REVIEW

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Reforms in Primary Health Care in Bulgaria - Past, Present, Future

ABSTRACT

The health of any nation, and the Bulgarian one in particular, is extremely important for the economy, security and development of the country. Unlike other European countries, due to defects in the structure and functioning, the Bulgarian health system could not achieve satisfactory final results in a number of important aspects of public health. One part of the essential problems includes high rates of morbidity, mortality, wide spread of health risk factors, and on the other - insufficient satisfaction of medical professionals (doctors, nurses, support staff) and patients. This, combined with the changes in the political administration of Bulgaria, led to a decision for a radical reform in the health care system. Conditionally, the changes can be divided, according to their nature, into 6 large groups: 1) Reforms leading to democratization of the system; 2) Reforms related to liberalization; 3) Reforms in the status of primary care practices; 4) Reforms in the organization, construction and structure of the system; 5) Reforms in financing and payment methods; 6) Reforms in the management of the primary care system and practices. The purpose of this review article is to present the theoretical framework, grounds and goals for the reform of the health care system in Bulgaria carried out in the past, with a focus on primary care and the current state.

Keywords: Primary Care, Health Care, Reforms in Primary Care.

Bulgaristan'da Birinci Basamak Sağlık Hizmetlerinde Reformlar - Geçmiş, Bugün, Gelecek

ÖZET

Herhangi bir milletin ve özellikle Bulgar milletinin sağlığı, ülkenin ekonomisi, güvenliği ve kalkınması için son derece önemlidir. Diğer Avrupa ülkelerinin aksine, yapı ve işleyişteki kusurlar nedeniyle, Bulgar sağlık sistemi, halk sağlığının bir dizi önemli yönünde tatmin edici nihai sonuçlara ulaşamadı. Temel sorunların bir kısmı yüksek hastalık ve ölüm oranlarını, sağlık risk faktörlerinin yaygın bir şekilde yayılmasını ve diğer tarafta tıp uzmanlarının (doktorlar, hemşireler, destek personeli) ve hastaların yetersiz memnuniyetini içerir. Bu, Bulgaristan'ın siyasi idaresindeki değişikliklerle birleştiğinde, sağlık sisteminde radikal bir reform kararı alınmasına yol açtı. Şartlı olarak, değişiklikler doğalarına göre 6 büyük gruba ayrılabilir: 1) Sistemin demokratikleşmesine yol açan reformlar; 2) Liberalleşmeye ilişkin reformlar; 3) Birinci basamak uygulamalarının durumundaki reformlar; 4) Sistemin organizasyonu, inşası ve yapısındaki reformlar; 5) Finansman ve ödeme yöntemlerinde reformlar; 6) Birinci basamak sisteminin yönetimi ve uygulamalarında reformlar. Bu gözden geçirme makalesinin amacı, birinci basamak ve mevcut duruma odaklanarak Bulgaristan'da geçmişte gerçekleştirilen sağlık sistemi reformunun teorik çerçevesini, temellerini ve hedeflerini sunmaktır.

Anahtar Kelimeler: Birinci Basamak, Sağlık Hizmeti, Birinci Basamakta Reformlar.

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INTRODUCTION

The health of any nation, and the Bulgarian one in particular, is extremely important for the economy, security and development of the country. Unlike other European countries, due to defects in the structure and functioning, the Bulgarian health system could not achieve satisfactory final results in a number of important aspects of public health. One part of the essential problems includes high rates of morbidity, mortality, wide spread of health risk factors, and on the other - insufficient satisfaction of medical professionals (doctors, nurses, support staff) and patients. This, combined with the changes in the political administration of Bulgaria after 1989 led to a decision to change the existing model of health care and carry out a reform at all levels - pre-hospital (primary and specialized) and hospital care. The good organization, financing and management of primary health care largely determines the functioning of the other floors of the system - secondary (specialized) and tertiary (hospital). Therefore, the beginning of the reform in the Bulgarian health care began with primary care in 2000, which followed a number of changes in the existing legislation of the country, as well as the appearance of new regulatory documents, structures and entities such as the national health insurance fund, practices in general medicine and general practitioners.

The purpose of this review article is to present the theoretical framework, grounds and goals for the reform of the health care system in Bulgaria carried out in the past, with a focus on primary care and the current state. The system is dynamic, which is why changes in it are not a single momentary act, but a sequence of actions. The analysis of the achieved results also shows the need to prepare a vision for its development in the future.

Theoretical Formulation, Foundations and Goals of the Reform: The structure, functioning and results of the activity of any health system are the product of the application of a certain system model (1).

The model is a theoretical "construction" that includes the main characteristics and properties that a health system should possess and reflects the main ideas and principles of a certain health doctrine. (2, 3, 4)

Over the last century, 3 main models have been used in the design of primary care systems:

- **Private-market model** - the healthcare system is a set of private medical institutions that work in market conditions and market competition. The producers of medical services (medical professionals) and the consumers (patients) are private individuals.
- **State-planned model** - the healthcare system is a collection of state-owned medical institutions, and its activity is organized on the basis of a state plan and state financing through taxes. There is no direct financial relationship between producers (medical professionals) and users (patients).
- **Social-market model (mixed model)** - the health system is a mixture of medical facilities with different ownership, state and private, in different ratios. Funding is mixed - health insurance, state and private. There are different financial relationships between producers (medical professionals) and consumers (patients). (2,4)

World experience shows that pure "private-market" and "state-planned" models lead to the creation of primary care systems that have many defects and negatively affect their efficiency and, consequently, individual and public health. (2)

In most European countries, primary care systems are built on the basis of the "social-market" model, with different ratios between state and private ownership, as well as between financing through health insurance, private and state payments. (5,6, 7- 9, 10)

Practice over the years has proven that this type provides opportunities for better efficiency and hence a greater contribution to people's health.

Health systems are complex and dynamic, constantly experiencing the impact of various external and internal factors (legal, economic, scientific, technological, socio-psychological, etc.) that change the conditions in which they work, and this forces them to constantly change to adapt to the new conditions.

These changes do not alter the main characteristics of the model on which the systems are built. They are a manifestation of good management, thereby creating better opportunities to achieve their goals - medical, economic, medical-social, psychological, social-psychological, etc. In the public space, very often they incorrectly present themselves for reform.

Reform is a type of ***change in the model of the health care system*** on which it is built.

As a technology, the reform is a ***set of different types and nature of activities*** (legal, economic, financial, organizational, etc.), ***through which the transformation of the systems is carried out.***

In Bulgaria, for more than 40 years, the primary care system has been built on the basis of the state-planning model (the so-called socialist model). The serious shortcomings of the model are the reason for the insufficient effectiveness of primary care in the recent past, which led to the deterioration of the health of the Bulgarian nation. (11,12)

In order to delay and stop this process, there was a public need for a reform of primary medical care. This became necessary with the political changes that occurred in Bulgaria after November 10, 1989 - "transition from totalitarianism and socialism to democracy and market economy".

The most important grounds for starting health care reform in Bulgaria are:

1) Change in the public and state system after 1989

2) Continuous deterioration of the indicators of the existing health

3) Unsatisfactory effectiveness of primary care

During the socialist period, large-scale health systems were created, with a high provision of certain types of resources (medical professionals), and with low economic capabilities of the state (insufficient funding).

Evidence analysis shows that the main reason for the lack of efficiency lies in the model that was used to build these systems. (13,14, 15,16, 4)

Gradually, the possibilities of primary care systems are exhausted because they do not contain the main driving forces for achieving higher quality and better efficiency:

• Existence of real economic interests of medical institutions, doctors and other medical professionals

• Existence of a market and market competition between medical institutions to stimulate their development and production of high quality services

• High economic and professional motivation of the medical staff

This is how it can be explained why the enormous efforts in recent decades did not lead to positive results in improving the activity of primary care medical facilities and their contribution to public health.

Primary care reform has a complex goal that can be decomposed into 4 consecutive sub-goals:

1. To be transformed according to the type of social market systems

2. To maintain good accessibility and increase the quality, effectiveness and efficiency of their activity

3. To increase its contribution to stop the processes of deterioration of public health

4. To improve the satisfaction of people, doctors and other medical professionals

The first ideas about the type of reforms appeared at the beginning of the democratic changes in Bulgaria after 1989.

In the political programs (1991-1997) of the main political parties, they proposed "solutions" for reforms - from minor to radical changes to the existing model and structure of the system, aligned with the doctrine of democratic and social market health care.

It was only in the period 1997-2000 that the shape of the reform was outlined and the main legal instruments for its implementation were created (the laws on health insurance and medical facilities, the Health Act, the Act on professional organizations of doctors and dentists, etc.). (17-21)

The reform can be considered, on the one hand, as a process of transformation of the model of primary care and on the other, as a set of changes of different types and nature - legal, organizational, managerial, economic, etc. with a view to implementing a selected model.

Content of the Reform in Primary Medical Care in Bulgaria: The beginning of the reform in primary medical care in Bulgaria was in 2000. Up to this point, the out-of-hospital system has been built on a regional basis. There were polyclinics that serve the population of a certain area of the settlement- city or village. They were staffed by doctors who have different specialties - internal medicine, pediatrics, cardiology and others. In the medical facility, there were nurses with the appropriate professional profile - pediatric, midwife and others. All medical specialists were employed on a contract at the polyclinic (health service), which is municipally owned, and had a fixed monthly remuneration (salary). Access to medical assistance was free and the patient himself decides and had the right to choose which specialist to turn to for consultation depending on the health problem.

This specialized model of medical care had a number of shortcomings, which is why a decision is made to carry out a reform, for which there was also the political will.

The content of the reform included various changes that led to the transformation of the existing system (state-planning) to the mixed social-market model.

Conditionally, the changes can be divided, according to their nature, into 6 large groups:

1) Reforms leading to democratization of the system;

2) Reforms related to liberalization;

3) Reforms in the status of primary care practices;

4) Reforms in the organization, construction and structure of the system

5) Reforms in financing and payment methods;

6) Reforms in the management of the primary care system and practices.

Each group included the mechanisms through which the primary care system is "transformed" with a view to achieving specific goals, namely greater efficiency and financial stability.

1. Reforms Leading to Democratization of Systems: They remove a number of existing restrictions and prohibitions on medical care left over from the totalitarian communist rule of the state, namely:

• The regional principle of receiving medical assistance according to place of residence and place of work

• The ban on private practice and private ownership of medical institutions

• The ban on free association by professional groups (doctors, nurses, dentists, etc.).

The following changes are the most important:

➢ ***The right of patients to freely choose a doctor and a medical facility,*** which lead to several important and essential consequences:

• The demand for medical assistance is determined by the patients according to their preferences, wishes, based on their own assessments (quality, living conditions, personal characteristics of the patients, etc.)

• Medical facilities become economically dependent on patients, which forces them to adapt to their preferences

• Conditions are created for the emergence of a market and market competition between medical institutions (doctors)

• significant changes in the behavior of medical institutions (primary care practices), placing the patient at the center of their activity

➢ ***The right of free professional association of doctors and other medical specialists***

Doctors are the main "producer" of medical services and are the most important for the good organization and management of the health system. This means that their active participation can only take place through free professional association.

In the socialist model, due to the fact that the state is a monopoly that "determines everything", doctors did not participate in an organized manner in making the most important decisions in health care.

Therefore, the restoration of the right to free professional association as a concrete manifestation of democratization is extremely important for changing the existing model. The restoration of this right takes place with the adoption of the Law on Professional Organizations of Doctors and Dentists, which leads to the restoration of the Bulgarian Medical Union. With it, the medical profession becomes an active participant both in carrying out the reform and in making decisions of a strategic nature.

After 2000 with the emergence of general practitioners, the need to create an association to protect the interests of this most numerous group of doctors in Bulgaria arises. This is how the National Association of General Practitioners in Bulgaria (NSOPLB) was registered, which expresses a professional expert opinion on issues related to general medical practice and actively defends its positions in front of the Ministry of Health.

2. Reforms Related to Liberalization: The liberalization of primary care involves an extremely diverse range of activities in the restructuring of ownership and of different types of activities.

Before the beginning of the reform in 2000, the state was the sole owner of the medical facilities and determined the construction, structure, resources in primary care. The state monopoly in ownership and management, combined with wrong management decisions, gradually leads to the exhaustion of the "potential" for providing quality and effective medical care. The state monopoly does not allow private money and ownership of medical institutions. Thus, health care is deprived of the driving forces of private interest, the market and competition, which has resulted in a deterioration of the quality and efficiency of outpatient care.

The removal of the state monopoly through the inclusion of new participants in outpatient care - the emergence of general practitioners, combined with changes in financing and payment models, are of fundamental importance in their transformation (remodeling). The right of free choice by patients of a general practitioner leads to the emergence of a market for outpatient services and market competition.

3. Reforms in the Status of Primary Care Practices: All medical facilities in primary care in 2000 become private - general practitioners found and register private medical facilities (primary care practice) under the Commercial Law and in this way they receive economic independence, autonomy in management, the right to profit, possibilities of bankruptcy and bankruptcy when the income does not cover the expenses, etc.

These changes lead to a total change of the existing model and from 2000 until now, primary medical care is based on private medical facilities that conclude a contract with the financing organization in Bulgaria - the National Health Insurance Fund.

The new commercial status of primary care practices requires radical changes in management, as the general practitioner is now the owner, and places him in a new position of manager. This necessitates the creation of a new attitude towards patients with a view to increasing their satisfaction and attracting new patients, etc., as well as the acquisition and improvement of new management skills, which are not typical for doctors up to this point.

4. Reforms in the Organization, Construction and Structure of Systems: The changes in the organization should lead to the transformation of the old unified medical system (primary, specialized and hospital care is simultaneously provided in one medical facility) into three independent systems with different objects of activity - the systems of primary, specialized out-of-hospital and in-hospital medical care.

The changes in the organization of the primary are of the most radical nature.

The model of the regional system (regional principle) has been replaced by the model of general medicine.

This shift has several ***important consequences:***

• Complete withdrawal of the state as a financing body and emergence of a health fund

• Emergence of a new type of doctor - general practitioner

• Creation of independent medical facilities-practices for primary medical care

• Introduction of free choice by patients of a general practitioner

• New sources of financing and methods of payment for the activities performed by the general practitioner

• Complete privatization of the activities performed by the general practitioner

• Partial privatization of property

The choice of this new model of primary care, based on the principles of general practice and carried out by a single doctor (general practitioner), has strong scientific and empirical grounds, as it has greater medical potential compared to the specialized model of the ward system and opportunity to apply the modern holistic approach.

During the implementation of the primary care reform, some mistakes were made, the consequences of which continue even now, 22 years after its beginning:

• No real advantages are created for disclosing group practices which led to a predominance of individual practices (about 95% of all practices in Bulgaria)

• A large package of medical and non-medical duties that can hardly be performed by one doctor, including and an obligation to provide 24-hour medical care under a contract with the Health Insurance Fund (22)

• Insufficient funds to finance primary care

• The reform started without giving the doctors who will work as general practitioners the opportunity to acquire the necessary competence in advance to work in general medical practice

• Difficult conditions for acquiring a specialty in general medicine (23)

• Introduction of rules that maximally limit the diagnostic and treatment freedom of general practitioners (24, 25)

The consequences of these mistakes continue to have a negative impact and create problems in primary care. Of greatest importance are the problems in the organization of medical assistance at night and on days off; limited access in some areas of the country (small villages in the mountains); the large number of referrals of patients to specialized medical care, the insufficient quality of clinical activities in some areas, etc.

5. Reforms in Financing and Payment Methods: Changes in financing and methods of payment of activities were essential to change the existing model of outpatient care.

The financial system was changing with the adoption of the Law on Health Insurance and introduction of the health insurance model.

The income and expenses for the financing of health care are separated from the tax and budget model and begin to be provided through insurance contributions (mandatory and voluntary), and the payment of medical facilities mainly through the budget of the National Health Insurance Fund or voluntary health insurance funds.

In this way, the state is separated from the direct financing (paying) of the medical facilities, and it remains a source of payment of insurance contributions only for certain categories of the population (children, pensioners, socially weak, etc.) and for payment of activities in certain types medical facilities (psychiatric, oncological, etc.).

The health fund became the main source of funding for primary care, from where it received more than 90% of its income. Radical changes in payment methods have completely replaced global budget financing.

Methods of payment for primary medical care in Bulgaria

The introduction of the model of general practice in primary care also required new payment methods that correspond to the nature and content of the activity in these medical facilities. (26,25)

When carrying out the health reform in Bulgaria, the experience of countries with multi-year systems based on general practice was used when choosing payment methods.

Primary medical care is financed through:

1) **Payment per Capita (per capita, capitation):** The capitation method of payment is established in the primary care systems, where the source of funding is the mandatory health insurance organizations (Bulgarian National Health Insurance Fund). It is a major prospective payment method that provides about 50% of revenue.

The payment of a capitation creates security for patients, providing them with the opportunity to use, if necessary, a certain package of medical care from the selected general practitioner, and the general practitioner thus undertakes to guarantee the performance of these activities. These are mainly activities related to the diagnosis and treatment of acute diseases. The method also creates a certain financial stability of the practices, since this is a guaranteed income that does not depend on whether the health-insured person will use the contracted services or not. The disadvantage is that the method is passive because it does not stimulate the activity of the general practitioner. There is net income for the practice if the health-insured person uses medical services less often.

The value of capitation payments is different according to age, and in our country people are divided into three age groups - from 0 to 18 years, from 18 to 65 years and over 65 years.

2) Payment for Medical Activities: Payment of certain medical activities performed in primary care is an active method. In contrast to capitation, when paying for activities, the more

patients and the more often they use this medical activity, the greater the income, respectively the profit for the practice. This stimulates the general practitioner to increase the amount of activities.

In Bulgaria, the method is applied by the Health Fund for payment of mandatory (since 2012 and recommended) immunizations, preventive examinations of children and adults, monitoring of normal pregnancy, monitoring examinations of patients with certain chronic diseases (arterial hypertension, ischemic disease of the heart, heart failure, type 2 diabetes, etc.).

World practice shows that, from an economic and medical point of view, the best ratio between capitation income and activity is 40:60. In Bulgaria, although it is gradually improving, this ratio is 55:45. (18,26)

3) Payment of User Fee (amount for each visit to the doctor): The introduction of this type of payment by the patient, or the so-called "copayment", has two functions:

- Regulatory - prevention of over-consumption, because although this financial "barrier" is low, it affects the person's decision to visit the doctor
- Co-financing - positive contribution to revenue

The user fee is paid by patients who have continuous health insurance rights for each visit to the general practitioner.

A large number of patients - children up to the age of 18, students, military personnel, socially weak, disabled, patients with various chronic diseases (experienced myocardial infarction with developed complications, experienced cerebral stroke with disability, etc.) are exempted from it, which is significant degree minimizes the expected effects of this type of payment.

At the start of the health reform in 2000 legal norms have been adopted that determine the amount of the user fee - 1% of the minimum wage for the country, and since 2012 a fixed amount independent of the minimum wage.

The user fee, as a type of co-payment by patients, is a continuous subject of public and political discussions regarding its increase, decrease or abolition.

And at the present moment, the budget of the Health Fund for primary care, as well as the prices for the activities performed by general practitioners, still do not correspond to the "priority" position of primary care in the health care system.

6. Reforms in Primary Care Management: The one-party political system before the reform (rule of the country by the Bulgarian Communist Party), combined with the state monopoly in health care (ownership, financing, etc.), determined the totalitarian nature of the management of the primary care system in Bulgaria. (19)

The specialized health authorities of central and local government (Ministry of Health and Municipalities), as owners, directly manage the entire system.

During communism in Bulgaria, the performance of management activities was linked to the achievement of a centrally imposed state plan. In this sense, "good governance" is that which brings about the implementation of the defined plan.

A major flaw in governance is the complete exclusion of doctors and other medical professionals and citizens from participation in decision-making.

The reforms in the country aim to increase the democratic and liberal character of the health systems, including primary medical care. The introduction of a new way of financing, the introduction of a commercial status of practices, the emergence of private medical institutions-practices in general medicine, the emergence of a market of medical services and competition, require the creation of a new type of management.

The goals of the management reform are threefold:

•Reduction of centralization - right to freely choose a general practitioner, regardless of place of residence

• Increasing democracy - possibility to make decisions about diagnosis and therapy at the level of general practice

• Creation of autonomy in management - the general practitioner is a doctor who is the manager of his practice

The main laws related to the implementation of the reform (the Law on Medical Institutions, the Law on Health Insurance, the Law on Professional Organizations of Doctors, etc.) become the legal basis for making changes in management.

Regardless of the goals set with the reform of primary care in Bulgaria, significant **current problems** still exist. The aging of general practitioners is significant, with the average age being around 60, and 88% being over 50. At the same time, the specialization in general medicine is associated with a number of defects, the training in general medicine in medical universities has insufficient hours provided in the programs, according to the uniform state requirements, 30 hours of lectures and 30 hours of exercises. This leads to low interest in this specialty and, accordingly, a small number of doctors enter the system. In addition, the "market" in large cities is distributed and it is difficult to start one's own practice, which is also associated with significant financial costs that are prohibitive for some young doctors, and this discourages them from this specialty. At the same time, there are regions of Bulgaria (especially the mountainous ones) where there are no people willing to work, and one general practitioner serves several villages, with

examinations only one day a week for a few hours. However, the state is not taking effective action to overcome these deficits, which are about to deepen. Problems also exist in the work organization of general practitioners. A large part of them share a common office, which necessitates the division of working hours, being in practice half a day. This greatly complicates the access of actively working patients. In group practices, there is no possibility to see another doctor, unlike in some countries, for example Great Britain. Due to increasing financial costs, a large number of doctors work without a hired nurse or other medical and non-medical staff, which makes it difficult and slows down the work, which also includes a number of non-medical activities, such as prescribing regular therapy for one or three months, for example, monthly reports to the Health cash register and others. According to the current rules, general practitioners must provide 24-hour patient care, which is physically impossible. In this regard, private structures are emerging in large cities that take over these functions, for which both the primary care practice and the patient pay. With the low standard of living and especially for the elderly, this is a significant barrier and they turn to emergency medical care centers, which are state-owned and free of charge. This causes them to be overburdened and may have to wait hours for a review. General practitioners are at the entrance of the health system and determine the movement of patients in it, expecting them to be able to make an initial decision about their health problem, as well as carry out regular consultations with other specialists. This is done by issuing a medical referral. For each individual or group general practice, the Health Insurance Fund determines this number according to an established methodology, which number is insufficient. This is usually a reason for conflict between doctor and patient, and in some cases it is the reason for changing the doctor and choosing a new one. The same applies to the directions for laboratory and imaging studies. Each practice receives a specific budget to use for these purposes. Practices usually face the imposed cash limits, which greatly hinders their freedom to operate. From June 2022 an electronic system was introduced in the country for registering examinations and issuing directions for consultations and research. This eased the work of the doctors in the practice, since the issuing of the documents is now done remotely, but at the expense of this, the phone calls on this occasion increased, which interrupts and interferes with the regular work of the doctor. Another significant problem is the home visit that general practitioners are required to carry out. Since they are not paid by the funding body (the Health Insurance Fund) and with the disappearance of the regional principle (a patient's home can be far from the doctor's practice), there has been a significant decrease in their number in recent years. Against the background of Bulgaria's aging population, which is increasingly in need of medical care, rising inflation and insufficient financing of primary care, **new opportunities for reform** in this part of the system are being discussed in the public space. In June 2022 started the electronicization of health care with the introduction of an electronic patient record, which is part of the current change in the work of primary health care. Based on this, one of the parties of the ruling coalition proposes radical solutions for future reform - abolishing the choice of a general practitioner and thereby ending the permanent relationship of a doctor with "his" patient and liquidating a patient list, giving freedom to the patient for a visit directly to a specialist without the need for a referral issued by the general practitioner, removal of capitation as a method of financing the practices, removal of the obligation for 24 hours service and transferring these responsibilities to emergency and urgent care structures. In practice, the listed proposals aim at a complete change of the previous model and the introduction of a new organization and financing of primary medical care, which will largely represent a return to the pre-2000 model.

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