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The Bulgarian hospital care system – challenges and reform plans

Abstract

This article aims to illustrate and discuss some of the contemporary problems and perspectives of the Bulgarian hospital care system. By taking this into consideration, the article concentrates on several important dimensions of the problem, based on a move to an insurance-based financing model; and liberalisation and privatisation. The first part delivers a short, synthesised review of the main goals and leading philosophy of healthcare reform from the period 1997-2001. The second part focuses on the hospital care sector in the country. The goal here is to explore the main development trends in the sector for the period subsequent to the reforms, according to two criteria – the accessibility of hospital care services; and the efficient use of resources. The third part discusses some of the new reform plans for the hospital care sector from the point of view of their adequacy as a solution to the existing problems. In conclusion, the article points to the existence of the four-party governing coalition providing an unstable basis for the driving forward of the necessary reforms.

***Keywords**: Bulgarian healthcare model, healthcare reform, hospital care, privatisation*

Introduction

Healthcare reform in Bulgaria during the 1997-2001 period had numerous important goals. Primarily, it laid the foundations of a new healthcare model that was expected to be more adequate as regards the changed conditions in the country. There was, however, also an expectation that the reform would establish a new, modernised healthcare system, capable of combining the effective use of resources with an efficient, quality answer to the health needs of Bulgarian citizens.

An evaluation of the results of the reform is still one of the most controversial questions for Bulgarian society. More than fifteen years later, there has as yet been no significant improvement in the overall health status of the population, while the country continues to lag behind the European Union (EU) average in almost all health indicators (Национална здравноосигурителна каса, 2014: 2-5). Furthermore, among the citizens and specialists working in the system there exists a growing understanding that an important part of the goals of the reform have not yet been attained. The reason for this is the existence and intensification of a whole multi-dimensional complexity of problems and failures in the functioning of the healthcare model, such as: the growing restriction of healthcare access; the deteriorating quality of healthcare services; the steady financial deficit; etc. In addition, the medium-term

demographic trend in Bulgaria heralds, with a high degree of certainty, a growing requirement for adequate and accessible healthcare, at the same time as we are seeing a decreasing generation of the necessary resources and of the possibilities for their collection.

The existence of these problems and the ongoing lack of political will and expertise to resolve them have already developed a crisis in Bulgarian healthcare. The result has been that, in the last couple of years, discussion about the need for further reforms, the nature of what is required and the challenges and overall perspectives for the healthcare system have gained a leading position in the political debate within the country.

There is broad consensus that the 'patient' is obviously ill, but questions about the 'diagnosis' and the possible paths of 'treatment' are still the object of significant controversy and discussions. The ongoing healthcare debate in the country has already pointed to the present situation having a whole complex of political, financial, organisational and managerial determinants.

This article does not claim to shed light on or resolve all these problems, but has a more limited and specific object. It does, however, aim to illustrate and discuss some of the contemporary problems and perspectives of the Bulgarian hospital care system.

The reasons for this choice of object may quite easily be summarised. First of all, hospital care is the sector that concentrates and spends the most significant part of all healthcare resources in the country. Secondly, it is precisely in this sector that the results of the healthcare reform are most controversial, while the existing problems and challenges have a direct impact on the quality of healthcare services and the overall health status of the Bulgarian population.

In taking this into account, the article concentrates on providing a consideration of several important dimensions of the problem it identifies. The first part delivers a short, synthesised review of the main goals and leading philosophy of healthcare reform during 1997-2001. The second part focuses on the hospital care sector in the country, in order to explore the main development trends in this sector for the period after the reforms, according to two criteria – the accessibility of hospital care services; and the efficient use of resources. The third part discusses some of the new reform plans for the hospital care sector from the point of view of their adequacy as a solution to the existing problems.

The new healthcare model in Bulgaria

The healthcare model before 1989

The Bulgarian social model before 1989 had significant similarities, but also specific differences, to the 'social-democratic regime of social policy', as defined by Gøsta Esping-Andersen (Esping-Andersen *et al*. 1990). Similar to a social democratic regime, the Bulgarian model was based on a broad complex of officially-recognised social rights for citizens. Until the beginning of the transition period, the constitution of the country explicitly guaranteed to every citizen the right to work, paid holidays, social benefits for old age, invalidity and sickness benefits and the right to

cost-free healthcare and education. Compared with the important role of the state in social policy under a social democratic model, however, the old Bulgarian social model was characterised by the full monopoly of the state over social policy, which was an inseparable part of the socialist model of society.

In this general context, the Bulgarian healthcare system before 1989 copied the ex-Soviet or 'semashko' model (Carrin *et al*. 2009: 280) and had the following characteristics: it was highly centralised; developed and ruled by a state monopolist administration; financed by taxes through direct payments from the state budget; and organised on an administrative territorial principle (within the administrative regions). All providers of health services (the out- and in-patient sector; dental services; and pharmacy) had a public form of ownership and their territorial allocation was relatively well-developed in confronting the health needs of the population in large and medium-sized cities, as well as some of the smaller ones. In comparative context, the healthcare system before 1989 showed very high levels in several parameters, such as: the number of physicians and medical personnel; the number of hospital beds per capita; and an over-developed capacity for traditional in-patient treatment (Normand, 1995: 228).

The collapse of the old regime in Bulgaria and the following period of economic downturn and hard reforms made the financing and functioning of the existing model of social policy, and the healthcare system in particular, impossible to maintain. The necessity for reform in social policy and the implementation of a new social model, more adequate to the changed conditions, became an inevitable part of the whole transition process in the country.

When discussing healthcare reform (in Bulgaria), we have to bear in mind that it is not an isolated process but only one element of the whole social policy reform that developed in the context of the transition and which was influenced, in its general philosophy and specific steps, by a combination of factors. In this sense, the general context of the transition (from planned to market economy; and from a totalitarian to a democratic political system) is a factor of significant importance.

In its complexity, the transition to a market economy (liberalisation, privatisation and opening up to global markets) has generally changed the overall logic of wealth accumulation, but it has also created qualitatively new conditions for the functioning of the whole social policy system. The plunging of the country into a deep economic crisis and the processes of economic restructuring have logically narrowed the volume and capacity of the available social budget. At the same time, the transition has brought social problems and consequences which are significant in their range and magnitude (poverty, unemployment) and which have pre-supposed a growing need for adequate social programmes and the increase of social expenditures. Trapped in this negative trend, the existing system of social policy in the country started to disintegrate and it was not able to respond adequately to the needs of citizens.

The second very important characteristic of the reform process in Bulgarian social policy is its strong commitment to the influence of the leading international financial institutions and organisations, such as the World Bank, the International Monetary Fund (IMF) and the Organisation for Economic Co-operation and Development (OECD). These organisations were not only leading partners of Bulgarian

governments in the transition process but, through their conditionality policy, they have exerted an influence over the general framework, philosophy and logic of the reforms which have been undertaken. The influence of these international factors on Bulgarian reforms, and on social policy reforms in particular, was, in many respects, based on their commitment to neo-liberal ideas and prescriptions (Deacon *et al*. 2000: 146-161).

The main part of social policy reform and the implementation of a new social model in Bulgaria started in the period after 1997. The prior years (1989-1996) comprehended a period of the almost complete structural and functional disintegration of the old system for social policy (Томова, 2000: 174-176). Only after 1997, and in the context of financial stabilisation and macroeconomic sustainability, did Bulgarian governments start the implementation of reforms in social policy. The reform concept was strongly influenced by, and worked out through the expert and financial support of, the IMF and the World Bank, Furthermore, it was primarily subordinated to goals such as macroeconomic, budgetary and public expenditure discipline, alongside privatisation and the individualisation of social risks. Specifically, the reform plans encompassed a restructuring of the three main social policy systems – healthcare; retirement; and social transfers – as well as labour market policy. The declared goals of the reforms were the modernisation and financial stabilisation of the Bulgarian social model.

The transformation of the healthcare system in Bulgaria: leading principles and goals

Being developed as a result of the fundamental social policy reforms undertaken after 1989, the contemporary healthcare system in Bulgaria is thus relatively new, although healthcare reform actually ran in three phases (Dimova *et al*. 2012: 139-140). The adoption of several acts – the Pharmaceuticals and Human Medicine Pharmacies Act (1995); the Health Insurance Act (1998); the Professional Organisations Act (1998); and the Health Establishments Act (1999) – created a new legal, financial and organisational framework for the system.

The reforms were bound up with two general directions of change: the transition to the insurance principle of financing; and the parallel privatisation and liberalisation of healthcare.

The first of these was realised by the introduction of the National Health Insurance Fund (NHIF),[1] while a second, voluntary level of health insurance was effected through Voluntary Health Insurance Funds (VHIF).[2] The full introduction of the health insurance principle was completed in 2001, when the NHIF started to function as the leading financing institution for healthcare in Bulgaria.

1 The NHIF became the institution responsible for the collection and governance of the contributions for mandatory healthcare insurance and for the payments made in respect of the healthcare services which were delivered.

2 In 2013, after a change in the Health Insurance Act, all the VHIFs were pre-registered as health insurance companies and were legally bound to function and work according to the regulations and conditions of the Insurance Code.

The realisation of the second reform goal proceeded through different dynamics. The first wave was initiated in the years between 1989 and 1996, with new regulations facilitating private health establishments and the privatisation of the existing pharmacy network and of dental services. In the period after 1997, this reform goal was further developed by the introduction of new outpatient care providers in the face of general practitioners (single or group practice) and medical centres. Another step in this direction envisioned partial cuts to existing hospitals and/or their privatisation, but this intention was abandoned after 2001. In consequence, the reforms in the hospital sector were reduced to legal amendments which introduced partial liberalisation as exemplified by the setting up of the three types of health establishments for hospital care (HEHC) – publicly-owned (by the state; and by municipalities) and privately-owned ones – all of them registered and functioning as trading companies.

Outcomes and challenges after the reform

In general, the outcome of the reforms was the transformation of the former healthcare system, universal in its coverage and budget-financed, into an autonomous insurance-based healthcare system, encompassing different levels of healthcare, different financial sources (public and private) and different healthcare providers (public and private). The reform package introduced a public-private mix in the financing of the healthcare system. This comes from compulsory health insurance contributions (8% from salary, divided 60:40 between employers and employees), taxation, direct payments from patients, voluntary health insurance premiums, corporate payments, donations and external funding.

The structure of health services providers is also based on a public-private mix. The new level of out-patients, providers of dental services, the pharmacy network and most of the specialist laboratories are private. A couple of provider categories operate at the in-patient level: privately-owned HEHC and clinics; publicly-owned HEHC (owned both by municipalities and by the state); public centres for emergency care; haemodialysis; transplants; and so on.

The governance of the healthcare sector has also been significantly changed. The NHIF and the VHIF have a dual role as collectors and payers of contributions, located between those who are insured and those who provide health services. All providers of healthcare services (except for emergency care centres) are allowed to sign contracts with the NHIF and the VHIFs for the services which are included in the funds' health insurance packages. Additionally, all healthcare providers have the legal right to direct payments from patients for those services which are not included in the funds' health insurance packages.

The healthcare reform did manage to restructure the old model, but it is certainly one of the most controversial topics in the country, especially when it comes to the evaluation of its outcomes. The causes lie in the multiple problems and serious defects in the functioning of the new system.

Perhaps the most significant problem, from the public point of view, is the restricted access to healthcare and the development of a group of Bulgarian citizens who do not have the right to healthcare. The initial statistical data after the reforms showed that, in 2003, more than two million Bulgarian citizens did not have health

insurance rights (Dimova *et al*. 2012: 58). This situation led to changes in the Health Insurance Act from 2004, targeted at improving access to healthcare through increasing public responsibility.[3] Despite this, access to healthcare continues to be one of the major problems in the country.[4]

There are different causes and determinants of such a development. A significant part of Bulgarian citizens in this group include long-term unemployed individuals who are incapable of paying their healthcare insurance fees, or individuals whose fees are not covered by the existing social help programmes. Unemployment and poverty are significant determinants; but there are, in addition, other factors and variables in play. Without doubt, we can speak of the existence of a relatively broad group of Bulgarian citizens that do not pay healthcare insurance fees not because of poverty but for different reasons (for example: they are working abroad; they are employed in the so-called 'grey sector'; experiencing dissatisfaction with the quality of healthcare; and so on).

Another set of problems in Bulgarian healthcare is the formation of a stable financial deficit, the continuing under-financing of the system and the increasing level of healthcare costs which have been transferred directly to citizens. A brief overview of the statistical data shows that, after the implementation of reforms, expenditure on healthcare has steady increased. In 1995, expenditure amounted to 5.3% of GDP but, in 2008, it reached 7.0% and, in 2013, 7.6% (World Bank, 2015). Equally, the amount spent on healthcare measured through Purchasing Power Parity (PPP) per capita has increased even more significantly – from $285 in 1995 to $910 in 2008.

Despite this, and if the data are placed in the EU context, it is easy to find that, in 2008, Bulgarian healthcare expenditure amounted to a relatively low share of GDP compared to the EU average – lower than in most other EU members except for countries like Romania, Poland, Lithuania, Latvia and the Czech Republic (Dimova *et al*. 2012: 48). Such a comparison pinpoints the low level of healthcare expenditure in Bulgaria: the average in the EU-27 in 2008 (in PPP) amounted to more than twice the level in Bulgaria – $1,968 (*ibid*: 48). The same tendency could be described in 2013, when the healthcare expenditure of Bulgaria was $1,213 (in PPP) – the lowest level in the EU except for Romania, where the figure was $988 (World Health Organisation, 2015).

This problem has another important dimension. The increased dynamics of healthcare expenditure is unevenly distributed between the public and private financing branches. If one follows the statistical data, it becomes obvious that the public

3 For the years since 2004, the state has taken financial responsibility (by making healthcare contributions) for groups like pensioners, students, children, the beneficiaries of social help programmes and some others. The second significant change was the increase of in the healthcare contribution level, from 6% of the monthly salary to 8%.

4 Unfortunately, there has been a significant shortage of reliable official information for the development of this trend in the years after 2003. The ongoing discussion about the number of Bulgarian citizens without healthcare rights has only brought new confusion and vagueness. Some publications in the press after 2013 have pointed out different numbers, in the range between 950 000 and two million Bulgarian citizens. However, the accuracy of these numbers is disputable and depends strongly on the methodology used in the calculations.

share (finances from the NHIF and the state and municipalities) remains unchanged at around 4% of the country's GDP. The result is that the lion's share of the growing healthcare expenditure is being met by Bulgarian citizens and is exemplified in so-called out-of-pocket expenditures – i.e. direct payments for health services – which amounted in 2008 to about 42% of all healthcare costs (Dimova *et al*. 2012: 47).

Furthermore, the official statistical data do not capture so-called 'unregulated' cash payments (i.e. under-the-table cash payments) made by patients for health services, even though these services are included in the health insurance package of NHIF.

This additional price and cost burden imposed on patients has multiple consequences. In the first place, it is one of the factors that push one part of Bulgarian citizens outside the healthcare system, because they are not able to meet any additional expenses.

'Unregulated' out-of-pocket payments also have an impact on other groups of Bulgarian citizens. The new healthcare insurance system is based on strong solidarity and the redistributive principle, and does not include any bonus mechanisms (broader than the basics for the NHIF healthcare package or higher service quality) for citizens making a significantly higher level of contributions. In this sense, one group of Bulgarian citizens has to bear a double financial burden (mandatory healthcare insurance and 'unregulated' out-of-pocket payments), without any compensation or reward for their bigger contribution to the financing of the system. This situation clearly does not help to legitimise the healthcare system; moreover, it has yet another important consequence – it influences negatively the development of the voluntary health insurance sector by absorbing additional finances from the population instead of directing them to the so-called second level of healthcare insurance. This is one of the factors why the voluntary health insurance funds in Bulgaria are still not playing a significant role in the financing of the healthcare system (*ibid*: 47).[5]

Furthermore, the general picture gets even more embarrassingly clear when some other negative trends in the development of the Bulgarian healthcare system over the last two decades are considered: a steadily declining quality of healthcare services; an overall worsening health status of the population; almost non-existent prevention maintenance mechanisms; a lack of efficiency and quality control in provided services; and so on.

Problems and challenges in Bulgarian hospital care

A significant part of the contemporary problems and challenges in the functioning of the healthcare system in Bulgaria is concentrated in the hospital sector. The reasons for this are easy to summarise. Hospital care takes up the majority of healthcare resources in the country and, at the same time, suffers from a steady and chronic

5 In 2008, only 2-3% of all Bulgarian citizens had additional healthcare insurance in one of the functioning VHIFs. The VHI sector generated (in 2008) only between 0.4% and 0.8% of all financial resources for the healthcare system and is far from a development stage of functioning as a real alternative or source of supplementary resources to the mandatory healthcare insurance system.

financial deficit while most hospital care establishments accumulate growing debts (*Институт за пазарна икономика, 2015: 5)*. Furthermore, it is precisely in this sector that the results of reform are more than controversial when we take into consideration criteria such as the quality of healthcare services and efficiency in the use of resources.

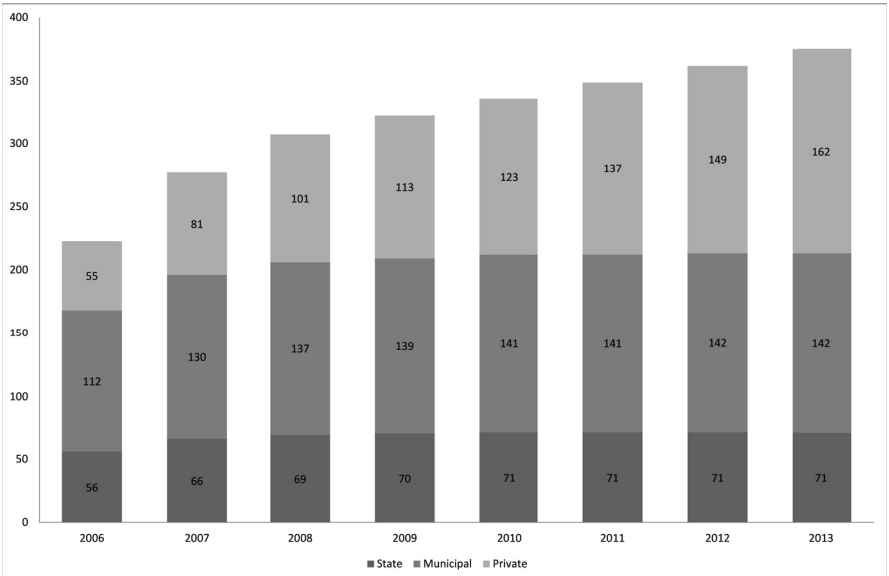
It is for this reason that this part of the study focuses on the existing problems and challenges in the Bulgarian hospital care sector. The discussion of problems within the HEHC sector encompasses multidimensional and complex correlations and questions. The functioning and the evaluation of this component of the healthcare system are bound up with the systematic interaction of multiple determinants and influence factors – political, financial, managerial, demographic, specific medical dimensions, and so on. This very complexity means that, out of necessity, a greater number of these influence factors are not discussed in this brief article.

With this in mind, the next part of the study contextualises the development of the Bulgarian HEHC system in the years after the reforms, according to two indicators: the dynamics of the total HEHC sector; and the territorial allocation of hospital units in the country. These parameters make it possible to account for two significant problems in the Bulgarian HEHC system that were supposed to have been resolved as a result of the reforms: namely, the improvement of access to hospital care services; and the efficiency in the use of resources with respect to the health needs of the population. The statistical data presented here are based on information from the Bulgarian Commercial Register (CR) for the 2006-2013 period.

Total number and territorial distribution of hospitals in Bulgaria

The development of the hospital sector in the period after 2001 has been marked by significant dynamics and controversial trends. A good example of this, especially when we bear in mind the situation before the start of the reforms, is the almost avalanche-like growth in the total number of hospitals in the country. This process was at its most intensive during the 2006-2013 period, when the total number of registered HEHC grew from 223 in 2006 to 375 in 2013 (see Figure 1).

Figure 1 – Health establishments for hospital care, by form of ownership (2006-2013)



Simbula Ltd. (2015) Health Establishments for Hospital Care in Bulgaria – Financial Outlook 2006-2013.

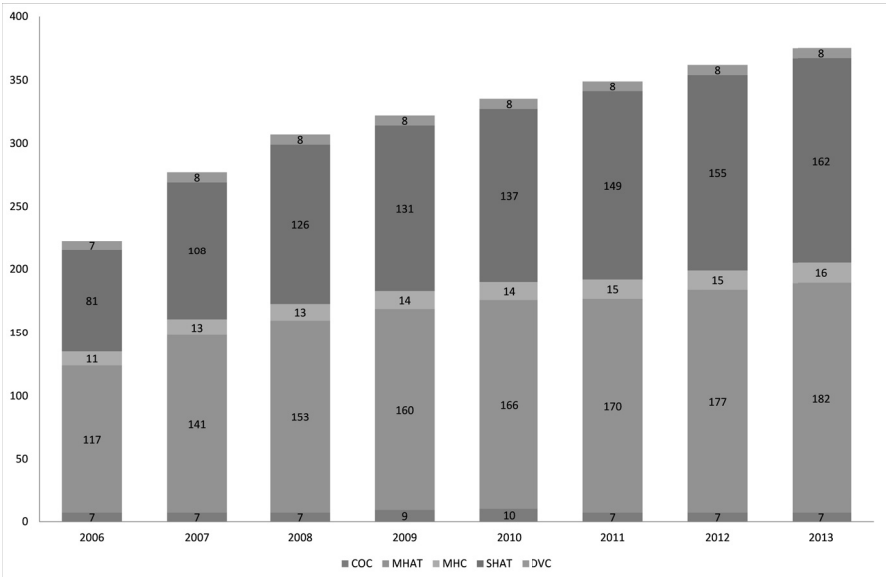
The trend of an increase in the total number of hospitals is indisputable, but it does need some clarification and explanation because of the specific character of the registration process as regards the Commercial Register. According to the available information (from the CR) for the period between 2008 and 2013, there were few new state or municipally-owned hospital created and, therefore, registered in the CR. This means that the growth in the total number between 2008 and 2013, which appears to be dominated by the private sector, is influenced also by the delay in the registration process and was not a result only of the emergence of hospitals new to the system.

However, even when taking into account these recalculations, it becomes obvious that, for the period between 2006 and 2013, the total number of hospitals grew by 107 new establishments. An interesting finding is that 100% of the growth is connected with the creation of privately-owned hospitals. Figure 1 demonstrates that their number multiplied three times for the accounted period: in 2006, their number was 55 and it grew to 162 in 2013.

Undoubtedly, the growing number of privately-owned hospitals signals that, in the years after the reform, there was a process of the emergence and consolidation of a dynamic private sector branch within Bulgarian health care establishments.

This representation of the dynamics in the total number would be pointless if it were not used as a basis for further research into the trends in the health sector. Figure 2 offers another dimension in this process.

Figure 2 – Health establishments for hospital care, by type of hospital (2006-2013)



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This illustrates the total number of HEHC, registered in the CR of Bulgaria for 2006-2013, and divided by hospital type.[6] According to this data, the highest growth of new hospitals was concentrated into two particular types of health establishments – SHAT units and MHAT ones. The total number of SHAT establishments underwent the biggest change, from 81 in 2006 to 162 in 2013. Furthermore, the majority of SHAT units are privately-owned. This is also true for MHAT units, despite their number growing by a smaller amount, from 117 in 2006 to 182 in 2013.

Figure 2 also highlights that, in the other types of health establishments for hospital care, there were no major changes in numbers over this same accounted period.

These trends become more illustrative with regard to the development of the HEHC system if they are placed in the context of some territorial considerations. The data for this indicator logically illustrate that the territorial distribution of hospitals is

6 Multifunctional Hospitals for Active Treatment (MHAT); Specialised Hospitals for Active Treatment (SHAT); Dermato-Venerological Centres (DVC); Complex Oncological Centres (COC); and Mental Health Centres (MHC).

characterised by a higher concentration in the biggest cities of the country. The highest number of hospitals, irrespective of the form of ownership, is concentrated in five districts: Sofiya Grad (90); Plovdiv (36); Varna (25); Burgas (24); and Stara Zagora (18). These five account for 51.4% of all hospitals in the country. Following on are the districts of Blagoevgrad (15); Haskovo (11); Pazardzhik (12); Pleven (12); Sliven (13); Sofiyska (13); Veliko Tarnovo (10); and Vratsa (14). These account for 26.6% of all hospitals. In the third tier are districts such as Dobrich (5); Gabrovo (7); Kardzhali (5); Kyustendil (4); Lovech (6); Montana (5); Pernik (6); Pirdop (1); Razgrad (4); Ruse (9); Shumen (6); Silistra (3); Smolyan (8); Targovishte (5); Vidin (3); and Yambol (5). These account for the remaining 22% of hospitals (see Annex).

If we contextualise this data in the division of Bulgaria into the six NUTS 2 regions, it is possible to reveal more precisely the territorial allocation of the HEHC system.[7]

The north-western region includes the districts of Vidin (3); Montana (5); Vratsa (14); Pleven (12); and Lovech (6). Here, we have 11.4% of the Bulgarian population (836 601 people), spread across a territory of 19 070 square kilometres (17.18% of the total territory of Bulgaria) and 10.6% of all the hospital units (*Министерство на регионалното развитие*, 2012: 2).

The north-central region includes the districts of Gabrovo (7); Veliko Tarnovo (10); Ruse (9); Razgrad (4); and Silistra (3). These account for 11.69% of the Bulgarian population (861 112 people) and a territory of 14 974 square kilometres (13.49%), with some 8.8% of all hospitals (*Министерство на регионалното развитие*, 2012: 2).

The north-eastern region includes the districts of Targovishte (5); Shumen (6); Dobrich (5); and Varna (25). These districts incorporate 13.12% of the Bulgarian population (966 097 people) and a territory of 14 487 square kilometres (13.05%), with about 10% of all hospitals (*Министерство на регионалното развитие*, 2012: 2).

The south-western region includes the districts of Sofia Grad (90); Pernik (6); Kyustendil (4); and Blagoevgrad (15). Here, we find around 29.1% of the Bulgarian population (2 131 233 people) and a territory of 20 306.4 square kilometres (18.3%). Some 30.6% of all hospitals are found in this region (*Министерство на регионалното развитие*, 2012: 2).

The south-central region includes the districts of Pazardzhik (12); Plovdiv (36); Smolyan (8); Kardzhali (5); and Haskovo (11). These contain 20.07% of the Bulgarian population (1 471 107 people), spread across a territory of 22 365.1 square kilometres (20.1%). Some 20% of all hospitals are found here (*Министерство на регионалното развитие*, 2012: 1).

The south-eastern region includes the districts of Stara Zagora (18); Sliven (13); Yambol (5); and Burgas (24). These districts encompass 14.46% of the Bulgarian population (1 078 002 people) and a territory of 19 799 square kilometres (17.8%). They contain 16% of all hospitals (*Министерство на регионалното развитие*, 2012: 2).

7 The data are relevant for 2011.

The last dimension presented here gives more information about the territorial allocation of hospitals according to their form of ownership. The territorial allocation of state hospitals is characterised by a high concentration in the Bulgarian capital (Sofia Grad – 26 hospitals, or 36% of all state-owned hospitals), while a majority of cities have only one or two HEHC (see Table 1).

Table 1 – Total number of state-owned HEHC, by district (2006-2013)

	2006	2007	2008	2009	2010	2011	2012	2013
Blagoevgrad	2	2	2	2	2	2	2	2
Burgas	2	2	2	2	2	2	2	2
Dobrich	2	2	2	2	2	2	2	2
Gabrovo	2	3	3	3	3	3	3	3
Haskovo	1	1	1	1	1	1	1	1
Kardzhali	1	1	1	1	1	1	1	1
Kyustendil	1	1	1	1	1	1	1	1
Lovech	2	2	2	2	2	2	2	2
Montana	1	1	1	1	1	1	1	1
Pazardzhik	3	3	3	3	3	3	3	3
Pernik	1	1	2	2	2	2	2	2
Pleven	1	1	1	1	1	1	1	1
Plovdiv	1	3	3	3	3	3	3	3
Razgrad	1	1	1	1	1	1	1	1
Ruse	1	1	1	1	1	1	1	1
Shumen	1	1	1	1	1	1	1	1
Silistra	1	1	1	1	1	1	1	1
Sliven	1	2	2	2	2	2	2	2
Smolyan	1	1	1	1	1	1	1	1
Sofiya Grad	20	24	25	26	26	26	26	26
Sofiyska	1	1	1	1	1	1	1	1
Stara Zagora	2	2	2	2	3	3	3	3
Targovishte	1	1	1	1	1	1	1	1
Varna	1	2	3	3	3	3	3	3
Veliko Tarnovo	1	1	1	1	1	1	1	1

	2006	2007	2008	2009	2010	2011	2012	2013
Vidin	1	1	1	1	1	1	1	1
Vratsa	2	3	3	3	3	3	3	3
Yambol	1	1	1	1	1	1	1	1
Total	**56**	**66**	**69**	**70**	**71**	**71**	**71**	**71**

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The case of municipally-owned HEHC is somewhat different. The highest concentration of municipal HEHCs is still formed in the biggest cities and districts of the country: e.g. Sofia Grad (12); Plovdiv (14); Sofiyska (11); Burgas and Haskovo (each with nine HEHC); Blagoevgrad and Stara Zagora (each with eight HEHC); and Varna, Veliko Tarnovo, Vratsa and Pleven (each with seven HEHC). Furthermore, their presence in districts and cities which are not so large is much more visible (between one and five municipal HEHC; see Table 2). The result of this is that it is well-grounded that municipally-owned HEHC are the providers that meet most of the health care needs of the population in the peripheral regions of the country.

Table 2 – Total number of municipally-owned HEHC, by district (2006-2013)

	2006	2007	2008	2009	2010	2011	2012	2013
Blagoevgrad	7	8	8	8	8	8	8	8
Burgas	7	8	9	9	9	9	9	9
Dobrich	3	3	3	3	3	3	3	3
Gabrovo	2	2	2	2	2	2	2	2
Haskovo	8	8	9	9	9	9	9	9
Kardzhali	3	3	3	3	3	3	3	3
Kyustendil	1	1	1	1	1	1	1	1
Lovech	3	3	3	3	3	3	3	3
Montana	2	2	2	2	2	2	2	2
Pazardzhik	3	4	4	4	4	4	4	4
Pernik	1	2	2	2	2	2	2	2
Pirdop						1	1	1
Pleven	6	6	7	7	7	7	7	7
Plovdiv	12	14	14	14	14	14	14	14
Razgrad	2	2	2	2	2	2	2	2

	2006	2007	2008	2009	2010	2011	2012	2013
Ruse	3	3	3	3	3	3	3	3
Shumen	4	4	4	4	4	4	4	4
Silistra		1	2	2	2	2	2	2
Sliven	2	2	2	2	2	2	2	2
Smolyan	2	3	3	4	5	5	5	5
Sofiya Grad	9	11	12	12	12	12	12	12
Sofiyska	9	10	10	11	11	11	11	11
Stara Zagora	6	8	8	8	8	8	8	8
Targovishte	1	1	1	1	2	2	2	2
Varna	6	7	7	7	7	6	7	7
Veliko Tarnovo	7	7	7	7	7	7	7	7
Vidin	1	1	1	1	1	1	1	1
Vratsa	2	5	7	7	7	7	7	7
Yambol		1	1	1	1	1	1	1
Total	**112**	**130**	**137**	**139**	**141**	**141**	**142**	**142**

Simbula Ltd. (2015) Health Establishments for Hospital Care in Bulgaria – Financial Outlook 2006-2013.

Unlike state- and municipally-owned HEHC, the formation of private HEHCs has taken place predominantly in the big cities and regions which have a relatively positive demographic and economic level of development: Burgas; Plovdiv; Sofia Grad; and Varna (99 private hospitals, or about 61% of all private hospitals in 2013).The biggest change is in Sofia Grad district where, in 2006, there were only fourteen but, by the end of 2013, there had appeared 52 privately-owned health establishments. The next biggest change was in Plovdiv district where, in 2006, there were only seven but, by the end of 2013, nineteen privately-owned health establishments.

At the opposite end of this trend are regions and cities which have a comparatively (in the Bulgarian context) low level of economic development and a declining demographic situation, where the emergence of private HEHC is very weak or even absent. Among the examples are districts such as Haskovo, Kardzhali, Lovech, Razgrad, Shumen, Vratsa and Sofiyska, which account for only one private HEHC over the whole period; or districts such as Pirdop, Dobrich and Silistra, where no private hospitals have emerged (see Table 3).

Table 3 – Total number of privately-owned HEHC, by district (2006-2013)

	2006	2007	2008	2009	2010	2011	2012	2013
Blagoevgrad	1	1	2	3	3	3	4	5
Burgas	2	4	6	9	9	12	13	13
Gabrovo	1	2	2	2	2	2	2	2
Haskovo	1	1	1	1	1	1	1	1
Kardzhali	1	1	1	1	1	1	1	1
Kyustendil	2	2	2	2	2	2	2	2
Lovech								1
Montana		2	2	2	2	2	2	2
Pazardzhik	4	4	5	5	5	5	5	5
Pernik			1	1	1	1	1	2
Pleven	2	3	3	3	3	3	3	4
Plovdiv	7	9	10	10	12	16	18	19
Razgrad	1	1	1	1	1	1	1	1
Ruse	2	3	4	4	4	5	5	5
Shumen						1	1	1
Sliven	3	7	7	8	8	8	9	9
Smolyan								2
Sofia Grad	14	23	29	33	38	41	47	52
Sofiyska				1	1	1	1	1
Stara Zagora	5	5	6	6	6	7	7	7
Targovishte		1	2	2	2	2	2	2
Varna	8	8	11	12	13	14	15	15
Veliko Tarnovo	1	1	1	1	2	2	2	2
Vidin								1
Vratsa		2	3	4	4	4	4	4
Yambol		1	2	2	3	3	3	3
Total	**55**	**81**	**101**	**113**	**123**	**137**	**149**	**162**

Simbula Ltd. (2015) Health Establishments for Hospital Care in Bulgaria – Financial Outlook 2006-2013.

Accessibility of hospital care

On the basis of this quantitative data, it is logical to conclude that the territorial allocation of HEHCs seems to be adequate to the demographic characteristics of Bulgaria's regions. This does not mean, however, that the hospital net and the accessibility of hospital services are at the same, adequate level in all the regions in Bulgaria. Even the available hospital beds in Bulgaria, which stand at 644 per 100 000 – one of the highest ratios in the EU (Eurostat, 2015) – is no more than a quantitative indicator for the system. There are also other important qualitative factors that significantly influence the degree of accessibility to hospital services, such as the geographic characteristics of the different districts (the territorial allocation of hospitals – i.e. the concentration in each region); infrastructural characteristics (roads; population density and concentration; and the topographical specifics of each district); or the characteristics of populations' hospital care needs (*Институт за пазарна икономика*, 2015: 5).

Actually, despite the quantitative data, the population's evaluation of the accessibility of healthcare services (in particular of hospital care services) shows a rather different picture in the country. For example, in a comparative context, Bulgaria, Latvia and Romania are the EU member countries in which the biggest part of the population claims that it does not have access to necessary health services. In 2006, this was the situation for 19.2% and, in 2013, for 8.9% of the Bulgarian population, compared to an average of 3.6% for the EU-28 in 2013 (Eurostat, 2015). One of the rare public opinion studies gives us even more convincing data about the functioning of hospitals in Bulgaria. In 2012, the highest positive rate concerning hospital services reached on average 60%, but only in the districts of Varna, Targovishte and Ruse (*Институт за пазарна икономика*, 2015: 17). Albeit lower, yet still clearly positive (over 50% in approval), is the evaluation of hospital services in districts such as Lovech, Silistra, Kardzhali and Pleven (*ibid*: 17). Placed at the opposite end of the scale are almost one-half of the country's districts, for instance Pernik, Kyustendil, Stara Zagora, Sofia and Plovdiv, where public opinion about the accessibility and quality of hospital services is predominantly negative (*ibid*: 17).

Summary – the Bulgarian hospital care system

Looking at this presented data and the trends they describe, it is possible to draw some conclusions and point to some problems which are relevant to the development of the Bulgarian hospital system. The first and most obvious conclusion is that some of the goals of the reform, started in 1997, have been formally reached. This is true with respect to the initial ideas of introducing elements of liberalisation and privatisation into the Bulgarian healthcare system. Concerning the branch of hospital healthcare, this is visible through the appearance of private HEHCs. Doubtlessly, the formation of a growing private sector in the Bulgarian hospital system has been the most dynamic trend for the period after 2001.

To draw a general conclusion about the appearance dynamics of new hospitals, in terms of the total number and their territorial allocation, is a good step towards acquiring some knowledge about the development of the system of Bulgarian HEHCs. However, the collected data and the trends they describe give much more concern to

think about the evolution of this system in general, especially when we take into consideration criteria like coverage, efficiency, and so on.

From this point of view, one of the important questions for discussion here is how to understand and explain the almost avalanche-like process of the growth of private hospitals in the Bulgarian HEHC system. In discussing this, we have to keep in mind firstly that, before the reforms, the Bulgarian HEHC system was often characterised and criticised as inefficient and hypertrophied with respect to the total number of hospital beds and the classic, inflexible (from a costs point of view) methods of hospital healthcare. Secondly, it is also important to note that, during the reforms, the existing net of public hospitals has remained relatively unchanged, taking into account the dimension of the total number of hospital beds. According to Eurostat data, after 1997 the dynamics of the total number of hospital beds per 100 000 people in Bulgaria shows relatively small changes. In 2000, the number was 741.1 and, in 2011, it dropped to 644.8, but it has remained pretty high compared to the EU average (564.4 for 2007) and is still one of the highest among the new member states of the Union (Eurostat, 2015). If we take into consideration that, after 2011, new hospitals have been created and the population has continued on its existing diminishing trend, it is obvious to presume that these numbers did not drop until 2013 and that, possibly, they have even increased.

In this general context, and only in terms of trying to think about the development and evaluation of the HEHC system as a whole, it is more than reasonable to discuss the process of this appearance of private hospitals.

At first glance, a reasonable – and partially correct – explanation is to interpret this trend through the results of healthcare reform after 1997. It is both logical and obvious to conclude that liberalised regulation has opened the doors to the existence and functioning of a much more flexible HEHC system, characterised by high levels of competition among the providers of hospital healthcare. There is no doubt about the importance of the competition element in the functioning of the Bulgarian HEHC system, and there are no serious arguments against the existence of a private branch of hospital care. To be as clear as possible: the problem does not consist in the dilemma 'public vs. private', but at the level of the whole HEHC system and its strategic development with regard to the coverage of hospital care and the effective use of limited resources.

The first step in this direction is to realise that the present development of the Bulgarian HEHC system is a result (both in its positive and negative aspects) of the reform process and its successes and failures. It was pointed out above that the liberalisation of the system is one of the successes and, indeed, this has managed to open hospital healthcare to private initiative and to new investments. However, when we think about the whole system, we also have to admit some very important failures of the reforms.

From a general perspective, and bearing in mind the inherited problems of a too costly HEHC system, overloaded as it was with hospital beds, the reforms did not achieve sufficient optimisation. One of the important failures in this direction was the rejection in 2001 of the original reform step to open up the existing HEHC system for partial privatisation and the refusal to close some hospitals. This political de-

cision led to significant consequences. Firstly, despite being liberalised in the sense of the possibilities which had been established for the entry of private providers, the existing public HEHC system was closed to private investment. Second, much of the stipulated modernisation and optimisation measures for the public branch were politically blocked or only partly completed.

In this way, the further development of the whole HEHC system was presupposed to proceed in a very specific and paradoxical direction from the point of view of strategy and efficiency. New investment was 'pushed out' of the existing hospital net and compelled towards the orientation of activities 'from scratch', with all the cost consequences that proceed from this (new buildings, all the necessary equipment, and so on). Furthermore, the chance of attaining positive synergies from a new public-private mix in hospital healthcare was lost almost irreparably, when we think about the different possible modernisation and optimisation dimensions such as, for example: building in a cost-friendly way on the existing capacity of the HEHC system; implementing modern and more efficient methods in hospital management; and so on.

It is pertinent to mention at this point one of the lasting and, perhaps, most critical consequences. From a strategic point of view, by separating and not co-ordinating the public and private HEHC branches, a 'Frankenstein-like' path of general development has been created. The wave of private investment started to structure its activities in parallel to the public HEHC net instead of modernising and optimising it, where both necessary and possible, or instead of upgrading and supplementing the system with health services that were lacking and with a better quality of delivery.

From the territorial point of view, the creation of new hospital beds was situated in those regions and cities where no such need existed. Furthermore, this led to an inefficient concentration of hospital resources in some regions, often disconnected with actual health needs, and a lack of these resources in others which were, often, peripheral in terms of their demographic and economic development. Last but not least, free entrance into the HEHC system was not bound up with, or subordinated to, any strategic medium- or long-term vision of development. Besides, the regulation of the system does not entail any possibilities and criteria (political, administrative or market-driven) for a denial of the entrance of a new provider, or for the disqualification of already-existing providers. In many respects, the result is an 'overcrowding' of providers which use all possible channels to access a portion of the limited resources for hospital healthcare, and without any mechanism for a 'sifting out' with reference to some meaningful criteria or strategic goal.

All of these trends and problems form a complex of fundamental challenges and are part of the paradoxical development path of the present-day Bulgarian HEHC system.

Furthermore, as already noted, this article is focused predominantly on two questions: the accessibility of hospital services; and the efficiency of the use of resources. In this sense, it therefore does not focus on other important challenges in the system, such as: the adequacy of the financial model of the HEHC system; the level of hospital management, the quality of hospital care services; and others.

Healthcare reforms as at 2015: adequacy and perspectives for success

The significant problems in the functioning of the Bulgarian healthcare system have led to an ongoing debate about the necessity of further reforms. However, the policy responses formed as far as 2014 have been focused on the preservation of the *status quo* and have predominantly encompassed attempts at improvements in system efficiency through administrative measures and restrictions in the growth of healthcare costs. It was in 2014 when, under the slogan 'Reform through goals' the new government presented a project for healthcare reform that was proclaimed to aim at improving the health status of all age groups in the population (*Министерство на здравеопазването*, 2014).[8] The instruments for achieving this goal are set into four basic reform packages aimed at regrouping each of: activities; financial resources; healthcare structures; and human resources (*ibid*.).

The analysis of the whole reform is a task beyond the scope of this article, not least because most of the intentions behind the reform are still at blueprint level and are scheduled to be implemented as specific actions in the coming future. Furthermore, the narrowed focus of the article presupposes the most detailed interest in the third set of changes – the regrouping of health structures. The essence of this element of reform consists in the implementation of the so-called National Health Map (NHM) which includes steps such as (*ibid*.):

- implementation of a system that renders an account of and evaluates the health needs of the population (according to types of illness)
- implementation of compulsory minimum and maximum standards on the territorial allocation of health structures, based on the health needs of the population
- transition to the principle of moderate polycentrism in the organisation and governance of hospital services
- planning of public and private investment in the healthcare system, based on an evaluation of objective needs and access to public finances on the basis of need
- optimisation of the structure of healthcare establishments
- implementation of an accreditation system for all healthcare establishments.

Of course, this brief description of the NHM gives only a general idea about the reforms that are intended. Insofar as the goal of this article is the evaluation of reform, it is necessary for the NHM project to be analysed here according to at least two criteria: its adequacy as regards the existing problems; and the perspective for its successful implementation.

8 The main goal is improvement in the health status of all population groups. This is to be operationalised through five national healthcare goals: for children between 0 and 1 year of age (a 20% decrease in the mortality rate within a ten-year period); for children between 1 and 9 years of age (a 20% decrease in the mortality rate within a ten-year period); for young people between 10 and 19 years of age (a 20% decrease in the mortality rate within a ten-year period); for citizens of work age between 20 and 65 years (an increase in working capacity and a 20% decrease in the mortality rate within a ten-year period); for citizens aged over 65 (a 20% increase in average life expectancy after the age of 65 within a ten-year period).

Adequacy of the National Health Map reform package

The reform project establishing the National Health Map (NHM) could be evaluated as an adequate step towards answering the existing problems and challenges in the Bulgarian hospital system. There are several grounds for such a conclusion.

It is of paramount importance that the NHM project in itself is evaluated as the first attempt after 1997 at the creation and maintenance of a structuralised regulatory and governance process in healthcare that is subordinated to some strategic goals and development criteria. In this sense, the NHM is based on two criteria: the governance and development of the healthcare system according to the health needs of the population; and a subordination of the usage of public resources to health needs. The combined implementation of these two governance criteria is aimed at creating a functional and developmental logic that is qualitatively different to the *status quo*, as well as at directly addressing some of the existing problems in the healthcare system.

A case in point is the intention to implement an evaluation of healthcare needs and setting minimum and maximum standards for the territorial allocation of healthcare structures in the country. This idea corresponds directly to the problem of the mis-match between the health needs of the population and the territorial allocation of healthcare establishments (including hospitals) and resources. Additionally, the implementation of quantity standards (for parameters such as the number of healthcare establishments; the number of hospital beds; the number and type of medical personal; and so on) opens up possibilities for a coherent and strategically-oriented path for the regulation and governance of healthcare structures and the establishment of a clear definition of public responsibility in the sector.

This is particularly visible in the in-patient sector through the principle of moderate polycentrism, as proclaimed by the government. The idea behind this is to stimulate the formation of flexible centres for hospital care (single hospitals or a consortium established on a functional or legal base) that are operationally capable of delivering the complex and full treatment of illnesses of national importance and of meeting the health needs of the population in the different regions of the country. Furthermore, the intended changes in the Health Establishment Act embrace and implement the idea that the use of public resources for hospital care, through contracting with the NHIF, have to be preconditioned by the capability of all hospital care establishments (regardless of their form of ownership or way of functioning and organisation) actually to deliver such complex and full treatments.

This step also attempts, in a specific way, to overcome the two-path development between public and private HEHC nets and to stimulate possible synergy effects with regard to the improvement of healthcare services and the treatment of the population. An additional element of system optimization as regards this step is the belated, but nevertheless declared, intention to restart and implement the process of the privatisation and merger of public hospitals.

The last component of the NHM, but not least in importance, corresponds directly to the problem that there are too many hospital care providers. In this case, the NHM is seeking to regulate the access of hospital care providers to available public resources by implementing new criteria based on quality and a verification of the necessity of the delivered services. In particular, the NHIF is allowed to choose its con-

tract partners in hospital care (through official procedures of hospital attestation and evaluation), according to the main criteria included in the NHM: the quality of the services delivered; and the capability of providing full and complex treatment of specific groups of illnesses. At its core, this reform step introduces two very important elements into the governance of the hospital care system: a mechanism for the 'sifting out' of providers; and a possibility that public resources for hospital care are used in a more efficient way, consistent with healthcare needs and national priorities.

Perspectives for successful realisation

Sufficient arguments have been pointed out to conclude that the NHM project has a high degree of adequacy with regard to the problems in Bulgarian healthcare and, in particular, with regard to the hospital care sector. Despite this, the future development and prospects for success even of this single reform package are riddled with uncertainty and difficulties.

One of the very important problems here is the significant lack of clarity on the method and procedures of the preparation and actualisation of the NHM and its 28 district segments. The vital role of the Ministry of Health here is indisputable. However, if this process does not embark on a maximum of interest representation and expert knowledge, there is a series of risks concerning the adequacy of the criteria and standards which are included in the NHM. Furthermore, the intended reform steps presuppose the availability of significant functional, expert and administrative capacity in all the institutions involved, as well as a high level of transparency and openness of its procedures. These are the single credible guarantee against any possible 'preferences by the administration' – or, to put it simply and bluntly, against corruption in the regulation of access to public resources.

Besides these dimensions, the successful realisation of the intended reforms directly depends on the character and structure of the political environment and the decision-making process. In this sense, all possible analyses and prognoses for the further development of the reform plans have to be built on shaky ground. In the first place, this is because of the fragmented and often quicksand-like structure of the majority in the present-day Bulgarian parliament with regard to a broad range of important political decisions. The existence of many veto-wielding players in the four-party government majority is a precondition for unpredictability and makes the change or even blocking of reform (or of some important elements of it) highly possible.

Furthermore, compared to the reforms in the period 1997-2001, the one from 2014-2015 has to be negotiated and implemented across a much more structured environment founded on institutionalised interests in the healthcare sector. The activation of the existing professional organisations and the growing number of protests against particular elements of the reform are a clear sign that some players in the healthcare sector prefer the *status quo* or, otherwise, have a different vision of the philosophy and content of the needed reforms.

References

In English:

Carrin, Guy (Ed.), with Kent Buse, Harald K. Heggenhougen and Stella R. Quah (Co-Eds.) (2009) *Health system policy, finance and organisation* Oxford: Academic Press.

Deacon, Bob (2000) 'Eastern European welfare states: the impact of the politics of globalization' *Journal of European Social Policy* 10(2): 146-161.

Dimova, Antoniya, Maria Rohova, Emanuela Moutafova, Elka Atanasova, Stefka Koeva, Dimitra Panteli and Ewout van Ginneken (2012) *Bulgaria: Health system review. Health Systems in Transition 14(3)* Copenhagen: WHO Regional Office for Europe.

Dimova, Antoniya, Maria Rohova, Miroslav Popov and Rachel Bernd (2012) 'Health reform in Bulgaria' in Will Bartlett, Jadranka Božikov and Bernd Rachel (Ed.) *New perspectives on South-East Europe. Health reforms in South-East Europe* UK and USA: Palgrave Macmillan, pp. 49-63.

Esping-Andersen, Gøsta (1990) *Three Worlds of Welfare Capitalism* Cambridge: Polity Press.

Eurostat (14 June 2015) *Self-reported unmet needs for medical examination, by sex, age and reason*
http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do

Eurostat (15 April 2015) *Hospital beds per 100 000 inhabitants*
http://ec.europa.eu/eurostat/tgm/table.do?tab=table&init=1&language=en&pcode=tps00046&plugin=1

Normand, Charles (1995) 'Choosing and funding a healthcare program in the transition' in Željko Bogetić and Arye L. Hillman (Eds.) *Financing government in the transition: Bulgaria. The political economy of tax policies, tax bases and tax evasion* Washington, DC: World Bank regional and sectoral studies, pp. 225-242.

Simbula Ltd (2015) *Health Establishments for Hospital Care in Bulgaria - Financial outlook 2006-2013* Sofia: Simbula Ltd (forthcoming).

World Bank (2015) *Health expenditure, total (% of GDP)*
http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS

World Health Organisation (6 September 2015) *Global Health Expenditure Database: Total expenditures on health/per capital at Purchasing Power Parity (NCU per US$)* http://apps.who.int/nha/database/ViewData/Indicators/en

In Bulgarian:

Институт за пазарна икономика (2015) *Регионални профили: характеристики на здравеопазването по области в България*, София: И.П.И.
http://www.regionalprofiles.bg/var/docs/HC_Regional_Profiles.pdf

Министерство на здравеопазването на РБ (2015) *Управленски цели и приоритети* http://www.mh.government.bg/bg/politiki/upravlenski-tseli-i-prioriteti/

Министерство на регионалното развитие (2012) *Северен централен район. Социално-икономически профил* http://mrrb.government.bg/?controller=category&catid=69

Министерство на регионалното развитие (2012) *Северозападен район. Социално-икономически профил* http://mrrb.government.bg/?controller=category&catid=69

Министерство на регионалното развитие (2012) *Североизточен район. Социално-икономически профил* http://mrrb.government.bg/?controller=category&catid=69

Министерство на регионалното развитие (2012) *Югозападен реайон. Социално-икономически профил* http://mrrb.government.bg/?controller=category&catid=69

Министерство на регионалното развитие (2012) *Югоизточен район. Социално-икономически профил* http://mrrb.government.bg/?controller=category&catid=69

Министерство на регионалното развитие (2012) *Южен Централен район. Социално-икономически профил* http://mrrb.government.bg/?controller=category&catid=69

Национална здравноосигурителна каса (2014) *Анализ на стабилността на здравноосигурителния модел – рискове и предизвикателства пред НЗОК и отчет за текущо изпълнение на закона за бюджета на НЗОК към 30.04.2014. и очаквано изпълнение на бюджета на НЗОК към 31.12.2014* София: НЗОК http://nhif.bg/c/document_library/get_file?p_l_id=11276&folderId=13219&name=DLFE-10559.pdf

Томова, Татяна (2000) *Теория на социалната политика* София: Парадигма.

Annex – Total number of health establishments for hospital care, by district and form of ownership (2006-2013)

Year	2006	2007	2008	2009	2010	2011	2012	2013
Blagoevgrad	**10**	**11**	**12**	**13**	**13**	**13**	**14**	**15**
Municipal	7	8	8	8	8	8	8	8
Private	1	1	2	3	3	3	4	5
State	2	2	2	2	2	2	2	2
Burgas	**11**	**14**	**17**	**20**	**20**	**23**	**24**	**24**
Municipal	7	8	9	9	9	9	9	9
Private	2	4	6	9	9	12	13	13
State	2	2	2	2	2	2	2	2
Dobrich	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Municipal	3	3	3	3	3	3	3	3
State	2	2	2	2	2	2	2	2
Gabrovo	**5**	**7**	**7**	**7**	**7**	**7**	**7**	**7**
Municipal	2	2	2	2	2	2	2	2
Private	1	2	2	2	2	2	2	2
State	2	3	3	3	3	3	3	3
Haskovo	**10**	**10**	**11**	**11**	**11**	**11**	**11**	**11**
Municipal	8	8	9	9	9	9	9	9
Private	1	1	1	1	1	1	1	1
State	1	1	1	1	1	1	1	1
Kardzhali	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Municipal	3	3	3	3	3	3	3	3
Private	1	1	1	1	1	1	1	1
State	1	1	1	1	1	1	1	1
Kyustendil	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Municipal	1	1	1	1	1	1	1	1
Private	2	2	2	2	2	2	2	2
State	1	1	1	1	1	1	1	1
Lovech	**5**	**5**	**5**	**5**	**5**	**5**	**5**	**6**

Year	2006	2007	2008	2009	2010	2011	2012	2013
Municipal	3	3	3	3	3	3	3	3
Private								1
State	2	2	2	2	2	2	2	2
Montana	**3**	**5**	**5**	**5**	**5**	**5**	**5**	**5**
Municipal	2	2	2	2	2	2	2	2
Private		2	2	2	2	2	2	2
State	1	1	1	1	1	1	1	1
Pazardzhik	**10**	**11**	**12**	**12**	**12**	**12**	**12**	**12**
Municipal	3	4	4	4	4	4	4	4
Private	4	4	5	5	5	5	5	5
State	3	3	3	3	3	3	3	3
Pernik	**2**	**3**	**5**	**5**	**5**	**5**	**5**	**6**
Municipal	1	2	2	2	2	2	2	2
Private			1	1	1	1	1	2
State	1	1	2	2	2	2	2	2
Pirdop						**1**	**1**	**1**
Municipal						1	1	1
Pleven	**9**	**10**	**11**	**11**	**11**	**11**	**11**	**12**
Municipal	6	6	7	7	7	7	7	7
Private	2	3	3	3	3	3	3	4
State	1	1	1	1	1	1	1	1
Plovdiv	**20**	**26**	**27**	**27**	**29**	**33**	**35**	**36**
Municipal	12	14	14	14	14	14	14	14
Private	7	9	10	10	12	16	18	19
State	1	3	3	3	3	3	3	3
Razgrad	**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**
Municipal	2	2	2	2	2	2	2	2
Private	1	1	1	1	1	1	1	1
State	1	1	1	1	1	1	1	1
Ruse	**6**	**7**	**8**	**8**	**8**	**9**	**9**	**9**

Year	2006	2007	2008	2009	2010	2011	2012	2013
Municipal	3	3	3	3	3	3	3	3
Private	2	3	4	4	4	5	5	5
State	1	1	1	1	1	1	1	1
Shumen	**5**	**5**	**5**	**5**	**5**	**6**	**6**	**6**
Municipal	4	4	4	4	4	4	4	4
Private						1	1	1
State	1	1	1	1	1	1	1	1
Silistra	**1**	**2**	**3**	**3**	**3**	**3**	**3**	**3**
Municipal		1	2	2	2	2	2	2
State	1	1	1	1	1	1	1	1
Sliven	**6**	**11**	**11**	**12**	**12**	**12**	**13**	**13**
Municipal	2	2	2	2	2	2	2	2
Private	3	7	7	8	8	8	9	9
State	1	2	2	2	2	2	2	2
Smolyan	**3**	**4**	**4**	**5**	**6**	**6**	**6**	**8**
Municipal	2	3	3	4	5	5	5	5
Private								2
State	1	1	1	1	1	1	1	1
Sofia Grad	**43**	**58**	**66**	**71**	**76**	**79**	**85**	**90**
Municipal	9	11	12	12	12	12	12	12
Private	14	23	29	33	38	41	47	52
State	20	24	25	26	26	26	26	26
Sofiyska	**10**	**11**	**11**	**13**	**13**	**13**	**13**	**13**
Municipal	9	10	10	11	11	11	11	11
Private				1	1	1	1	1
State	1	1	1	1	1	1	1	1
Stara Zagora	**13**	**15**	**16**	**16**	**17**	**18**	**18**	**18**
Municipal	6	8	8	8	8	8	8	8
Private	5	5	6	6	6	7	7	7
State	2	2	2	2	3	3	3	3

Year	2006	2007	2008	2009	2010	2011	2012	2013
Targovishte	**2**	**3**	**4**	**4**	**5**	**5**	**5**	**5**
Municipal	1	1	1	1	2	2	2	2
Private		1	2	2	2	2	2	2
State	1	1	1	1	1	1	1	1
Varna	**15**	**17**	**21**	**22**	**23**	**23**	**25**	**25**
Municipal	6	7	7	7	7	6	7	7
Private	8	8	11	12	13	14	15	15
State	1	2	3	3	3	3	3	3
Veliko Tarnovo	**9**	**9**	**9**	**9**	**10**	**10**	**10**	**10**
Municipal	7	7	7	7	7	7	7	7
Private	1	1	1	1	2	2	2	2
State	1	1	1	1	1	1	1	1
Vidin	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**3**
Municipal	1	1	1	1	1	1	1	1
Private								1
State	1	1	1	1	1	1	1	1
Vratsa	**4**	**10**	**13**	**14**	**14**	**14**	**14**	**14**
Municipal	2	5	7	7	7	7	7	7
Private		2	3	4	4	4	4	4
State	2	3	3	3	3	3	3	3
Yambol	**1**	**3**	**4**	**4**	**5**	**5**	**5**	**5**
Municipal		1	1	1	1	1	1	1
Private		1	2	2	3	3	3	3
State	1	1	1	1	1	1	1	1
Grand Total	**223**	**277**	**307**	**322**	**335**	**349**	**362**	**375**

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