primary health care budget and the drug budget should be avoided.
- Hospital closures will not provide a silver bullet for increasing efficiency during the downturn, in part because much of the over-capacity exists outside the direct control of the state (e.g., at municipal hospitals or highly specialized private providers), and partly because detailed transition plans are needed (e.g., transportation arrangements for the nearby population; implications for hospital staff; possible conversion into LTC facilities). However, the **downturn offers an opportunity to send a clear signal that reforms to promote hospital efficiency are being initiated**, and stakeholders should begin to undertake their own preparations for this eventuality.