BULGARIA
Health Policy Note
DRAFT

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1. Introduction

1. After 1989, the health care reform process in Bulgaria can be divided into three phases: (1) before 2001, (2) between 2001 – 2005 and (3) after 2005.

2. The phase before 2001 can be characterized as setting the legislative and regulatory framework which will lead to introducing more market mechanisms in the system. The NHIF is created as independent – single purchaser, that is financed partially form contributions of economically active and partially from state contributions for economically inactive population. The legislation for hospitals privatization was adopted in 2000, but never implemented. In September 2000 the hospitals were changed into business entities, unfortunately they remained under soft budgetary constraint until present. The benefit package is set too wide, and in next years is never narrowed and remains a huge financial burden which the system is unable to finance. Cosmetic surgery and IVF are excluded. National Health Map is introduced as the criterion of minimal network.

3. The period during 2001 – 2005 is characteristic due to more centralistic approach to health care system. Privatization of hospitals was stopped by law in 2002 due to doubts about its transparency and not unified vision of key stakeholders. The position of BMA was strengthening. The political pressure on NHIF was imposed. There were 5 directors in 3 years. The management cancelled the training center and from auditing section, more than 100 people were released. The NHIF refused to pay for the 6 of 10 delivered information modules. Selective contracting was abolished. According to law amendment, the NHIF is obliged to contract every provider. Public hospitals are regularly bailed out from state budget. The purchasing function remains fragmented between NHIF and MOH. The NHIF is the only purchaser of out-patient care, but in-patient care is financed partially form NHIF (55% based on CCP) and partially from MOH (45% based on "quazi "quazi"" DRG system (17 groups according to ICD 10). IVF is included in Benefit Package.

4. After 2005. Bulgaria is in a key stage to decide about the strategy for the forthcoming years. The new government has to decide, whether (1) to keep the status quo or (2) it will continuously fine-tuning the current system or (3) has the political will to introduce profound changes that would lead to a more market oriented system. All these scenarios will be happening during the EU accession.

5. This health policy note is to summarize the key problem of Bulgarian health system and offer both the World Bank and the Bulgarian government possible scenarios for upcoming years. The HPN includes a Policy matrix for all three scenarios and a draft of implementation plan as well as some thoughts on the role of the World Bank in Bulgaria.

2. Macroeconomic Background

6. Economic performance reaches 32% of EU 25 average.

7. Solid GDP growth (5-6%)

8. Inflation

9. Fiscal policy. The Bulgarian government keeps the public expenditures under control and the deficits are close to zero, or they report a surplus. According to MOF, the deficit of public finances in 2005 was 0,0 % of GDP and this positive trend will continue also in the forthcoming years (Table 1). In 2006 and 2007, the MOF expect the public finances to be in surplus.

Table 1: Fiscal outlook for Bulgaria, % of GDP

	2005	2006	2007
Total revenues of public sector (taxes and contributions)	39.6	39.4	38.7
Total expenditures of public sector (state budget and social and health insurance)	39.6	38.7	38.0
Balance	0.0	+ 0.7	+ 0.7

Note: the projections are made according to current (2005) rates for taxes and contributions, increase of contribution rate form 6 to 8% and introduction of new rate for personal income tax or other changes are not included
Source: MOF, June 2005

10. The redistribution rate - measured by the portion of public expenditures to GDP - reached 39% and is one of the lowest compared to EU25 states and the government intends to follow this tendency with slowly decreasing redistribution rate (38% in 2007). The future plans for fiscal policy are as follows:
    a. Personal income tax: two levels 19% for rich and 9% for poor, the are three variants of the division line, but generally, the average earner should pay 9%
    b. Corporate income tax: decrease from 15% to 12.5%
    c. Tax on dividends: 15%, no change
    d. VAT: there is one single rate (20%), after 2007 down to 18%
    e. Health contribution rate: 6%, after 2007 it will rise to 8%

11. In NHIF financing, the ratio between resources from state budget (economically non-active population – approx 4.0 million people) and economically active will remain stable at 40:60 in the future. Payment of state for its one insuree is BGN 7.8 monthly in 2005 and in next years will rise by 2.5%. This improvement is linked to minimal insurance income (BGN 130), which is linked to average income (BGN 300) that will rise by 2.5% annually.

12. Technically, one the biggest challenges for the next government will be to unify the purchasing function in tertiary care by transferring all the resources from MOH to NHIF in amount of BGN 300 million. There are two possibilities to do this. First, in a non-systemic way by introducing a direct subsidy. Second, in a systemic way by increasing the payment for state insuree.

13. Public debt (46,2% of GDP and continuously decreasing!)

14. Unemployment rate is decreasing but is still high.

15. Health expenditure reaches 4.3% of GDP. Under funding is obvious, but efficiency issues are more important first in 2005 and 2006 (hospitals restructuring, flexible drug policy, hospital payment mechanism changed, privatization of hospitals, only the strategic

hospitals will be state owned, clear definition of BP to support voluntary insurance for adding additional quality) then increasing the contribution rate (only 2007). The goal of government is to increase the level of public expenditures to 4.8 to 4.9% of GDP.

3. Political Background

16. On the last elections, held on June 25th were won by socialists (32%), followed by the "Kings party" (19%).

17. World Bank loan to support health policies

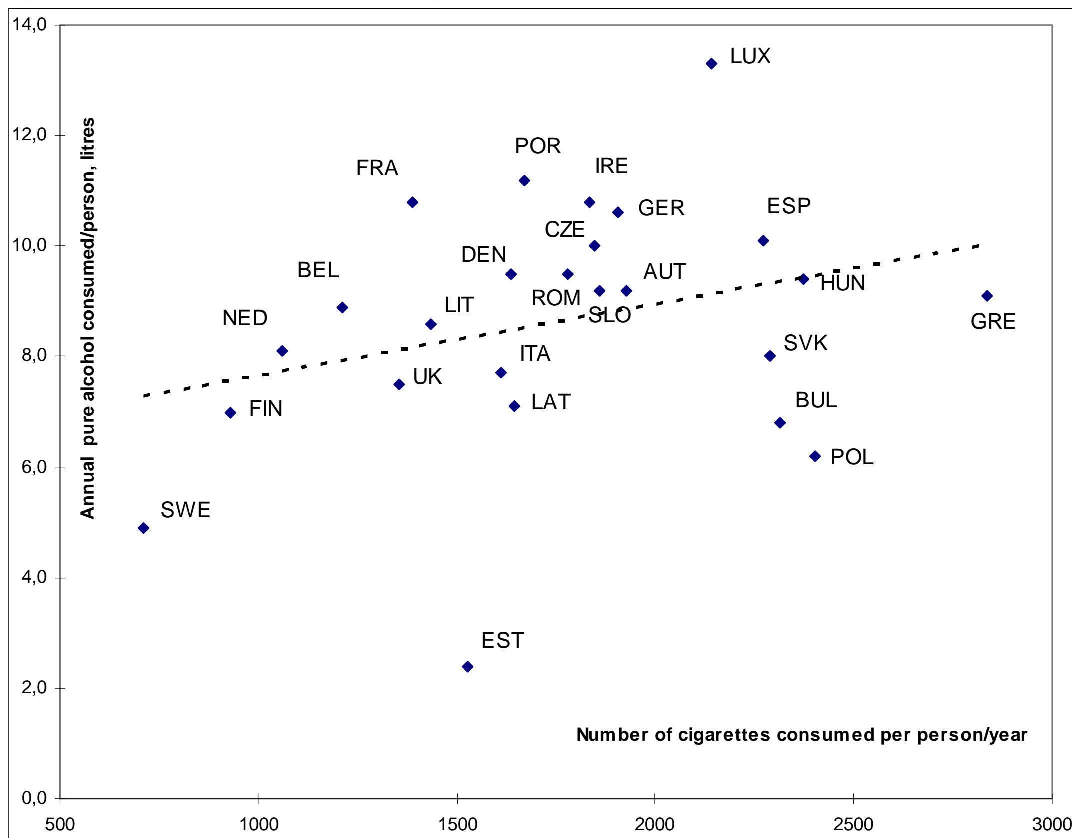
4. Health Status and demography

18. Life expectancy.

19. Diseases. Respiratory diseases.

20. Bulgarians are much rather "smokers" than "drinkers". According to WHO, their cigarette consumption is one of the highest, but on the other hand, the alcohol consumption is one of the lowest among European countries.

Figure 1: Alcohol and cigarettes consumption



Source: calculations of Authors based on WHO data

21. Age structure in Bulgaria is very similar to the EU15

Table 2: Age structure in Bulgaria

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
EU15												
0-24	32,0	31,5	31,1	30,6	30,2	29,9	29,6	29,3	29,0	28,8	28,6	28,5
25-64	53,0	53,3	53,5	53,7	54,0	54,2	54,3	54,5	54,5	54,5	54,5	54,5
65+	15,0	15,2	15,4	15,6	15,8	15,9	16,1	16,3	16,4	16,7	16,8	17,0
EU8												
0-24	36,3	36,1	35,8	35,4	35,0	34,5	34,0	33,4	32,9	32,3	31,8	31,3
25-64	51,7	51,7	51,7	51,8	52,0	52,2	52,5	52,9	53,2	53,6	53,9	54,3
65+	12,0	12,3	12,5	12,8	13,0	13,3	13,6	13,7	13,9	14,1	14,3	14,5
BULGARIA												
0-24	33,5	33,2	32,7	32,3	31,9	31,6	31,0	30,5	29,3	29,0	28,5	28,0
25-64	52,2	52,2	52,4	52,5	52,8	52,9	53,1	53,4	53,8	54,1	54,5	55,0
65+	14,2	14,6	14,8	15,2	15,4	15,6	15,9	16,1	16,7	16,9	17,1	17,1

Source: Eurostat, 2005

22. Fertility Rate is declining – since 1980 and nowadays is only about 1.2.

23. Bulgaria is dying out! According to Eurostat, between 2005 and 2050 will Bulgaria loose one third of its population!

Table 3: Population projections to 2050

	2005	2010	2015	2020	2025	2030	2035	2040	2045	2050	2050-2005	oproti 2005 v %
EU (25 countries)	458,5	464,1	467,3	469,3	470,1	469,4	467,0	463,0	457,3	449,8	-8,7	-1,9
EU (15 countries)	384,5	390,7	394,7	397,5	398,8	398,7	397,3	394,6	390,3	384,4	-0,1	0,0
EU 8	**72,8**	**72,0**	**71,3**	**70,5**	**69,8**	**69,2**	**68,3**	**67,0**	**65,4**	**64,0**	-8,8	-12,1
Poland	38,1	37,8	37,4	37,1	36,8	36,5	36,1	35,4	34,5	33,7	-4,4	-11,5
Czech Republic	10,2	10,1	10,0	9,9	9,8	9,7	9,5	9,3	9,1	8,9	-1,3	-12,7
Hungary	10,1	10,0	9,8	9,7	9,6	9,5	9,4	9,2	9,1	8,9	-1,2	-11,9
Slovakia	5,4	5,3	5,3	5,3	5,2	5,2	5,1	5,0	4,9	4,7	-0,7	-13,0
Lithuania	3,4	3,3	3,3	3,2	3,1	3,1	3,0	3,0	2,9	2,9	-0,5	-14,7
Latvia	2,3	2,2	2,2	2,1	2,1	2,0	2,0	1,9	1,9	1,9	-0,4	-17,4
Slovenia	2,0	2,0	2,0	2,0	2,0	2,0	2,0	2,0	1,9	1,9	-0,1	-5,0
Estonia	1,3	1,3	1,3	1,2	1,2	1,2	1,2	1,2	1,1	1,1	-0,2	-15,4
Bulgaria	7,7	7,4	7,1	6,8	6,5	6,2	5,9	5,6	5,4	5,1	-2,6	-33,8

Source: Eurostat, 2005

5. Legislative framework

24. Bulgarian health care system operates within a legislative framework which was substantially changed during the reform in 1997 – 2001. However amendments to the laws approved in the later years slowed the process of implementing some market principles in the sector.

5.1 Health Insurance Act

25. The key reform act settles the health insurance in Bulgaria. The health insurance is mandatory and voluntary. The mandatory health insurance is provided by a public monopoly – the *National Health Insurance Fund (NHIF)* and its regional branches. The Assembly of Representatives of NHIF is controlled by the state which has an effective

majority of the representatives since the amendment of the law in December 2002. The Assembly of Representatives elects the Managing Board which holds a competition for a Director of NHIF. Thus the Director's position is strongly dependent on the political situation. Frequent changes on that position in last three years prove this dependency.

26. The scope of health services covered by the mandatory health insurance is set very vaguely in the law and the specification of it is shifted to the *National Framework Contract (NFC)*. It is negotiated by the NHIF (the Director and the Managing Board) on one side and the *Bulgarian Medical Doctors' Association (BMA)* on the other one. The NFC is countersigned by the Minister of Health. NFC is supposed to be re-negotiated every year. If consent between NHIF and BMA is not reached the contract from the preceding year indexed by the official inflation continues in the next year.

27. Contracts between regional branches of NHIF and the providers have to be in compliance with NFC. If a provider fulfills the NFC requirements he has the right to get a contract with NHIF. Neither the scientific activity nor the medical education carried out in health establishments can be reimbursed by NHIF. NHIF has no right to possess any health establishments.

28. The contributions are collected by the *National Social Security Institution (NSSI)* and transferred to the account of NHIF. The law says who are the insurees (e.g. all Bulgarian citizens who are not citizens of another country); what are their rights (to emergency care and to the medical care according to actual contracts between the regional branches of NHIF and the providers) and duties (contribution payments, prophylaxy). The contribution base is calculated over the taxable income. For people who have none (children up to 18 years, retired persons, people with right on social welfare etc.) is the contribution based on a minimal income paid by the state. The minimal and maximal contribution base is also defined.

29. Administrative fees have been introduced in this law as following: 1 percent (= BGN 1.50) of the minimal salary for every visit in the outpatient care and 2 percent (= BGN 3.00) of the minimal salary for every day of hospital treatment. However there are some exemptions for vulnerable groups.

30. The voluntary health insurance can be provided only by joint-stock companies licensed by the State Agency for Insurance Supervision. These companies are allowed to possess health establishments incl. pharmacies. The voluntary health insurance should cover the services beyond the range of mandatory health insurance. The NHIF has cannot carry out the voluntary health insurance.

31. Ministry of Health supervises both mandatory and voluntary health insurance with administrative and punitive rights.

5.2 Health Establishments Act

32. According to this law almost every health establishment in Bulgaria is a commercial company – entity founded according to the Commercial Law (Art. 3, Par. 1). However, few exemptions are mentioned in the law: emergency centers, transfusion centers, stationary psychiatric care establishments, the homes for medical and social care and the

health establishments at the individual ministries (Defense, Internal Affairs, Justice, Transport and Communication). These are “corporate bodies at budget support for their specific functions” (Art. 35, Par. 2).

33. Although the Act declares the health establishments should be of equal status regardless of their ownership (Art. 4, Par. 2) in reality this goal wasn’t reached yet. The capital expenditures by MoH and the annual bailing out of the hospitals owned by the state and/or municipalities discriminates the private hospitals.

5.3 Act on Medical Doctors’ and Dentists’ Union

34. In 2001 the current government planned creation of health professionals’ chambers but the necessary legislation wasn’t approved yet and even the discussion on the topic didn’t happen. The chambers should have replaced the “almighty” position of BMA which rights in the current system exceed their responsibilities by far.

5.4 Transplantation Act

35. Though presented as a very modern law the transplantation act is almost non-applicable since it always requires an informed consent (to the contrary of many European countries). The change of this regulation seems to be a crucial condition for further transplantation projects development.

5.5 Act on National Health Insurance Fund Budget and Act on State Budget

36. Both laws are annually considered simultaneously by the National Assembly. The NHIF Budget Act determines the rate of the health insurance contribution (current rate is 6 %). In the case the NHIF Budget Act is not approved by the parliament until the beginning of the budget year, NHIF runs under the budget for the preceding year.

5.6 Act on Drugs and Pharmacies in Human Medicine

37. The regulations on pharmaceutical sector handles with standards of manufacturing, registration, administration, advertising and selling of medicines.

6. Collection of contributions

38. At the beginning, the intention behind creating the NHIF was to establish a institution, that will be a politically independent single purchaser. After 5 years, NHIF is neither a purchaser, nor politically independent. Rather a non-transparent redistributor that is heavily under political pressure.

39. For collection of premiums, the National Social Security Institute (NNSI) is responsible. The client pays directly to NSSI to various special accounts (pension, health, unemployment) and the money is directly streamed to National Health Insurance Fund (NHIF).[1]

40. The NHIF started in 1999 and during his first year it accumulated a surplus in amount of BGN 750 million. The money is deposited in Bulgarian National Bank and is used to cover the annual deficits of the NHIF, which according to NHIF representatives will reach BGN 111 million, but according to a study funded by World Bank it can achieve up to BGN 250 million[2]. This deficit was also supported by the opinion of IHHI leaders, who expect only hospitals deficit to reach BGN 220 million in 2005. Following this trend, the accumulated reserves will be eaten up in next seven to three years. Besides this accumulated surplus, the NHIF creates annually a legal 10% reserve for unexpected expenses which are usually used to cover the expenditures in the very same fiscal year.

41. For the vulnerable groups (approx. 4 million persons) - such as children (up to 18 years of age), pensioners, women on maternity leave, soldiers, socially vulnerable, unemployed - state pays contribution to the NHIF in the amount BGN 7.8 monthly, which follows the law requirement of 6% of the minimum insurance income (BGN 130). The unemployed must register and must be subject to social assistance; otherwise they are obliged to pay monthly to NHIF a premium of BGN 7.8. To get a status of socially vulnerable, persons need to register to regional branches of Agency of Social Assistance. The state contribution for the vulnerable groups represents approx. 40% of the NHIF revenues.

42. Health premiums for economically active (employed and self-employed) are linked to wages and count for 6% of gross wage. The burden was divided between the employer and employee in share 80:20. Until 2006 the share will be 50:50.

43. There are several scenarios assessing the impact of increasing the contribution rate, which is compared to any international standard quite low. These scenarios are crucially dependent on the elections outcome. It seems highly probable, that there will be no government without Socialists party[3] (30% in opinion polls). According to their political priorities, it is expected that they cancel the co-payments in primary care (BGN 1.5 per visit) and increase the contribution rate to 8%. These was officially not stated, but we

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[1] The government intends to introduce a new single collector for taxes and contributions, a National Revenue Collecting Agency (NRCA) for better contributions enforcement

[2] Opyrchal, T. and Beaston-Blaakman, A.: Study on the Mid to Long Term Fiscal Sustainability of the National Health Insurance Fund, 2004, Final Report, Project Document PAL3PRD - DOC004

[3] It is highly probable, that the Socialist party will win the elections and will have the mandate to create a majority in Parliament and thus a government. There are three alternatives of possible coalitions: (1) Socialists with Turkish Party, (2) Socialists with Simeon II or (3) Socialists with Turkish Party and Simeon II. The government led by socialist will probably: (1) not de-list form NATO, (2) not stop the accession process towards EU, (3) exercise prudent fiscal policy, and (4) show some social orientation

build on a slogan that "the goal is the financial sustainability of NHIF", which is not imaginable without increasing the contribution rate, or lowering the Benefit Package.

44. The enforcing of payables is the responsibility of NSSI. Due the Health Insurance Act, the non-contributors are excluded form provision of health services. In May 2005 approximately 1.1 million people[4] were on the "non-contributor list". The reason for being listed is the fact, that there are at least 3 "missing months" in contribution commitment. Usually, persons listed did not pay contributions from 3 up to 36 months. There are several reasons to become a non-payer:
    a. As employed persons, the employer did not pay to the NHIF
    b. As self-employed, you did not pay for yourself to NHIF
    c. As unemployed with expired rights, you did not pay for yourself to NHIF
    d. As agricultural worker, you are not registered, though nobody pay for you
    e. As a person living abroad, you were obliged to pay, but you did not (between 2001-2003)

45. Being a non-payer you still always have access to emergency care, which is state paid and does not belong under NHIF.

46. There are several ways how to get back to the system:
    a. Pay all the debts, irrespectively your social and economical status
    b. As employee, self-employed or unemployed, you have sign a declaration with NHIF to repay all your debts until 31.12.2006. Such a declaration must be signed until 21.10.2005. After signing it, you have to start paying monthly contributions, but you are not obliged to repay the debt, only until 31.12.2006. Frankly, the representatives of NHIF do not expect that these people will ever pay the money back, so the NHIF does not calculate this additional revenue as income in next fiscal year. The sum of accumulated debts of non-payers amount to BGN 300 million (approx. BGN 270 per non-payer).
    c. As employee, when it was a fault of employer, you are de-listed and they get after the employer. Basic condition for this process is all your contracts and documents transparently showing your correct approach. Since then, the employee is released and the whole issue must be handled by NSSI and the employer.
    d. As person from abroad, you have to pay at least 6 months in a row and agree on a payment plan with the NHIF or pay a 12 times a month premium (BGN 7.8) at once, if you do nit declare income. People that were abroad before 2003, must re-pay the whole debt.

47. The list of non-contributors is managed and enforced by NSSI. GPs and doctors contracted by NHIF are receiving a list of non-contributors, or they can easily check it via internet. For such patients, the GPs do not get capitation fee and the patients must pay for all provided health service in cash.

48. Nowadays, the NSSI is responsible for contributions enforcement. After a certain grace period, they have standard tools as execution of property in portfolio to enforce the claims. Unfortunately, non-paying contributions is not considered to be a criminal activity.

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[4] In 2004, it was more than 1.7 million people

49. This system of exclusion with very easy open-ended inclusion can be quite risky. It can serve as legal channel for opting out of system with very low marginal costs to re-enter it again. It supports adverse selection, while patients with no, or low health risks have no motivation to contribute – and rather pay directly cash. On the other, facing a serious and costly illness, they have easy way to re-enter the system.

7. Redistribution and Pooling

50. The NHIF pools the collected money according to redistribution formula respecting the following:
    a. Age and Gender (by age groups)
    b. Number of contracts in the given region
    c. Morbidity (?)

51. Usually, regions with university hospitals overspend. To Sofia, 22% of whole NHIF budget is allocated; similarly Varna obtains 15% of total NHIF budget.

8. Financial Stability of NHIF

52. According to NHIF, in 2005, the revenues of NHIF are projected at BGN 873 million[5] and expenditures will reach BGN 984 million[6]. Thus, the deficit will reach BGN 111 million and will be covered from the accumulated surplus (BGN 750 million)[7]. So the accumulated surplus will reach BGN 650 million at the end of the year 2005. According to study funded by World Bank, the deficit may reach BGN 250 million. To stabilize the NHIF certain steps must be implemented:
    a. Rationalization of Benefit Package
    b. Unification of financial flows to hospitals
    c. Increasing efficiency of the system

53. To stabilize the financial situation of NHIF a step towards unification of cash flows must be taken. The MOH budget on hospitals (BGN 300 million), capitals expenditures (BGN 50 million) and special expenditures on drugs (BGN 80 million) must be channeled to NHIF. This will also contribute to decreasing the impact of political influence on health care system

54. Another issue of stabilizing the financial situation is raising the contribution rate from 6% to 8% and increasing the payment of state for its own insurees. The increase of contribution rate will mean additional revenue of BGN 277 million. The NHIF plans to use the money to cover the projected deficits in next years and to increase coverage on drugs, in terms adding more drugs in a free list or lowering co-payment on partially reimbursed drugs.

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[5] 97% of all resources comes from contributions and 3% are other resources, like interests
[6] Total expenditures in health system in 2005 are estimated at BGN 1 777 million, out of which BGN 984 million will be covered by NHIF, BGN 500 by MOH, and the rest by other ministries and municiaplities
[7] The acumulated surplus was generated in 1999. The NHIF started on July 1st, 1999 and people paid their contributions, but NHIF did not purchase any care until 31.12.1999.

55. The increasing of contribution rate is feasible to be done only after efficiency of the system is improved. Increasing financial resources in an inefficient system, under soft budgetary constraints, highly corruptive and politically manipulated environment is a hazardous game that will not contribute to better outcomes. We understand, that the temptation to increase contribution rate in order to increase the share of health expenditures on GDP is politically attractive, but not immediately necessary, since Bulgaria is spending accurate level of money respecting its economic performance. Secondly, the increase of contribution rate would increase the overall redistribution burden[8] and may negatively affect the competitiveness of Bulgarian economy. On the other hand, introducing flat tax for personal income tax may generate some financial reserves, which may be used not only for strengthening domestic demand but also for increasing the contribution rate for health care leaving the redistribution rate unchanged.

9. Purchasing

56. NHIF is a single purchaser only in primary and secondary care. In tertiary care, the hospitals are paid also form MOH. The GPs in primary care are paid on a capitation and fee for service base. The specialists are paid on a capped fee for service base. The hospitals are paid in a dual system. The first channel is NHIF based on CCP (approx 50% of hospital budgets), the second is MOH based on clusters of diagnosis (approx 50% of hospital budgets).

Table 4: Expenditures on Health, 2004

Type of care	Expenditures by channel of financing (BGN million)	
	NHIF	MOH
Primary care	103.5	
Specialists	94.0	
Medical Diagnosis	41.0	
Dental care	49.0	
Hospitals	245.1	280.0
Drugs for home treatment	236.5	
Total	878.1	566.3
Unexpected and other expenditures (reserve)	75.6	
Deficit	84.1	

Source: IHHI, 2005
Municipalities (only 2003 data): 143.1 (out of which hospitals 69.0)

57. Since CCP is not a payment mechanism, rather a quality assuring mechanism, and especially in Bulgaria the CCP is set up on NFC negotiations very subjectively, without objective data background, the CCP remuneration is very unfair. So the US AID helped to develop the DRG for Bulgaria in the pilot project where 39 hospitals were involved. After data collection, the grouper (700 to 1000 groups), base rate and the weights were set for Bulgaria. The DRG should start in January 2005, but was delayed due to political decision. The implementation of DRG does not need any changes in legislation, only good will on NFC negotiations. The ownership to the DRG is with NHIF, so they will be submitting it on the next negotiations in November – December 2005 to negotiate NFC

[8] According to BIBA, the redistribution rate (public expenditures/GDP) reached in 2004 approx 40%

for 2006. Most probably, compromises on both sides will be needed to reach consensus, but there is high chance to get the DRG added into NFC with a gradual implementation plan for 2 years. The main conditions are unification of financial flows into NHIF and shifting capital expenditures also to NHIF to cover amortization in DRG rate.

58. The goal is to unify the financial flow to hospitals in 2006 with NHIF as a single purchaser in tertiary care supported by a new DRG based payment mechanism, which is now under construction. The money from MOH to NHIF can be channeled through increasing the money the state pays for socially vulnerable groups. Also the amount on capital expenditures could be added to remove political decisions on distribution the investments. This would mean a change form state budget financing towards a more performance based remuneration.

59. Basically, every provider that meets the criteria (education, license from Bulgarian Medical Association, and equipment approval form NHIF) has a contract with NHIF. To enter the secondary care, a referral form GP is needed with a type of specialization and signed form GP. The contracts are signed by the Regional Branch Director of NHIF. The NHIF does not exercise any type of selective purchasing.

60. To introduce selective purchasing, minimal network is needed in every region. Theoretically, the National Health Map should serve as this minimal definition by regions, but according to the Law, the NHIF is obliged to contract every provider. According to NHIF, the overcapacity in outpatient care is approx 10%, but regional differences may occur (In Sofia and Plovdiv, the overcapacity is approx 15%).

61. Canceling the contact is not easy, also in clear cases, because in the National Framework Contract, the BMA put obstacles to such behavior and the NHIF also did not manage to increase sanctions towards providers.

62. The withdrawal of contract is mainly due to over-reporting of providers towards NHIF. In last years, approx 15 contracts were canceled, mainly with specialist. When over-reporting takes place in hospital sector, the NHIF is not canceling the contract, but does not pay for reported, but not provided procedures and services.

63. The price rates on capitation (age groups), fee for services and CCP are set in the National Framework Contract and are re-negotiated between the NHIF and the BMA every year. If no consent is reached, the previous NFC indexed by official inflation rate is valid for the next year. BMA negotiation power is very strong, since they have nothing to loose. BMA represents almost 100% of all doctors in Bulgaria. Paradoxically, the BMA is moving form a professional organization rather to towards a political subject with pretty strong competences defined in the legislation.

64. Besides prices and rates, the National Framework Contract sets the scope of Benefit Package, which is defined very vaguely with no clear-cut between services covered and not covered by health insurance (still there is a negative list of services excluded, like plastic surgery). The Benefit Package is set better for outpatient services and very unclearly for hospitals and tertiary care. This is the reason for slow penetration of private insurance. They can only provide supplementary insurance and can not replace NHIF. While the Benefit package is not well designed and defined, they are rather oriented on offering better service (some also hip replacement) or higher comfort.

65. Drugs for home treatment represent almost 25% of total expenditures of NHIF[9]. Drugs for hospital treatment are covered under CCP paid to hospitals partially from NHIF and MOH. The market entry is regulated by National Institute for Drugs that certifies drugs for internal market. MOH issues a positive drug list (more than 1000 items) based partially on INN and partially on brand names and generics that can be procured and reimbursed by NHIF. Based on this, NHIF after consultations with BMA issues its own drug list (900 items) for reimbursements only with brand names, where free drugs (200) are listed as well as drugs with co-payments (700) ranging from 25% up to 75%. The co-payment procedure is approved by special Commission in NHIF. Transparency improved a lot during last years, but for adopting the EU Transparency Directive, many things must be implemented.

66. Drugs are sold exclusively in pharmacies[10]. To operate a pharmacy, one person from management must have a specified education and some basic conditions must be met. It is allowed to own a chain of pharmacies. If the drugs sold in pharmacy are to be reimbursed by NHIF, the pharmacy needs a contract with NHIF. Otherwise, they can sell drugs only for cash.

67. Prescription can be signed by a GP or a specialist. It has a special form and protection. The NHIF has a developed tracking system, knowing who signed the prescription, in which pharmacy it was validated and what was reimbursement.

Table 5: Drug expenditures, BGN million

	2004
NHIF	250.0
MOH (special drugs – life saving)	100.0
Hospitals	120.0
Co-payment of patient	410.0
Total	880.0

Source: IHHI, 2005

68. Patient accounts are in the beginning stage. The NHIF has prepared some modules, like:
    a. GP and patient module to track the enrollment into the system and the capitation
    b. Pharmaceutical module to link the prescription to the doctor, pharmacy and patient
    c. HR module
    d. NSSI link for data on non-contributors and collection

69. Nowadays, the NHIF is preparing to procure an integrated health care information system to fully cover patient records, including revenue side (collection) and expenditure side (only after all hospitals are paid from NHIF on per case base).

70. National Health Map should serve as the definition of minimal network. According to MOH representatives, there is an overcapacity among GP of 2 – 3%. No of specialist is 5000 according to map. But there more than 7000 contracts, because the employed doctors in hospital are allowed to run a private out-patient practice (!). The NHM is approved by

[9] In real terms, the drug budget represent only EUR 125 million in total; per capita EUR 15 per capita, which is very low compared to EU8
[10] According to WHO, The pharmacy infrastructure is heavily under-developed (only 16 pharmacies per 100 000 compared with 80 as average in EU15)

the council of ministers (that was also a condition to PAL). Above this, according to IHHI the actual number of doctors rose by 6800 persons from 27800 in 2002 up to 34600 as a result of canceling selective purchasing and putting a condition of obliged contracting of all doctors by NHIF. This was used by retired doctors to re-open their practices.

71. The BMA is enjoying a special unique (monopolistic) position in the system (for example BMA signs the NFC).

10. Drug policy

72. Entering the market with a medicinal product in Bulgaria is a long and bureaucratic process. It takes approximately 18 to 24 months to get all the paperwork done which allows the producer to sell the drug. The legislation doesn't fit to the EU Transparency Directive. The process is ineffective and non-transparent. Only few market tools are used in the drug policy.

73. The process consists of the four following steps:
    a. *Registration at the Bulgarian Drug Agency (BDA).* The registration process takes maximally 210 days by law but various administrative tools are used to prolong this period up to an average 12 months.
    b. *Ceiling price setting by the MoH which takes 2-3 months.* The ministry has to be provided by the same documents which were necessary in the registration process.
    c. *Application for including in the Positive List published by the MoH.* The Positive List is prepared by ministerial commission and consists of priority diagnoses for which drugs might be reimbursed. The drugs are mentioned in the List both by INN names and by trade names. The inclusion in the list however is no guarantee the drug will really be reimbursed – it is just one of preconditions. The Positive List is issued every year in October and the deadline for applications is the 31st of May each year. E.g. if a pharmaceutical company gets the price for its product on 1st of June, it has to wait another one year to have the possibility to be included in the List and maybe then reimbursed. Again, the applicant shall include all the documents mentioned above.
    d. *Negotiations between the NHIF and the producer on the Reimbursement List.* The price of the medicinal offered by the producer must not exceed the average price of this product in 8 reference countries otherwise the drug will be not included in the list. There are four ranges of reimbursement rates (up to 25 / 50 / 75 or 100 %). The negotiations are hold within the range set before the negotiations begin. The applicant shall include the same documents for the fourth time.

74. The ceiling margin of the wholesaler is 10 %, the ceiling margin of the pharmacy is 25 %. VAT (20 %) applies also on drugs.

75. The generics take 66 % in total volume and 34 % in total budget of the Bulgarian pharmaceutical market.

76. All the numbers however may not be precise since the grey economy is also part of the drug market. Different prices of the same medicine depend on whether VAT is paid or not. There are several ways how to avoid paying VAT. The domestic producers are not obliged to declare the real volume of production consignments which they use (they

produce more than they declare). Another way is a fictitious re-export of foreign medicines or the imported drugs stored in custom warehouse on the territory of the distribution company are taken out of the warehouse without informing the customs. Estimated 10 - 15 % of the turnover raised in the pharmaceuticals sector comes from illegal drug sale.[11]

77. Estimated BGN 40 million is lost only through very slow administrative process and the fact the Reimbursement List is dependent on the NFC. If the NFC is not signed, the previous Reimbursement List is in force (this was the case in 2004) and no price competition can be enforced.

78. Some recommendations:
    a. the drugs should be generically prescribed (by INN names)
    b. the administrative process for market launch should be made at one desk (from the registration through price setting to the reimbursement list)
    c. there should be only one positive/reimbursement list issued by the MoH (not NHIF) at least twice a year based on the reference price of INN drugs.
    d. price setting process and positive/reimbursement listing process should consider only the pharmaco-economical side since the efficacy, safety and quality issues are already reviewed by the BSA. This could lead to less paperwork and speed up the process.
    e. the decision process on reimbursement rate should be transparently set in the law, based on verifiable criteria and it should include also the remedies available to the applicant under the laws in force (according to the 89/105/EEC Transparency Directive).
    f. increase coordination of BDA, the tax and custom administration in exercising control on the drug market in Bulgaria

11. Corporate governance

79. In spite at the beginning it was not planned, the NHIF is under strong political pressure. In last three years 5 directors were changed. The MOH has 18 representatives in the Assembly of representatives that has altogether 36 members. The representatives of state are nominated by the Council of Ministers, thus, MOH enjoys de facto majority of votes. The board (9 persons) is appointed by the Assembly and stays in office until December 2005. To whom is such a “construction” accountable and responsible?

80. The Board and the Assembly are de facto not accountable to anybody in the system and no-one seems to bear financial and political responsibility for deficits or un-efficient decisions. No external audit. State control. The deficit is legitimate.

12. Private expenditures

81. There are controversial data on the volume of private expenditures. Sources close to MOH say, that the private expenditures are similar to the public ones (4.5% of GDP)[12]. That

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[11] Source: Dessislava Nikolova*: Grey Market of Medicines in Bulgaria 2004,* Capital Weekly Nr 17/2005
[12] That would mean a funding mix 50:50 and would mean, that Bulgaria is far away from EU8 (78:22) or EU15 average (72:28).

would mean a portion of more than 4% of GDP (out of which 70% are informal payments and 30% are formal payments). According to our calculations, the private expenditures do not exceed 1.5% of GDP[13]. The private expenditures consists of following:

a. Formal co-payment in out-patient care. For visiting a general practitioner or a specialist BGN 1.5. One night in hospital BGN 3.0, but maximum for 20 days annually. Emergency, transport and prescriptions are for free.
b. Formal co-payment for drugs.
c. Formal payments for higher standard and comfort, mainly in hospitals. These are "quasi legal" co-payments and form a legal policy of supplementary services (VIP room, personal bathroom, choice of team). In a public hospital such a package by birth covering regular follow up, VIP room, and a special team costs approx BGN 400.
d. Formal payments of non-contributors
e. Formal payments for services outside of Benefit Package
f. Informal payments for health services. They are rare in primary care, more frequent among specialist and usual in hospital sector.

82. The informal payments are rare in primary care (evidence exists). In secondary care, informal payments are more frequent (range is not known, but it is around BGN 15 to 20). In hospitals, informal payments are very frequent. The standard payment ranges form BGN 100 to 300 (a birth approx BGN 200 – 300).

13. Out-patient care

83. The out-patient care is solely purchased by NHIF. In the primary care, there are 6000 GP and 8000 dentist registered as individual entrepreneurs. Above this, there 270 group GP practices (3-13 GPs per group practice) and around 100 group practices. All contracts are signed on annually basis.

84. GPs are paid on partially on capitation basis and partially they are remunerated by providing services under different programs (child care, dispensarization). The GP must have at least 800 patients listed; otherwise he cannot sign a contract with NHIF. There is no upper ceiling on the number of patients. The capitation is set in NFC, and is approximately BGN 1.1 per capita per month. The average GP earns approx BGN 1200-1500 on capitation, and 30-50% of capitation on taking part in different programs.

85. The access to out-patient secondary care is based on a referral. There is 6000 specialist in individual practice, 100 group practices, 500 medical centers (at least 3 different specialist), 110 diagnostic-consulting centers (at least 10 specialists) and 800 medical-diagnostic laboratories. Every lab has a special contract with NHIF and the patient to freely choose the lab. The number of referrals is strictly limited by the NHIF on a monthly basis, which creates ideal environment for informal payments, since doctors can "blackmail" the patients by limited number of referrals requiring from them an unofficial payment for speeding up their treatment or allowing them to go the certain diagnostic procedure. In other case the patient is added to a "waiting list". This applies only to elective care, since emergency cases are treated separately and are paid by state budget.

[13] According to Eurostat, in 2000 the health expenditures formed 2.8% of total household expenditures (EU8 3.2% and EU 15 3.4%).

86. Beside the referrals, the NHIF regulate also the number of drugs prescribed by time period (1 month) and type of specialist.

14. Equity

87. The equity in Bulgaria is distorted since access to care is in most cases conditioned by forced unofficial payments. Access to care is often based not on insuree status but on preparedness to pay. For services financed by NHIF patients usually have to wait, unless they do not pay an unofficial payment.

15. Enforcing patient rights

88. The enforcement of patient rights is very complicated. First, patient have fear to raise against the doctors. Second, there is neither an sovereign "Patient Ombudsman", neither an independent Authority to protect patients. The MOH has no patient protection unit and the BMA has a very relaxed policy in case of maltreatment. The courts are the only, but very long-lasting way of law enforcement.

89. The BMA withdraw in last years three licenses, but they had to be given back, since the doctors attacked the BMA. There is only one case in last years that a patient was successful, and he got a financial compensation of BGN 400 form the MOH.

16. In-patient care and legal status of hospitals

90. The legal status of all hospitals is equivalent to private companies, but allowing regular bail out, the hospitals are still operating under soft budgetary constraints. Therefore, no hospital was closed or went bankrupt.

91. From legal point of view, all hospitals are commercial entities, but according to their ownership, there are four types of hospitals:
    a. Completely private hospitals. The management board is nominated by the owner.
    b. Municipal hospitals (250). They belong 100% to given municipalities[14]. The management board is appointed by the municipality.
    c. Regional hospitals. The ownership is divided between the state (owns always 51% of shares) and the municipalities form given region[15] (49%). The board is appointed by the state and municipality representatives. In spite almost the half of the hospitals is regional; they are rather under ministerial control and governed by MOH.
    d. National University Hospitals. They are located mainly in Sofia and are linked to universities. They are 100% owned by the state. If state would privatize its stake in regional hospitals, these hospitals would stay state owned.
    e. Special hospitals owned by different ministries – like the interior, defense (with closed system due to security issues), or transport with open system to everybody.

[14] In Bulgaria, there are 262 municipalities varying from in size and population.
[15] In Bulgaria, there are 28 regions, in all of them there is a big hospital

92. Corporate governance. The management board is nominated by the owner.

93. Management issues. Managers can hire and fire staff under the condition of minimal requirements set by MOH. Generally the trend is rather to over staff, than try to get close to minimal standards. Wages used to be set centrally, nowadays the hospitals are under a public commercial company status, the wage policy is up between the management and trade unions in a contract. The management uses usually 40% of CPP payment to motivate the employees and differentiate the wages

94. The official average salary of a doctor in hospital is BGN 600, but some specialists have BGN 2000. An average nurse earns BGN 330. Many, but not all doctors earn an additional BGN 600 from unofficial payments[16]. According to hospital managers, on a macro level, the hospitals need approx BGN 1 500 million and from the NHIF and MOH they get BGN 1 000 million. So the rest BGN 500 million is in the unofficial payments.

95. There is only one case that a doctor was accused by corruption, lately he was fired, but paradoxically, he won the court and must be taken back to hospital.

96. As the reaction to increased corruption in the hospital sector the hospital started to establish foundations by every ward in hospital[17]. These leads to higher transparency, though results may vary, because according to Health Act doctors are allowed to have a private praxis directly in hospital, and many do so.

97. Assets and liabilities. Hospitals are free to acquire and procure equipment. Since they do not have enough cash, they rely on the capital expenditures from MOH. The MOH has a special chapter in its budget – but it is mainly used for state owned hospitals. Others can apply to a special Competitive Fund which a part of MOH. The CF makes regular survey on what is needed. Based o survey, the central procurement follows. Consequently, the equipment is delivered to hospitals on a leasing or loan basis.

98. The hospitals are free to take loans from a bank.

99. The hospitals are paid unusually on a CCP basis. The CCP payment is calculated as average for all hospitals. But many "subjective" factors change the relative value of CCPs. Under this system, the excellence is not paid and the most equipped university hospitals usually have to take care on very expensive patients, because smaller hospitals send their patient to a "higher" institution. For example Alexandrovska hospital spent in this year on 8 expensive patients more than BGN 114 000 and received form the NHIF only BGN 4 000, so the pure loss was about BGN 110 000. Another problem of hospitals as "bumpers" are the non-contributors, who do not pay, but need health care. The Alexandrovska hospital has 15 to 20 such people monthly and their treatment is not reimbursed by NHIF. These are the reason, why the hospital asked for additional bail out and has been awarded by a special subsidy of BGN 9 million to keep the hospital balanced with expenditures reaching BGN 35 million.

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[16] According to BIBA, the corruption is consumer driven and not induced by doctors

[17] A foundation by neuroserugery ward in Alexandrovska hospitals bought last year equipment in amount of BGN 400 000

100. US AID prepared a strategy for hospital restructuring in 4 pilot regions (Gabrovo, Razgrod, Lovech and STara Zagora). The outcome of the project included closing, merging, consolidation and re-functioning of all hospitals in given regions and were presented to the MOH. The regions refused the recommendations.

Table 6: Hospital Infrastructure

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
EU (25 countries)	744,7	737,4	720,2	714,1	692,1	677,4	656,1	651,9	641,6	639,1	
EU (15 countries)	711,6	705,7	692,0	686,2	664,1	648,9	625,0	622,9	612,8	611,3	
EU 8	**987,4**	**955,0**	**910,3**	**877,8**	**846,6**	**832,4**	**820,7**	**804,5**	**783,0**	**765,0**	**876,6**
Czech Republic	1218,5	1209,7	1134,5	1107,4	1125,2	1113,6	1104,1	1092,6	1095,8	1107,1	1137,2
Lithuania	1173,9	1108,1	1083,0	1055,6	983,0	961,5	938,0	923,2	869,4	892,8	866,1
Hungary	1004,1	990,6	909,1	910,9	826,4	831,1	836,8	839,1	806,3		
Latvia	1203,0	1184,3	1099,3	1025,0	961,3	922,2	885,2	855,1	809,5	773,4	779,3
Slovakia				832,7	815,2	804,6	795,7	784,1	766,9	756,9	723,9
Poland	791,7	784,0	768,7	766,9	757,8	744,0	735,1	718,7	717,5	709,9	
Estonia	941,8	830,9	804,1	757,6	738,2	722,8	716,5	682,9	681,8	605,9	
Slovenia	578,7	577,7	573,6	566,6	565,3	559,1	554,0	540,6	516,9	508,9	
Bulgaria	1047,9	1017,7	1034,1	1044,1	1024,0	838,1	747,7	739,3	699,2	646,6	626,7

Source: Eurostat

17. Debts

101. Hospitals regularly overspend and wait for additional money from state budget. The approach of overspending with regular bail out from MOF by direct subsidies was also a subject to IMF criticism. I last years, arrears are slowly decreasing. The MOF said there will be no bail out this year, but most probable reaching November the direct subsidy will save the hospitals again. Generally, such a system of soft budgetary constraints creates bas incentives and does not improve the managerial skills and does not support the corporate governance, which is crucial for improving technical efficiency in hospitals.

102. There is an uneven position on market and discrimination of private hospitals. The private hospitals:
   a. Do not obtain capital expenditures form state budget and the amortization is not included in the payment mechanism
   b. Do not get money to bail out their debts (and they do not create debts)
   c. Do not have automatically contract with NHIF

18. Health Policy Strategy for next years

103. For the 2005 government, there are three main scenarios of Health Policy Strategy. All three scenarios are respecting the basic values of the Bulgarian health system, like universal coverage, equity and solidarity. Much more, the third scenario has also the ambition to improve allocative efficiency and minimize regional disparities in health provision.

104. The three scenarios of the Health Policy Strategy are as following:
   a. "*Bankruptcy scenario*". Maintaining status quo in health financing, delivery, regulation and organization of health care. This would lead to slow financial

bankruptcy of the health system after all the reserves would be eaten up until the end of 2007

b. *"Parametric reform"*. Changes the parameters of current system to ensure financial stability by increasing contribution rate and implements minor changes in delivery, regulation and organization of health care. Has only minimal impact on improving allocative efficiency, since all the sources will be channeled through one single, politically controlled redistributor of money.
c. *"Paradigmatic reform"*. Separates the purchasing from political pressure, what is decidedly important in a highly corruptive environment. This scenario can be named also as "New purchasing scenario".

105. In the bankruptcy scenario, no changes are made in the system. The revenue side remains under funded and the system produces a deficit approx. BGN 250 million annually. With this scenario, all the risks persist – single purchaser, under political control in highly corruptive environment.

106. The parametric scenario financially stabilizes the health system and ensures balanced financing in mid-term. We assume that the main failures of the system will persist. First, the NHIF will be under heavy political control. Therefore, no selective purchasing and no optimalization of hospitals network will be introduced. The hospitals will be regularly bailed out at the end of the year. Following steps need to be done:

a. Increase contribution rate form 6% to 8%
b. Transparent rules for defining the contributions (not in state budget, but for longer period)
c. MOH money flows into NHIF (transfer to NHIF)
d. Change the propositions in NFC (strong BMA)
e. Capital expenditures are canceled and channeled to NHIF
f. Benefit Package is clearly defined and narrowed
g. Drug Policy
h. DRGs are introduced to reimburse hospitals
i. Patient accounts (revenue side and expenditure side) are introduced

107. The main idea behind the paradigmatic reform is to split purchasing from political influence. Especially in former Soviet countries the corruption is daily present in decision making. Bulgaria ranks one of most corruptive countries (Transparency International). In such a highly corruptive environment, a single purchaser strategy leads to suboptimal allocation of resources and decreasing allocative efficiency. The New Purchasing is based on following pillars:

a. The collection of money is done by the National Revenue Collecting Agency (NRCA).
b. The money is redistributed according to special formula to respect the regional disparities and is based on age, gender, and poverty and region profile.
c. Every region gets the same amount of money on every citizen corresponding with its risk index. This ensures equitable distribution of resources across country.
d. To use this money, public tender will be called and consortia of providers can apply for the money, while the Benefit Package is defined, the minimal network is defined and basic quality criteria are assessed.
e. The winning consortium obtains the license in the given region for three years and becomes a single purchaser in the given region independent on the political pressure.

f. The state is leaving its position as service provider, since its entire stake in regional hospitals (51%) will be sold. The state becomes a supervisor of the system through the Health Market Authority. To ensure the independence of HMA, its members are voted by the parliament and every two years, the 1/3 of the Board is changed.

108. Introducing of New Purchasing might be divided into three steps
   a. Preparation phase. Creating the redistribution formula. Preparing the Benefit Package and Minimal Network. Choosing the pilot regions, where the New Purchasing will be tested.
   b. Testing phase. The New Purchasing is tested in three selected regions. The success of the project will be measured on following criteria:
      i. Financial stability
      ii. Patients satisfaction
      iii. Allocative efficiency
   c. Implementation phase. After the project was successful in selected regions, the system can be applied in whole Bulgaria.

109. The ambition of New Purchasing is to improve equity in the system and minimize the regional disparities in health care provision. The second goal is to increase allocative efficiency towards outpatient care with lower weight on drugs. Management of patient.

110. All three scenarios will be also affected by the process of EU accession. Generally, there are three important issues, that must be dealt with caution:
   a. Mobility of patients (Directive 1408)
   b. Mobility of doctors and nurses
   c. Transparency directive in drug policy

19. Role of the World Bank

111. To implement a reform the Bulgarian government needs a vision, knowledge and financial resources to cover transformation costs. The World Bank may help the Bulgarian government to formulate the vision, can advise and is ready to provide temporary financial coverage in a form of a loan.

112. The role of the Bank in implementation of these three scenarios is various. In the "bankruptcy scenario" the role of the World Bank is very limited.

113. In the "Parametric scenario", the World Bank can help with SECAL oriented on incremental reforms. The main fields of expertise and investments are:
   a. *hospital master plan* (technical assistance and loan to hospital providers to modernize health infrastructure, hospital network optimalization and restructuring)
   b. introduce *transparent criteria for selective purchasing* based on a Donabedian approach - structure, process, outcome (technical assistance and loan for NHIF to improve information system)
   c. *finalize DRG* per case (technical assistance and loan)
   d. *introduce individual medical accounts* – revenues and costs (loan to improve information system)

e. *introduce patient management* (vouchers, call centers, prevention…) – technical assistance and loan to NHIF for improved patient management
f. *drug policy* – technical assistance

114. The highest involvement of the World Bank team could be in the “New Purchasing” scenario, where the World Bank could use its broad knowledge in strategic purchasing and increasing allocative efficiency, while maintaining equity. The World Bank can help by technical assistance, expertise, management of the project, or conditional loans. All these can be added to areas described in paragraph above.

20. Policy Matrix

<table>
<tr><th>Scenario</th><th>Area</th><th>Financing and Pooling</th><th>Payment mechanisms</th><th>Regulation</th><th>Organization</th></tr>
<tr><td>Bankruptcy scenario</td><td>Soft budgetary constraints</td><td>Regular bailing out

Monopolistic position of NHIF, under political control</td><td>The purchasing function is not separated from political decisions</td><td>Monopolistic position of BMA

The Benefit Package is not defined</td><td>State and municipality owned hospitals</td></tr>
<tr><td rowspan="3">Parametric reforms</td><td>Increase efficiency of the system</td><td>No bailouts of system</td><td>Unify the flow of financial resources to tertiary by shifting the hospitals budget from MOH to NHIF

Shift all capital expenditures form MOH to NHIF

NHIF as only source of public funding for tertiary care

Implement DRG as single payment mechanism in tertiary care.

Increase allocative efficiency of NHIF</td><td>Benefit Package rationalization.

Transparent drug policy in place. Replace the brand names with ATC group, with one free drug in every ATC group.

National Framework Contract revision and re-arrangement

National Health Map as real document defining the minimal network of providers in every region

Selective purchasing introduced

New drug policy</td><td>Define strategic hospitals with three levels of hospitals (hierarchy). These will not be sold

Define special hospitals with special procedures and special remuneration

Privatization of hospitals (51% in regional hospitals)

Restructuring of hospitals (mergers, closing, changing the function, duplicities, outsourcing…)

Introduce hard budgetary constraint on hospitals</td></tr>
<tr><td>Increasing access and equity</td><td>Introduce transparent redistribution formula to improve equity and access</td><td></td><td></td><td></td></tr>
<tr><td>Increasing financial stability</td><td>Increasing contribution rate from 6% to 8%</td><td></td><td></td><td></td></tr>
<tr><td>Paradigmatic reform</td><td>Split of political power and purchasing function</td><td>De-monopolization of NHIF

Introducing competition and multiple purchasers</td><td>Definition of Benefit package

Implementing a suitable redistribution formula

Definition of minimal network (time access and physical access to care) – restructuring of National Health Map</td><td>Canceling NFC

Introducing free market prices on purchasing</td><td>Full privatization of hospitals</td></tr>
</table>