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Patient payments and the problems in medical services provision in Bulgaria

Key words: patient charges, health care system, stakeholders, Bulgaria

Introduction

During the past decade, the reform in the Bulgarian health care sector was in the focus of policy and research discussions at national and international level. As the evidence suggests, in spite of the great expectations after the introduction of social health insurance in 2000, efficiency, equity and quality problems in health care provision in Bulgaria continue to exist. Some of these problems are attributed to the unequal start of the reform in outpatient and hospital care, namely to the delay in restructuring the hospital care sector [1].

Among other issues, the reform included the implementation of formal patient charges, which was a part of the philosophy of the health insurance system established in the country. Formal patient charges were introduced to serve a specific goal, in particular, to improve the efficiency of health care utilization. The type of patient charges selected for Bulgaria is the so-called co-payments (flat-rate fees). Such charges are applied to all levels of medical services with the exception of emergency care. The size of the fees is regulated by the Law on Health Insurance and is linked to the minimum wage in Bulgaria set annually by the government. The co-payment for each visit to a general practitioner (GP) and medical specialist that provide outpatient care (after a referral from a GP), is equal to 1% of the minimum wage for the country. The co-payment for hospitalization in a health care establishment amounts to 2% of the minimum wage for the first 10 days of the hospital stay and is paid once per year, i.e. no fee is paid for a subsequent hospitalization during the year. The amount of these co-payments increases with the rise of the minimum wage [2, 3]. In case the patient decides to contact a medical specialist directly, the patient has to pay the full service costs.

Patient charges are not obligatory for all citizens and all services. On the one hand, this is expected to improve equity, but on the other hand this hinders the equal access to medical care. For instance, children aged below 18 and certain professional groups, who are not necessarily low-incomers or frequent users, are completely exempt from co-payments, while elderly persons (above 60 years old) who often need health care, and individuals with low income are only partially exempted or pay reduced fees. Also, co-payments do not apply to emergency care, which makes this part of medical services most vulnerable to overuse and turns it into the widest gate of access to the system. This may cause delays for those who really need emergency care.

The Parliamentary elections in June 2009 brought about a governmental change promising major reforms in a number of fields, including health care. The new Ministry of Health Care has declared a determination to continue the health care reforms but at the same time, the Minister has announced new intentions to base the reform actions on current analyses about the state of the health care system. The opportunities for dealing with informal patient payments (and more generally with the elements of corruption in the society) have also become a priority for the new government. Informal patient payments are perceived as a considerable problem in Bulgaria since they are evidenced in empirical research before and after the implementation of formal patient charges. Thus, the current mechanism of official fees for health care services was unable to eliminate this type of payment during the past decade. Therefore, the option of amending the fee mechanism has been discussed by Bulgarian policy-makers.

This paper presents empirical results on the opinion and attitudes of different health care stakeholders (incl. consumers, providers, insurers and policy-makers) toward patient charges from the perspective of the state of the Bulgarian health system. The data were collected via focus group discussions and in-depth interviews carried out in Bulgaria in May-June 2009. The results and their discussion are used to out-line recommendations for policy related to patient payments.

The state of the Bulgarian health care system

The introduction of social health insurance in 2000 brought about important changes in the organization and funding of the Bulgaria health care system. Most importantly, the social health insurance allowed for an earmarked system funding independent from the state budget and government priorities (in contrast to the previous tax-based funding). It also brought about a split between service provision and system funding (which is now the responsibility of National Health Insurance Fund – NHIF). As a result, a contract-based relation between the insurer and health care providers was established with the objective to create competition even though the level of this completion is still limited at present.

The reform also involved the restructuring of outpatient care, and in particular the establishment of a system of GPs (also called family physicians). At present, the outpatient care is well-developed but the irregular territorial distribution of GPs and medical specialists continues to exist. It is a known fact that there are disproportions in the distribution of population groups served by one GP. The work overload of Bulgarian GPs in some areas is a problem, which should not be underestimated since GPs present the first health care level responsible for the provision of timely and competent medical care. Another problem is the qualification of the GPs (maintenance and improvement of GPs' qualification), which is left only to their desire. Furthermore, most of the physicians working as GPs have never been trained for GPs. During the 10-year period determined by the health legislation for the acquisition of a specialization in general medicine, only 10–12% of the GPs acquired this specialty. This may explain to a certain extent the low level of patients' trust in GPs services, and patients' attempts to circumvent primary care and search for medical services at a higher specialist level.

While the international standards indicate that outpatient care should cope with at least 80% of the cases requiring medical care, in Bulgaria this rate is estimated to be 70% or even lower [4]. The lack of specialists in some medical specialties (e.g. anaesthesiology, obstetrics and gynaecology, lung diseases and physiatrists, epidemiology and infectious diseases) has an adverse effect both on access to and the quality of the care provided [5]. Moreover, the type of payment to GPs (i.e. capitation) turned out to be an insufficient incentive for providing quality care, which in its turn, leads to an increase in the share of referrals to specialized outpatient and hospital care.

In the hospital sector (where the medical services are provided by health care establishments owned by the state, the municipalities or private structures), various problems are observed mainly due to the delay in restructuring the hospital care sector [1]. For instance, during the recent years, there was a trend toward an oversatiation with hospital health care establishments. The reasons for this fast growth can be found in the "loopholes" in the legislation and the absence of clear regulations in hospital care. The completion of the development of the National Health Map, which has to determine the number of health care establishments that are necessary in the regions, was left beyond the scope of the continuous changes. This created a niche for easy registration of private specialized health care establishments oriented toward the provision of the most cost-effective and profitable services financed by the NHIF.

The growth of the hospital sector in the country leads to an increase in overall hospital costs and to an unbalanced allocation of health care funding. For instance, in 2008, 57.7% of the NHIF budget for 2008 was allocated to hospital care while only 7.5% was allocated to primary care [4]. The increased network of hospital establishments also implies a reduction in the absolute and relative size of the revenue received by the hospitals per unit of care, as well as deprivation of the remaining levels in the health care system from a more effective and fair distribution of the scarce financial resource.

Table I shows the difference between Bulgaria and the EU member states according to selected indicators for hospital care. It becomes clear from the table that the difference between Bulgaria and the EU member states is more conspicuous with regard to the number of hospitals (1.5 times higher in Bulgaria) than with regard to the number of hospital beds. In spite of the considerable reduction in the number of hospital beds after the start of the health care reform in year 2000, due to the requirements for accreditation of the health care establishments, the level of bed utilization remains below the optimal values.

The irregular provision of health professionals for the outpatient and hospital care continues to be a common problem. In 2006, the ratio "physicians : nurses" was 1:1 versus 1:2 in the EC member states [5]. The trend toward the continuously diminishing number of nurses and midwives is alarming, a fact which can be accounted for by the limited possibilities for education and training of these health professionals (i.e. sustainable small-scale and limited students' admission), as well as by the emigration processes. The emigration of medical specialists is also becoming a serious problem for the Bulgarian health care system. In 2009, the number of physicians who left the country was approximately 450, and during the first nine months of 2010, more than 340 physicians and 500 nurses left the country [6].

Indicators	Bulgaria	EU – 10	EU
Hospitals per 100 000 inhabitants	4.4	2.6	3.0
Hospital beds per 100 000 inhabitants	636	625	570
Percentage of bed utilization, %	64.1	70.6	76.3
Average stay in hospitals for active treatment	10.7	7.6	6.5

Table I. *Indicators for the hospital sector: Bulgaria and EU countries.*

Source: WHO, data base "Health for all" 2008.

For the last several months, the Ministry of Health Care has undertaken active measures toward a change in health policy. Three of the main priorities of the new health care reform include the draft for amendment of the Law on Health Insurance, a change in the type and number of health care establishments and a change in the costing of the clinical pathways that are used to fund the hospital sector.

Nevertheless, the weak management and organization of the Bulgarian health care system, the chronic system under-financing, as well as the lack of long-term strategy and consensus on a vision for its development by the various political forces, led to the collapse of the system and the replacement of three ministerial teams at the Ministry of Health Care.

One of the most discussed issues in the social and professional circles is the problem of additional funding for the health care system. It is frequently recognised that the gaps in health care system funding are filled in by informal or indirect payments by the patients. The analyses of the European Commission and the World Bank indicate that in Bulgaria, in addition to the official health care expenditure (about 4.2% GDP), around 3.5% of GDP is infused into the health care system as unofficial payments (the so-called "payments under the table" or informal payments). Owing to these additional payments, extra funding is "poured" into the hospital and outpatient care, which however hinders the efficiency and equity objectives of the health care reform [7]. Therefore, one of the purposes of the new reform is to increase the share of the health care costs which is officially paid by the patient. Thus, the informal payments are expected to become formal if a better control over health care provision and payments can be achieved simultaneously.

The study

Given the key policy issue related to patient payments in the Bulgarian health care sector, focus group discussions and in-depth interviews were carried out in Bulgaria in May-June 2009. Their objective was to study the opinion and attitudes toward patient payments and to identify criteria important for the assessment of patient payment policies.

The following target groups were considered:

- Health care consumers; including working individuals, families with children, pensioners, students, disable and chronically sick individuals and individuals living in rural areas.
- Health care providers; including GPs, outpatient specialists, physicians and nurses in city hospitals, GPs practicing in rural areas and physicians in district hospitals.
- Health insurance representatives; including social health insurance representatives at national and regional level.
- Health policy-makers; including health policy-makers at national and regional level, financial policy-maker at national level and the chair of the three-party committee on health care in the country.

Data among health care consumers and providers were collected via focus group discussions. Since these target groups are rather large and diverse, focus groups discussions allowed including more individuals. Nevertheless, the objective was to assure the homogeneity of each focus group in order to easily reach a consensus during the discussion. As a result, 12 focus group discussions were organised: 6 focus groups with consumers and 6 focus groups with health care providers. On average each focus group included 8 participants. The groups were defined based on the description of these two target groups presented above.

The data among policy-makers and health insurance representatives were collected via face-to-face semi-structured in-depth interviews. This choice of data-collection method was based on the fact that these target groups are relatively small and moreover, they might feel more comfortable to express their opinion if contacted individually. In total, 5 in-depth interviews were carried out with policy-makers and 5 in-depth interviews with health insurance representatives.

For the purpose of the focus group discussions and in-depth interviews, a list with key questions was developed based on a preliminary literature review. The same key questions were used for all target groups with slight modifications to reflect the specificity of a given target group. The key questions were used to develop guides for focus group discussions and in-depth interviews, as well as a standardised questionnaire to collect additional quantitative data on the topic.

The views of health care stakeholders in Bulgaria on patient payments

The analysis of the information collected during the focus group discussions and in-depth interviews is presented at an aggregate level for each of the four target groups – health care consumers, providers, policy-makers and insurers.

The opinion of health care consumers

The attitudes of consumers toward formal patient payments are divided. Pensioners, working individuals, disable and chronically sick people are overall against official patient charges. On the contrary, students and families with children support the existence of such charges. However, this second group is against patient charges for emergency care. The first group shares the opinion that the social and economic status should be the main criterion for the exemption of patients from payment obligations, whereas the second group accepts age and health status as a base for such exemptions, e.g. children, pregnant women, people with chronic diseases. With regard to policy goals of formal patient payments, a consensus exists among consumers that these payments generate additional financial resources for the health care system and discourage the unnecessary use of medical care, thus, contributing to the system improvement. A consensus also exists among the health

care consumers that it is impossible to reduce the existing informal patient payments by the introduction of official charges.

The opinion of health care providers

The opinion of health care providers on formal patient charges is unanimous. Providers indicate that these payments are beneficial because they restrict health care demand, and have an educational and financing function. According to health care providers, the current direct collection of formal fees by the physicians is insulting to their profession and has to be changed toward a formal administrative collection. Some providers point out that the magnitude of patient payments should reflect the type and quality of services provided. Providers commonly suggest that the current co-payments in Bulgaria are low and need to be increased up to 2 to 4–5% of the minimum wage for the country for outpatient and hospital care respectively. Health care providers working in the city think that formal patient payments should apply to all types of health care, while providers in rural areas and district hospitals do not accept patient payments for emergency care and services of general practitioners respectively. Health care providers are unanimous that the existence of informal patient payments is not affected by the introduction of formal ones. They point out a number of additional problems in the Bulgarian health care system, including problems with uninsured patients and the absence of an adequate system of costing the medical services.

The opinion of health insurance representatives

Health insurance representatives support the existence of official patient charges although there are occasional views against these payments. They find the magnitude of current co-payments appropriate because according to them it is affordable for patients. Some insurance representatives express the opinion that patient payments should be related to the services type and to whether the patients' route is determined by a physician or by the patient's personal choice.

The view prevails that co-payments are currently the most appropriate form of patient payments in Bulgaria but there are opinions in favour of deductibles (payments of the actual service cost/price up to a given limit) and co-insurance (fees equal to a given percentage of the actual service cost/price). Health insurance representatives suggest exemptions from patient payments related to health status and demographics (children, pregnant women and chronically sick), as well as socio-economic status (e.g. pensioners and low-income people). Exemptions for health care providers are also proposed. Health insurance representatives agree that the policy objective of official patient charges should be the restriction of health care demand but these charges do not present a mechanism capable of reducing informal payments in Bulgaria.

The opinion of policy-makers

Policy-makers indicate that formal patient charges are in accordance with the health insurance philosophy and therefore, they should exist. However, there are concerns that the way these payments are applied in Bulgaria causes dissatisfaction for both consumers and providers. The predominant view is that the magnitude of current patient charges is overall adequate but it is necessary to make a differentiation based on the patients' socio-economic status. Some policy-makers propose the application of deductibles that are updated annually, as a more suitable option than the current co-payments determined by the minimum wage for the country.

There is no unanimity among policy-makers with regard to what health care services should be provided with patient charges. The opinions vary from the existence of official patient charges at all levels of health care to their total rejection. Patient charges for emergency and hospital care are especially controversial. However, the opinion prevails that children, pregnant women and disabled people should be exempted from such charges. The reduction of unnecessary health care use, generation of additional resources and increase in providers' income are proposed as key policy objectives of patient charges. Policy-makers admit the fact that official payments are not capable of reducing informal payments.

Comparison between the groups

Overall, the opinions of the four groups included in our study are divided with regard to who should be the beneficiary of patient charges. Consumers most often point out the NHIF and the physician who offers the service, and they rarely point out the health institution or the state. The opinion of the health care providers that the physician should benefit from the fees, is not surprising. Only the nurses do not support this option. If patient charges are collected by the physician, they can become an additional income for the providers and, although they are not of crucial significance at a national level, the providers will have an interest in their existence. Policy-makers also support the opinion that the physicians who offer the services, should receive these payments, while for the health insurance representatives, those should be the health organisations which create the environment and the conditions for treatment.

The health care consumers and providers do not support the establishment of higher patient payments for the more expensive health services as well as for services with better quality. If official patient payment exists and there is a limitation on these payments per patient, policy-makers and insurers define that this limitation should be as maximum total fee per month/year. According to the consumers and health care providers this limitation on patient payments should be defined as maximum number of services per patient per month/year.

Recommendations for patient payment policy in Bulgaria

It becomes clear from the results presented above that some of the organisational problems in the Bulgarian health care insurance system continue to exist and to wait for their effective solutions. Based on the main findings of this analysis, several recommendations for policy-making related to patient payments could be outlined.

- The legislation on patient payments in Bulgaria needs to be carefully revised and the application of these payments should be specified.

At present the best defined patient payment is the one for hospital care. The latest changes related to the reduced patient payment for pensioners and the obligation for all patients to purchase a large part of the medicines only against a prescription, created preconditions for illegal collection of patient payments in outpatient care. The mechanism for collecting the patient payments by the GPs and the non-issuance of a financial document for a receipt created a negative attitude towards the first level of the health care system among the health care consumers.

- The collection and use of patient payments should be administratively regulated by creating a pool for that purpose.

Despite the fact that there exists regulation for the collection of patient payments, the absence of control on that regulation creates mistrust and discontent among the health care consumers. The founding of a common pool and transparency in the process of collecting those payments may reduce the weight of this problem. For the hospital care this pool may have an institutional character, as it is at present. For the outpatient care, where it is not possible to make such a pool, the transition to deductibles and further distribution of the resources according to the services rendered could be a solution.

- Patient payments need to differentiate based on patients' health status, demographics, socio-economic status, service type and patients' route.

In most cases social thinking is spread among the population and it is in the basis of introducing differentiation of the payments as an expression of socio-economic justice and solidarity. This philosophy exists also in the current regulation of patient payments with regard to pensioners, but it needs to be refined.

- A strategy should be worked out against the informal payments.

Bulgarians are very sensitive on the subject of corruption in health care and the Bulgarian government considers the two concepts of "corruption" and "health care" as mutually incompatible. Informal payments have compromised the health care sector and it is placed in the leading triad of corruption occurrence. The problem is highly significant and clearly defines the wish to create an effective system for centralised and patient anticorruption control [8, 9].

The question of patient payments for health care services appears to be a major challenge to the Bulgarian government. This question gives rise to vivid discussions in the Bulgarian society. Some weeks ago, the proposal for concrete policy solutions to this problem led to the change of a second ministerial team at the Ministry of Health Care. The social sensitivity on the issue of patient payments requires broad discussions before policy decisions are implemented. These decisions should be based on public opinions and research evidence. There is also a need for a well-thoughout communication strategy on the issue of patient payments by the Ministry of Health Care.

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Abstract:

During the past decade, the reform in the Bulgarian health care sector was in the focus of policy and research discussions at national and international level. In spite of the great expectations after the introduction of social health insurance in 2000, efficiency, equity and quality problems in health care provision in Bulgaria continue to exist. The unequal start of the reform in outpatient and hospital care (namely the delay in restructuring the hospital sector) is one of the causes of these problems. Among other issues, the reform also included the implementation of formal patient charges. At present, formal patient charges are applied to all levels of medical services with the exception of emergency care. Nevertheless, informal patient payments continue to exist. The aim of this paper is to present the attitudes of health care stakeholders toward patient charges from the perspective of the state of the Bulgarian health care system. The data are collected via focus group discussions and in-depth interviews carried out in Bulgaria in May-June 2009. The results are used to out-line recommendations for policy related to patient payments.

Streszczenie:

Dopłaty pacjentów i problemy w świadczeniu usług medycznych w Bułgarii

Słowa kluczowe: opłaty pacjentów, system opieki zdrowotnej, udziałowcy, Bułgaria

W ciągu ostatniej dekady reforma bułgarskiego systemu opieki zdrowotnej była tematem dyskusji politycznych i naukowych tak na szczeblu krajowym, jak i międzynarodowym. Pomimo ogromnych oczekiwań dotyczących efektów wprowadzenia w 2000 r. społecznych ubezpieczeń zdrowotnych nadal istnieją problemy związane z efektywnością, równością i jakością bułgarskiego systemu opieki zdrowotnej. Różne momenty startu reformy w opiece ambulatoryjnej i w opiece szpitalnej (opóźniona restrukturyzacja sektora szpitalnego) są jedną z przyczyn występujących problemów. Reforma systemu z 2000 r. obejmowała m.in. wprowadzenie formalnych opłat pacjentów. Obecnie opłaty te dotyczą wszystkich poziomów świadczeń medycznych z wyjątkiem ratownictwa medycznego. Mimo tego nieformalne opłaty pacjentów są nadal powszechne. Celem artykułu jest przedstawienie stosunku różnych udziałowców systemu opieki zdrowotnej w Bułgarii. Prezentowane dane zostały zgromadzone poprzez zogniskowane wywiady grupowe i pogłębione wywiady przeprowadzone w Bułgarii w okresie maj–czerwiec 2009 r. Wyniki badania zostały użyte do zarysowania rekomendacji w zakresie polityki dopłat pacjentów.

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